Personal Qualities of the Clinical Psychologist

by

Rebecca Daw

A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Clinical Psychology

Coventry University, School of Health and Social Sciences and

University of Warwick, Department of Psychology,

May 2006

Table of Contents

List of Tables

Dedication

In memory of my Nan.

Acknowledgments

I would like to thank my academic supervisor, Stephen Joseph, for reading endless drafts of work, providing constructive feedback and for his kindness and morale boosting at times when I felt overwhelmed by the whole process. I am also grateful to Maxine Richards for her valuable feedback about report drafts and her help with the qualitative aspect of this report. Thanks to Ruth Fishwick for helping with editorial changes too.

I also thank the professionals who took part in the study. The project would not have been possible without those who agreed to take part. The honesty and openness with which they described their experiences made the project seem worthwhile.

Finally, some forms of social support and companionship are beyond measure. My very good friends Kelly, Niki, Adele and Zoë have always remained supportive and enthusiastic about my endeavours as has Jason. I'd like to acknowledge their part in this (keeping me sane) I hope I have made them proud.

Declaration

This thesis was carried out under the academic supervision of Stephen Joseph, Chartered Health Psychologist, who helped to design the study; assisted in the statistical analysis in chapters two and three and lent his editing skills to the written reports. Maxine Richards aided with the qualitative analysis in chapter three. Apart from this input the thesis is entirely my own work and has not been submitted for a degree to any other university. Authorship of any papers from this work will be shared with the above.

The literature review (chapter one) is being prepared for submission to Clinical Psychology Review (Daw & Joseph, in preparation). The main and brief papers (chapters two and three respectively) are being prepared for submission to Psychology and Psychotherapy: Theory Research and Practice (Daw & Joseph, in preparation; Daw and Joseph in preparation).

Summary

The person within the Clinical Psychologist is not often addressed in Clinical Psychology. The aim of this study as a whole was to consider the person who practices as a therapist and question why as a whole the profession does not acknowledge the more personable aspects of the profession.

The literature review (chapter one) looked at the development of Clinical Psychology in the United Kingdom. It illustrated how economic trends and the predominance of the medical model have affected Clinical Psychology practice and training in this country. The review suggests that the more personable aspects of therapy and empirical research are not given their due credence because of the overarching arm of the medical model and it's "specificity" mentality. The first study (chapter two) looked at psychological mindedness (PM) in therapists; something deemed to be almost inherent in this population. The study aimed to gain empirical evidence that PM is associated with adaptive therapist attributes. Correlational analysis revealed significant positive associations between PM and clinician empathy, self-understanding and the therapeutic relationship. The second study (chapter three) was concerned specifically with personal therapy in qualified therapists. Interpretative phenomenological analysis (IPA) of responses to questionnaires revealed personal and professional benefits of engaging in personal therapy. The study also hypothesised that the small response rate evident in this study highlighted the longstanding reluctance of psychotherapists in this country to discuss personal experiences of therapy, a concern and matter for further research. Finally the research review (chapter four) considers how I now value the people as paramount in the therapy room rather than the diagnosis. The process which facilitated this change in me is documented and reflected upon.

CHAPTER ONE

The Therapeutic Relationship in Clinical Psychology: A Review of Evidence and Theory

Abstract

In the United Kingdom Clinical Psychology began to emerge as a distinct profession after the Second World War. At this time Clinical Psychologists engaged in legitimising a psychological approach to mental ill health in a context dominated by the medical model. Today psychological approaches in treating mental ill-health are mainstream practice.

This review draws the reader's attention to ways in which the historical development of the profession has shaped current Clinical Psychology training and practice. The paper has four aims; 1) to outline Clinical Psychology's development in the UK. 2) To review the empirical evidence regarding therapeutic change in psychotherapy. 3) To put forward the evidence base regarding "common factors" and the "therapeutic relationship" and consider the medical model, current economic market conditions and state-of the-art manualised treatments in this evidence. 4) To discuss current practice trends and implications for Clinical Psychology.

The paper concludes that further empirical evidence, generated by Clinical Psychologists, is needed to show the efficacy of the therapeutic relationship and inadequacies of manualised treatments. It also suggests that to coexist medicine and psychology should come to value the different intervention pathways that each has to offer to the other.

1.1. Introduction

In the United Kingdom Clinical Psychology began to emerge as a distinct professional sub-group after the Second World War, which brought the small number of practicing psychologists into applied work. Initially the profession was involved in two struggles, one within the profession, the second outside. Within the profession confusion regarding the role of the Clinical Psychologist predominated. Whilst trying to establish common ideas and goals within the profession Clinical Psychologists also engaged in legitimising a psychological approach to mental ill health in a context dominated by the medical model.

Since these fraught beginnings Clinical Psychology has developed significantly and is now perceived as a profession in its own right, able to effectively treat various psychiatric disorders. Psychological approaches in treating mental ill-health are now mainstream practice. In the UK, as the prominence of psychological perspectives has grown so have the number of professions offering psychological interventions to reduce distress. Clinical Psychology sets itself apart from these professions by highlighting its "scientist" ideology. This review draws to the attention of the reader the ways in which the historical development of the profession has shaped current clinical practice.

1.1.1. Aims of the paper

The paper has four aims; 1) to outline the context within which Clinical Psychology has developed in the UK. 2) To review the empirical evidence regarding what facilitates therapeutic change in psychotherapy. 3) To put forward the evidence base regarding "common factors" and the efficacy of the "therapeutic relationship". Then consider how the medical model and current economic market conditions have shaped the ability of the profession to produce and review empirical evidence contrary to empirical, state-of the-art manualised treatments. 4) To discuss current practice trends and ask why defined, manualised ways of working are more readily accepted. Potential accommodations within Clinical Psychology regarding common factors and the therapeutic relationship are discussed as are potential stumbling blocks.

1.1.2. The Beginnings: An Historical Overview of Clinical Psychology in the UK.

Clinical Psychology claims a unique identity as a healthcare profession grounded in the science of psychology. Clinical Psychologists market and promote themselves as "scientist-practitioners", practitioners using therapeutic skills in conjunction with scientific evidence and method to apply psychological knowledge to individual distress. As such this includes the review of empirical evidence regarding the efficacy of interventions and their application, as appropriate, to service users. If an evidence-based intervention does not exist the Clinical Psychologist is equipped to apply scientific principles of observation, hypothesis generation and testing to the

individual (Shapiro, 2002) and hence derives a tailor made intervention grounded in science.

The premise of "scientist" in Clinical Psychology is deep rooted. In the UK it can be linked to both the historical context of the emerging profession; dominated by the medical model and its positivist and empirical foundations and Eysenck's vision of Clinical Psychologists as "diagnostician-researcher" with an emphasis of experimental method in the pursuit of empirically driven knowledge (Corrie and Callahan, 2000).

1.1.3. The Influence of the World Wars

In the UK the profession really developed after the Second World War. Until then psychological models of adult mental ill health were not accepted by the medical profession. Hall (personal communication) refers to psychologists working with children in "child guidance settings" before this time. Skultans (1979) argued that the medical profession conceptualised "madness" as an "illness", a medical problem to be managed and cured, originating from degenerate human stock. Such a model located the problem as belonging inside the individual rather than in the social context of the time (Pilgrim and Treacher, 1992). Some authors have argued that psychological approaches were put forward before this time but were not taken seriously (Castel, 1985; Digby, 1985; Donnelly, 1979).

The Boulder Conference (in Colorado in 1949) crystallised and defined the scientist-practitioner model, to the emerging profession. This advocated the importance of training psychologists to be equally skilled in research and therapeutic practice reflecting the belief that psychologists should contribute to scientific psychology and achieve a precision in therapeutic practice to mirror the discipline of academic psychology more generally (Corrie and Callahan, 2000). The dual function of this model was to safeguard the public against poor practice and give the profession a clear identity and direction (Long and Hollin, 1997).

In the UK psychologists were still attempting to establish a clear identity by advocating themselves as a viable discipline to the medical profession. The practice of UK Clinical Psychologists was originally derived from medical practice and predominately involved assessment. The scientist-practitioner model was interpreted in the UK to mean a heavy emphasis on "testing" and statistical analysis (Hall, 1993; pp5). Hans Eysenck was the most influential advocate, in the UK, of professional psychology at this time. In contrast to the US scientist-practitioner model he regarded the therapeutic role as "alien" to Clinical Psychologists (cited in Pilgrim and Treacher, 1992; p41). Rather, he believed that the role of the Clinical Psychologist was pure "scientist" and that social need (the post war economic boom and expanding National Health Service) should not interfere with scientific requirements. In 1952 he published a paper regarding the lack of efficacy of verbal psychotherapy arguing that therapeutic intervention should not be an essential part of training for Clinical Psychologists. Interpreting the "Boulder model" in light of empiricism he stated

Clinical Psychology demanded competence in diagnosis and research and nothing else. Eysenck stipulated if practicality made this role desirable then a separate discipline should be created to work alongside Clinical Psychologists (Eysenck, 1949). Eysenck argued that diagnosis and research were large enough areas to work within and the inclusion of therapy would inevitably result in lower skill and knowledge in all three areas. Similar views were shared by other predominant psychologists of the time Raven (1950) claimed that the main task of the psychologist "*was to understand clients – therapeutic involvement could only contaminate this process*" (cited in Hetherington, 1981; p13).

1.1.4. Psychologists Practice Therapy

Eysenck's position ultimately proved unsustainable and therapeutic practice now underpins the training of the profession. This transition occurred in the late 1960s and early 1970s when the profession began to flesh out the role of Clinical Psychologists (Pilgrim and Treacher, 1992). Psychologists wanted to become active practitioners who were willing and able to offer therapy. At that time, mental health care also required skilled therapists and training for Clinical Psychologists became increasingly practice orientated. Although Eysenck's position now appears misguided his emphasis on expertise in research design, diagnosis and scientific status ensured the profession would have a unique role to play in post-war health care (John, 1984) and gained the necessary prestige to ensure the survival of the profession (Lavender, 1996 in Corrie and Callahan, 2000).

Behaviour therapy, developed during the 1950s, gave Clinical Psychologists a platform to deliver psychological therapy derived from established psychological theory. It was an empirically testable model of human change that could generate healthy, refutable hypotheses (Horvath, 2005). Use of an evidenced-based therapy by Clinical Psychology increased the legitimate expansion of training numbers necessary to acquire greater independence from dominant medical models. Therapy could now be delivered without jeopardising the scientific kudos of the Clinical Psychologist. Horvath (2005) states the advantages and opportunities offered by the behavioural model were significant in shaping a "scientifically based profession".

There was little exploration of other therapeutic models, at this time, other than the well-established psychodynamic models. However these were not regarded as what "*forward thinking Clinical Psychologists of 1968 ought to be doing*" (Hall, 1993 p5). Excluding everything except that which could be observed meant concepts such as the therapeutic relationship and cognitive processes were outside the realms of empirical research. Subsequently when other theories such as "Personal Construct Theory" were developed it gave way to a new type of therapy. The psychologist was required (and allowed) to understand, explain, interact and intervene. These novel practices were based on science; but until now had not been accepted by the majority. Practitioners were to involve themselves in therapeutic practice and intervention. The scientist-practitioner model of working was finally established.

The 1970s saw clinicians increasingly beginning to deliver therapy in contexts very different from their academic origins (Kennedy and Llewelyn, 2001). The profession had grown rapidly and continued to do so as social changes in attitudes towards mental health problems ensued and the number of undergraduate courses in psychology grew.

1.1.5. Eysenck's Legacy

The context in which Clinical Psychology developed illustrates how Clinical Psychology was borne in a "scientist" ethos predominated by the medical model, positivist and empirical thinking. Psychologists traditionally were diagnosticians and researchers. The profession developed in a political, social and economic context where the medical model prevailed. The influence of the medical model and economic market is still apparent today, most evidently in the ethos of evidence-based or manualised treatments. This approach dictates that specific treatments should be used to treat specific disorders, as specific drugs are used to treat specific aliments. This culture encapsulates a medical model mentality which is observable in everyday practice within Clinical Psychology.

1.2. Psychotherapy: The Evidence

The uncertainties of Eysenck (Eysenck, 1952) and like-minded critics on the psychotherapies now lay dormant. Today it is well established that psychotherapy is effective (Lambert and Bergin, 1994; Wampold, 2000). The therapeutic benefits are no longer questioned. More than 40 years of outcome research, generated by

Eysenck's argument, makes clear that therapists are not witch doctors or over achieving do-gooders but valid health care professionals (Hubble, Duncan and Miller, 1999). Meta-analyses have provided an efficient, objective and empirical way of reviewing literature regarding psychotherapy outcome. Findings consistently show that psychotherapy treatment is better than no treatment (Andrews and Harvey, 1981; Landman and Dawes, 1982; Shapiro and Shapiro, 1982; Smith and Glass, 1977; Smith Glass and Miller, 1980).

Evidence of therapy's efficacy has been accompanied by rapid growth in the number of therapeutic interventions available. (Miller, Hubble and Duncan (1996) state the number of psychotherapies has grown by 600% since the 1960s) Research regarding the efficacy of interventions, specific components of interventions and the therapeutic process is also prevalent. Hence the areas of process, orientations, client and therapist characteristics have been explored in an attempt to identify what facilitates positive change.

Further to this the present economic and political climate makes it inevitable to question what intervention is most cost-effective and so the competition to become the "gold standard" of psychological interventions continues. Techniques such as the "randomised control trial" have been developed specifically to establish empirically validated treatments and therefore define what works best with whom to purchasers and consumers alike.

1.2.1. What works in Psychotherapy

Practitioners unfortunately are yet to agree on what enables psychotherapies to work. The debate that dominates literature is whether beneficial effects of psychotherapy are due to specific components of interventions or factors common in all therapies (Wampold, 2000). Two schools of thought exist regarding this area; the first group argues that efficacies of treatments are attributed to their specific ingredients, the second attributes efficacy to common factors.

"Specificity" versus "common factors"

"Specificity" can be defined as techniques which can be found and outlined in treatment manuals (Chambless and Hollon, 1998; Wilson, 1996; Task force on Promotion and Dissemination of Psychological Procedures, 1995). They can also be conceptualised as technical manoeuvres therapists engage in based upon theoretical orientation (Butler and Strupp, 1986). Ann and Wampold (2001) argue this is a hallmark of the medical model. They suggest these treatments are seen as an alternative to medical treatments as outcomes are attributed to specific ingredients of the intervention; commonly known as specificity.

Wampold and Bhati (2004) argue the evidence-based treatment movement (within which randomised control trials yield treatment manuals based on specificity) places sole emphasis on treatment. The absence of client and psychologist is perpetuated from consideration when thinking about interventions. Like Eysenck and the medical model, the majority of treatment manuals take "people "out of therapy. This

movement reflects the desire of Clinical Psychologists to use evidence-based practice – something central to the scientist-practitioner philosophy. However in emphasising the treatment rather than the people in therapy a wealth of evidence is overlooked. Wampold and Bhati (2004) suggest the importance of the people in therapy has been belittled in this approach additionally the importance of factors that are found in virtually all therapeutic interventions; common factors have also been ignored.

Hence the opposing school of thought stipulates that common factors in psychotherapy are the important therapeutic catalyst (Catty, 2004; Frank and Frank, 1991; Wampold, 2001). Rosenzweig (1936) first suggested that common factors of therapy may facilitate positive change rather than theoretical principles and techniques. He advocated that some factors cut across all treatments and for this reason different treatments with different approaches may all work equally well. Hence Rosenzweig predicted the empirical evidence which follows.

1.2.2. What works: The Empirical Evidence

In keeping with the tradition of Clinical Psychology it seems that only empirical evidence should be utilised when investigating the facts concerning specificity and common factors. Recent research has tried to resolve this debate using scientific methods such as meta-analyses, component studies and comparative studies (see Wampold, 2001, for a discussion on the research strategies used to look at specificity). Lambert and Ogles (2004) state that since Smith and Glass's 1977 review there have been extensive meta-analytic reviews for the treatment of

depression (N=19), anxiety (N=28) and other miscellaneous treatments and disorders (N=57). The most recent studies are summarised in the next section of this paper. The first group of studies presented use comparative methodology to verify whether one intervention is superior to others. The second group of studies look at the specificity of interventions using component studies in a bid to define what facilitates therapeutic change.

1.2.2.1. Comparative Studies

If specific ingredients are rudimentary in treatments for particular problems then one would hypothesise that some treatments are better than others. Many older reviews have analysed studies comparing psychotherapies (Bergin and Lambert, 1978, Beutler, 1979; Rachman and Wilson, 1980) the conclusion of most is that there is little or no difference between therapies. Such reviews drew these conclusions without meta-analytic procedures. Nevertheless, more recently, meta-analytic methods have been applied to large groups of comparative studies with similar results (Wampold, 2001). The next section reviews this evidence and specifically critiques three more recent comparative studies.

Comparative studies, where two or more modalities or treatment orientations are compared, frequently show generally all treatments produce equal outcomes (Wampold, 2000; 2001; Wampold, Mondin, Moody, Stich, Benson, and Ahn, 1997). This is also true of particular disorders such as depression (Elkin, Shea, Watkins, Imber, Sotsky, et al., 1989; Robinson, Berman and Neimeyer, 1990) and anxiety

(Wampold, 2001) with few exceptions. These studies failed to find any consistent differences in outcomes between modalities or orientation (Beutler, 1991; Lambert and Bergin, 1994; Miller, Duncan and Hubble, 1997).

Early meta-analytic reviews often illustrated a small, but consistent, advantage for cognitive and behavioural methods over traditional verbal and relationship-orientated therapies (Shapiro and Shapiro, 1982; Smith et al. 1980). Derubeis, Brotman and Gibbons (2005) highlight this in a recent paper stressing evidence for four cognitive and / or behavioural psychotherapies for which effective specificity has been identified: "*exposure and response prevention for obsessive compulsive disorder; cognitive therapy for panic disorder; exposure therapy for post-traumatic stress disorder; and cognitive behavioural group therapy for social phobia*" (Derubeis et al. 2005 p175). Unfortunately Derubeis et al., (2005) do not detail the studies from which these conclusions are drawn so it is difficult to critique this evidence however historically such differences have been explained through closer inspection of studies' methodologies (Lambert and Ogles, 2004).

For instance Smith et al., (1980) reported significant differences between behaviour therapy and other approaches using meta-analysis. These differences were reduced when the review took into consideration that the outcome measures were more reactive to experimental demand. Hence Smith et al., (1980) concluded that the differences between therapies were minimal. Smith et al's research also relied on cross-study comparisons; comparing behavioural therapy in one study with verbal

therapies in another. Lambert and Ogles (2004) suggest this methodology encompasses confounding variables within the studies, not just treatment modality they argue such comparisons are not as conclusive as within study comparisons.

Shapiro and Shapiro's (1982) extensive meta-analysis of 143 studies exclusively used studies comparing two or more active treatments (cognitive, behavioural) with control conditions. Their data contained more replicated comparisons between treatment methods ensuring more scientific comparison. Shapiro and Shapiro (1982) found that cognitive and various behavioural therapies yielded better outcomes than dynamic and humanistic therapies. In spite of this the authors attributed the differences to strong biases in the literature towards mild cases and highly reactive criteria. Shapiro and Shapiro (1982) suggested the cases and treatments studied were not representative of clinical practice. Lambert and Ogles (2004) warn that such criticisms should be heard but may not do justice to cognitive and behavioural interventions as they are based on post-hoc analysis.

Wampold et al. (1997) completed the most recent meta-analysis which reviewed evidence comparing treatments over a 25 year time period. This meta-analysis is regarded as more empirically sound for the following reasons. Only studies which directly compared two or more treatments were included, this eliminates the potential confounding variables as discussed before. Treatments were not classified into general types and only "bona-fide" psychotherapies were included in the analysis. Bona-fide treatments were described as "*those that were delivered by trained*

therapists and were based on psychological principles, were offered to the psychotherapy community as viable treatments or contained specific ingredients" (Wampold et al., 1997, p205).

To test whether one treatment was better than another, the calculated effect sizes of the two comparable treatments were randomly given a positive or negative sign. The distribution of effects was then tested to verify whether the variability in effect sizes were homogeneously centred around zero. Several data sets (dependent on the inclusion criteria of the studies) did not yield effect sizes that were heterogeneous, i.e. no true outcome differences between bona fide psychotherapies existed. Wampold et al. (1997) also state that the size of the effects were not associated to publication date. Improved research methods did not unearth "better" effect sizes, a finding Stiles, Shapiro and Elliott (1986) would expect. Stiles et al. (1986) argue all psychotherapies appear equally effective because research methods are insensitive to true differences among treatments. They suggest as methods improve, such differences will be revealed. Wampold et al's (1997) finding disputes this argument. Wampold et al (1997) concluded "*the evidence from these analyses supports the conjecture that the efficacy of bona fide treatments are roughly equivalent*" (Wampold et al, 1997. p203).

1.2.2.2. Component Studies

Component studies allow the investigator to determine the efficacy of an "ingredient" of an intervention by manipulating it. If specific ingredients of an intervention are

responsible for its benefits then this effect should be obvious when the intervention's ingredients are manipulated. The next section reviews two recent meta-analyses of component study literature.

Ahn and Wampold (2001) conducted a meta-analysis of component studies conducted over a nine year period. The meta-analysis investigated the degree to which studies support the "specificity" of psychological interventions. A comprehensive search for literature regarding outcome studies, between 1990 and 1999, was conducted. For a study to be included in the meta-analysis the necessary statistics had to be published and the authors checked studies were comparing psychological treatments that were bona fide, using the same criteria as Wampold et al. (1997). Ahn and Wampold's methodology stipulated;

> *"The treatment had to contain at least two of the following four elements: 1) The treatment was based on an established treatment that was cited, 2) a description of the treatment was contained in the article, 3) a manual was used to guide administration of the treatment, and 4) active ingredients of the treatment were identified and cited. Finally the study's design had to involve a comparison of one group with another group, and one of the following two conditions had to be satisfied: 1) one, two or three ingredients of the treatment were removed, leaving a treatment that would be considered logically viable (i.e. coherent and credible), or 2) one, two or three ingredients that were compatible with the whole treatment and were*

theoretically or empirically hypothesised to be active were added to the treatment, providing a "super-treatment"

(Ahn and Wampold, 2001; p252).

These parameters yielded 20 studies that compared 27 treatments. Ahn and Wampold (2001) stated components selected for addition to and subtraction from the treatment were *"hypothesised by the researchers to be efficacious according to the theoretical tenets of the respective treatment"* (p.254). Results indicated that treatment conditions with fewer components outperformed the treatment conditions with more components. The aggregate effect size for comparisons was not significantly different from zero and the effect sizes from the 27 comparisons were homogeneous. Ahn and Wampold (2001) concluded there were no variables that would change the overall effect size, which was not different from zero. Thus the meta-analysis did not support the notion that specific ingredients of psychological treatments are responsible for beneficial outcomes in psychotherapy. Ahn and Wampold (2001) went on to conclude that all treatment approaches result in similar beneficial outcomes.

In a later meta-analysis Baskin, Tierney, Minami and Wampold (2003) tested whether structural inequalities between placebo and active treatments contribute to the debate regarding efficacy in psychotherapies. They found that benefits from "placebo" psychological treatments were not substantially different from the benefits of "active treatments" (cognitive / behavioural treatments) if the placebo control was well designed i.e. the placebo treatment had the same number of sessions as the active

treatment and both groups contained equally trained psychologists who were permitted to discuss topics of importance to the patient. The reported aggregated effect size was statistically different from zero but negligible. These findings suggest specific components, even those highlighted and manipulated on the basis of theoretical tenets, do not benefit interventions significantly more than well designed placebos. Nevertheless Baskin et al (2003) recognise that all placebos in psychotherapy research contain one fundamental flaw: therapists are aware they are delivering a treatment that doesn't contain theoretically prescribed actions. Baskin et al (2003) suggest that therapists with this knowledge may not deliver treatment with the required commitment. In turn this may lead to less enthusiasm, less hopefulness, less engagement and less empathy hence the common factors in such controls may be comprised. Baskin et al (2003) maintain nonetheless that despite these flaws well-designed placebos are nearly as beneficial as active treatments.

1.3. Discussion

The discussion will entail 1) a summary of the evidence base, 2) the implications of explicitly incorporating common factors and the therapeutic relationship in Clinical Psychology training and clinical practice (point 3) and 4) consider future implications of this.

1.3.1. Summary of the Evidence Base

Specificity predicts that certain treatments will be particularly effective with clients with certain problems however theoretically predicted interventions between

treatments and client characteristics have very rarely been demonstrated as shown in Derubeis et al's (2005) article. The majority of research is not supportive of benefits of specific ingredients. Empirical evidence supports the notion which states benefits of psychotherapy are derived from common factors, further to this evidence suggests the therapeutic relationship accounts for most of the outcome variance (Silverman, 2005; Norcross, 2000). Wampold (2001) argues the lack of empirical findings suggests there is little evidence for specific ingredients facilitating positive change in psychotherapy. This is in direct conflict with the current trend of identifying evidenced-based treatments that report to be distinctively effective. Research spanning decades does not support the notion of one superior intervention or technique for specific disorders (Lambert and Ogles, 2004).

Is evidence put into practice? The Therapeutic Relationship

Due to the consistent findings on common factors research in this area has grown significantly. Grencavage and Norcross (1990) state the therapeutic relationship is the most frequently mentioned common factor. Most theoretical definitions of the therapeutic relationship have three common themes; a) the affective bond between client and therapist, b) the collaborative nature of the relationship and c) the client's and therapist's ability to agree on treatment goals and tasks (Bordin, 1979; Gaston, 1990; Horvath and Symonnds, 1991). Empirical research supports the link between a good therapeutic relationship and positive therapeutic outcome (Weinberger, 2002). Evidence suggests if a good relationship is established between client and therapist, the client will experience the interaction as therapeutic regardless of the theoretical

tenets of the intervention. Research advocates (Derubeis et al, 2005) that therapists who are unable to form a good working therapeutic relationship will rarely be successful in bringing about beneficial change in clients.

The literature investigating the relationship between the therapeutic relationship and outcome is vast. The two most recent papers are outlined which reviewed, through meta analysis, the empirical evidence regarding this phenomenon.

In the most recent review of studies concerned with the relationship between the therapeutic relationship and outcome Martin, Gaske and Davis (2000) conducted an update on Horvath and Symonds 1991 study. Martin et al. (2000) conducted a meta analytic review on empirical literature concerned with the therapeutic relationship and outcome. After an extensive literature search the data from 79 studies (58 published, 21 unpublished) were aggregated using meta analytic procedures. Martin et al. (2000) concluded there was a moderate but consistent association between the therapeutic relationship and outcome overall (22% of the variance). In addition, they stated that this occurs regardless of other variables which are said to influence this relationship (type of outcome rater, the time of assessment of the therapeutic relationship, the type of treatment provided or the publication status of the study).

Horvath and Symonds (1991) earlier meta-analysis, which Martin et al., (2000) based their study on also included published (N = 58) and unpublished (N = 21) empirical studies. The therapeutic relationship was found to have a reliably positive and

moderate effect on outcome across all forms of treatment. Further to this they reported that 26% of the difference in the rate of therapeutic success was accounted for by the quality of the therapeutic relationship. Similarly Gaston, Maramar, Gallagher and Thompson (1991) found that the therapeutic relationship was related to outcome even when initial symptomatology and symptom change were accounted for.

Hence the result of longstanding empirical research is supportive of the hypothesis that the therapeutic relationship may be therapeutic in and of itself (Horvath and Symonds, 1999; Horvath and Luborsky, 1993; Martin et al., 2000). Decades of research indicate that the main curative component in therapy is the nature of the therapeutic relationship (Lambert and Barley, 2001). Reviews of the empirical research have consistently reported a positive relationship between the therapeutic relationship and therapeutic outcome across studies (Gaston, 1990; Horvath and Greenberg, 1994; Horvath and Luborsky, 1993; Horvath and Symonds, 1991).

It is not obvious that this wealth of empirical evidence is explicitly accommodated into clinical psychology training or state-of-the-art practice. The next section discusses why this should be the case.

1.3.2. Training implications

Recent trends in training and practice favour models of treatment with narrow applications and precise definitions. Specific well defined interventions for identified

populations are fast becoming the norm. The following section of this review hypothesises why this is the case.

The meta analyses previously outlined concerning the "therapeutic relationship" encompasses a well researched and documented data set. Over a time span of decades this literature yields robust empirical evidence suggesting the therapeutic relationship is the "vehicle of success" (Catty, 2004; Freud, 1912). Lambert (1992) states it accounts for approximately 30% of client improvement (techniques account for 15%), yet this empirical evidence has not warranted the "therapeutic relationship" any real status or concrete place in the field. Consequently the therapeutic relationship is not given weight in training courses which predominately teach Clinical Psychologists how to bring about therapeutic change.

This phenomenon may be because no universal explanation as to how or why the therapeutic relationship facilitates change exists. Rosenzweig (1936) hypothesised that the relationship socially (re)conditioned the client. Psychoanalysts see the therapeutic relationship as a solid base or as providing a safe haven (Lachmann, 1971; Silverman, 1979). Humanists have discussed the freedom to make choices in complete safety (Meador and Rogers, 1984; Rogers, 1957b, 1958). There is no agreement on how or why the therapeutic relationship is therapeutic. Decades of empirical evidence suggests the therapeutic relationship is one of the most important facilitators of change. This is not translated into training possibly because a rationale cannot be agreed upon.

Further to this one might suggest that being able to engage with clients thus forming therapeutic relationships, is a skill clinical psychologist trainees should possess inherently. This is one skill that can be developed (through listening skills and counselling skills training) but not one that can be attained if it is not present to start with.

Presently Clinical Psychology sees itself as facilitating the integration of science and practice in training, although it evidently oversees longstanding evidence regarding common factors and the therapeutic relationship. Deegar and Lawson (2003) suggest by teaching trainees specific approaches and skills associated with evidenced-based research (specificity) the reliability of training is enhanced. Conversely Garfield (1998) argues by defining a specific list of evidenced-based treatments, rather than introducing the notion of common factors, training is restricted to a limited number of disorders. The use of a manual for each specific type of disorder would require mastery of hundreds of manuals, a frightening prospect for any trainee (Beutler, 2000b). Bohart (2000) suggests this approach is too closely based on the medical model, similar to prescribing a drug. To quote Wampold et al. (2001, p270) *"there is absolutely no scientific justification for continuing to think of therapy as a pill"*. Little similarity exists between medicine and the clinical work of psychologists. Clinicians see clients with multiple symptoms, maladaptive behaviours and sometimes serious character disorders - the messy world of real clients that a manual

does not address. Messer (2004) highlights such inadequacies in his paper about "Mrs. T":

> "*The point to be made here is that an EST* [empirically supported treatment], *while of some help in this case, could not by itself cover other ground that truly mattered to this woman. Hers was not a case of pure or even typical PTSD, as is true of many cases that are dually or triply diagnosed and multifaceted. In fact, the complexity of people's lives is not readily captured by diagnosis altogether*" (Messer, 2004, p585).

The group design that gives rise to evidence based manuals typically employs the application of one "pure form" theoretical approach which is then compared to another treatment for a specific problem. This research design does not reflect the idiosyncrisities that often define clinical practice. It does not allow for client characteristics, client-therapist dynamics and blending of treatments which occur in almost every clinical intervention. The vigorous parameters this research must endure to meet science actually decrease external validity and consequently the generalisability of findings to clients in the real world (Goldfried and Wolfe, 1996).

The medical model subscribes more readily to the specificity side of the debate. On the basis of limited findings which suggest some specific techniques are more effective than others (Derubeis et al., 2005) professionals continue to promote specific techniques. Advocates state the same to be true eventually of other disorders. As mentioned previously Stiles et al., (1986) suggest that research methods were insensitive to true differences among treatments and that as methods improved, such

differences would be revealed. Ahn and Wampold (2001) found this not to be the case. This idea dismisses the body of evidence for common factors. Defenders continue the search for specificity evidence with the premise that improvements in research will lead to evidence regarding its benefits (Ogles, Anderson and Lunnen, 1999). The evidence for common factors has remained steady over decades in spite of developments of standardised and manualised treatments, reliable outcome measures, developments in statistical methods and collaborative research designs (Wampold, Ahn and Coleman, 2001). One should question why some researchers hold on to the hope so zealously that evidence will be found regarding specificity.

1.3.3. Clinical Implications

If psychologists were to acknowledge the importance of common factors and predominately use the therapeutic relationship as the "vehicle" in therapy then they would have to acknowledge their impact on the relationship. Potential personal vulnerabilities which could produce counter-therapeutic reactions would require consideration. Such awareness allows vulnerabilities to be understood rather than manifested in the therapy. Personal reflection is a recognised way of facilitating this understanding in the therapist. Traditionally the *person* of the Clinical Psychologist has never become a legitimate area of discussion within psychology (Pilgrim and Treacher, 1992), the therapist (like the scientist) was traditionally trained in objectivity and hence the subjectivity of the person (the psychologist) was neatly ignored. Historically psychologists do not address "I" in the relationship. Eysenck

was emphatic that psychologists should not engage in personal therapy. He argued this would undermine the Clinical Psychologist's ability to be scientifically detached (Eysenck, 1949). One hopes that such an extreme view would be hard to find today however perhaps it is this legacy which keeps personal therapy and personal development optional components of most present day training courses.

1.3.4. Future Implications

If research findings regarding the therapeutic relationship and "common factors" were wholly accommodated by the profession implications for training and practice would inescapably follow.

<u>Training and Clinical implications</u>

Psychologists must of course make every effort to stay up to date with research and clinical findings in the field, including specialised treatment techniques. It is crucial however that psychologists engaging in therapeutic work acknowledge consistent empirical evidence which demonstrates relationship factors correlate more highly with client outcome than do specialised treatment techniques (Lambert and Barley, 2001). Psychologists' time should be devoted to developing the therapeutic relationship remembering that the development and maintenance of the therapeutic relationship is a primary curative component of therapy. The relationship provides the context in which specific techniques exert their influence. Given the importance of the facilitative conditions and the therapeutic relationship for successful treatment outcome, training in therapeutic relationship skills for the trainee Clinical

Psychologist is essential. Novice therapists should be educated about conditions and prerequisites which help build good therapeutic relationships. As much emphasis should be given to this element of training as is to training in techniques. More therapeutic models need to be developed that emphasise and give kudos to common factors and general relationship-building skills.

In order to objectively look at these elements within the relationship therapists should be given the opportunity to enhance their self understanding through "reflection" facilitated in professional and personal development. Bennett-Levy (2003) stated "*Reflection hasn't had just a poor press in psychology. Over the past 60 or so years, it has had almost no press at all*" (Bennett-Levy, 2003; pp16). He argues that the growth of behavioural and experimental psychology sent reflection into "*exile*" (pp16) stating that "*reflection is a behavioural scientist's nightmare – almost impossible to define tightly, and well nigh uncontrollable*" (Bennett-Levy, 2003; pp16). Perhaps this helps us to understand why such practice, until recently, has not been given kudos in Clinical Psychology training courses. Lavender (2003) also argues that the positivist approach to science which was adopted by Clinical Psychology (as discussed earlier in this review) meant that acknowledging or trying to find other ways of "knowing about the world" (pp12) were put on a back burner. He suggests that the dilemmas that this has produced are still evident in many current training courses and professional debates.

A recent study of training schemes illustrates this point. The majority of Clinical Psychology training course tutors, in the UK, emphasised evidence-based approaches, critical analytic thinking and academic ability as the key elements for future trainings 2000-2010 (Kennedy and Llewelyn, 2001). In this thorough and broad survey, there was no emphasis on either reflective practice or personal-professional development. Trainers repeatedly ranked research as higher in importance than did a matched sample of non-training clinicians. Interestingly, it was only the trainees in the study who indicated that clinical skills, therapeutic knowledge and good communication would be crucial elements (Thomas, 2004). Interestingly as a result of this research a number of predictions were added to this list during national meetings on Clinical Psychology Training (Kennedy and Llewelyn, 2001). These were that in the future courses will also place emphasis on trainees' personal awareness and personal qualities, and on the core competencies: consultancy skills, qualitative research methods and the need to carry out service related research which mirrors the idiosyncrasies of "real" work (Kennedy and Llewelyn, 2001).

The Committee on Training in Clinical Psychology has recently endorsed the "reflective practitioner" model within the new accreditation criteria for Postgraduate Training Programmes in Clinical psychology. The British Psychological Society now requires that Clinical Psychologists be trained as competent reflective scientist-practitioners (British Psychological Society, 2001). The required learning outcomes for trainees currently include "*the ability to demonstrate self-awareness and work as a reflective practitioner as well as think critically, reflectively and evaluatively*"

(Stedmon, Mitchell, Johnstone and Staite, 2003, pp30). This move towards reflective practice model recognises the importance of giving equal value to the different sources of knowledge that are utilised in Clinical Psychology (Stedmon et al., 2003).

Gillmer and Marckus (2003) report on a reflective workshop conducted by Hagen to examine and foster personal and professional development (PPD) in Clinical Psychology training (Hagen, 2001). Gillmer and Marckus (2003) suggest that PPD is central to the notion of a reflective practitioner but this remains peripheral to the real training issues which they believe lie in the domain of the scientist practitioner. Gillmer and Marckus (2003) asked Clinical Psychology training courses to comment on PPD in their curriculum. Just over half of the courses who responded (n=17) understood PPD to be concerned with self-awareness and the effect of individual history and training on professional development. Only one course specifically defined PPD as a focus on reflective scientist practitioner training. Gillmer and Marckus (2003) conclude that PPD is seen as the part of the curriculum that is dedicated to developing in trainees the ability to reflect critically and systematically on the work-self interface; developing self-awareness and resilience however they suggest PPD has been operationalised, in some training courses, but still remains an "*essentially atheoretical construct*" (pp 23).

A close look at references to "reflective practice" or developing "reflective practitioners" in the introduction / philosophy or background section of course outlines in the 2006 Clearing House for Postgraduate Course in Clinical Psychology

Handbook (Leeds University, 2006) revealed that 20 of the 30 postgraduate courses in this country state they help develop and facilitate this ethos and practice in their trainees.

If a therapist does not have self-awareness they cannot acknowledge their part in an interaction and hence they cannot objectively look at the relationship and utilise their scientific knowledge in trying to understand it. PPD is now a compulsory component of training courses which will hopefully facilitate this process (although note the concerns of Gillmer and Marckus, 2003) and thus bring the objectivity that Eysenck argued it would tarnish. It seems that training courses are beginning to acknowledge this phenomenon with a growing recognition (Galloway, Webster, Howey and Robertson, 2003) that there is a need to balance the longstanding position as scientific practitioner with an understanding and use of the processes of reflective practice (Lavender, 2003).

If Clinical Psychology training programmes were to give space to teach trainees about the importance of common factors it is unclear where this would be found. The recent introduction of reflective practice in Clinical Psychology Postgraduate training courses means that such discussions are more readily on the agenda in Clinical Psychology training. However accommodation could potentially realise Eysenck's fear of de-skilling the profession in other areas. However Eysenck's fear was based on the assumption that Clinical Psychologists should not treat clients whereas today, by large, this is Clinical Psychology's predominant role

Ogles et al., (1999) argue that because of the cyclical nature of psychological trends it is highly unlikely that current trends will continue unquestioned. In 1999 they suggested a move towards developing standardised, highly specific protocols will meet a trend that emphasises more individually tailored, customised therapy that relies more on common factors and relationship skills. They argued that if the trend of specificity and manualised treatments continued the practice of psychotherapy may become a highly standardised and technical operation that can be practised by less psychologically educated practitioners with narrow areas of expertise. In these cases each client would receive a diagnosis which would be matched to a specified protocol of intervention.

Seven years on it seems that this trend is prevalent. Psychologists and other health professionals can deliver highly defined psychological therapies to specific client groups. Such a strategy seems a useful one; psychological therapies can be delivered to many by many, keeping waiting lists down. Practitioners state however that a client who embarks on therapy for a specific disorder and leaves therapy having only discussed or addressed that specific disorder are few and far between, as highlighted by Messer's account of Mrs. T (Messer, 2004).

The client does not enter the room as a diagnosis and therefore should not be treated as a "diagnosis" by the service. The client enters as a person and so should be treated as a person whilst engaged in psychotherapy. A rigid intervention programme does not allow for human element within the diagnosis and so leaves the practitioner ill

equipped to deal with the person before them. Clinical Psychologists, due to their intensive training in the theories and models of human behaviour, do have a broader understanding of human behaviour. However to a certain extent the climate of the National Health Service does expect Clinical Psychologists to treat and cure specific clients in a specific way often stipulating how this should be done and over what period of time. Perhaps this pressure shapes the training courses and hence indirectly advocates the kudos of therapeutic techniques rather than the more human element of therapeutic interventions; the relationship and "I". The current climate in Clinical Psychology courses is however starting to address work-self interface through the introduction of reflective practice. One would hope that such developments would continue to develop a profession who advocate that the "people" are paramount within a clinical intervention.

1.4. Conclusion

This review initially described the influence of the medical model and empiricism on Clinical Psychology in the UK. The paper suggests this context shaped what is advocated by the profession as credible psychological research (evidenced-based manuals). It summarised the body of evidence regarding the importance of common factors in effective therapeutic work and suggested that this generally has not been given enough emphasis by the Clinical Psychology profession. The recent introduction of "reflective practice" could be hypothesised as the start of addressing the effect of the self in therapeutic interventions and hence puts on the agenda the

therapeutic relationship in Clinical Psychology training courses. Hypotheses were generated as to why, historically, the profession responded as it has.

In conclusion this paper is not suggesting; 1) that evidenced-based manuals and techniques should be abandoned by Clinical Psychology or 2) that Clinical Psychologists cannot work within the medical model. The review advocates that techniques and "specificity" should be emphasised alongside the therapeutic relationship and common factors in order to actually reflect the available empirical evidence and that this should be made explicit within the profession. Training courses should give more weight to process issues and the therapeutic relationship which facilitate therapeutic change and less to highly specific manualised ways of working. It seems that this journey has started with the recent introduction of competence in "reflective practice" which is now a requirement for trainee Clinical Psychologists (British Psychological Society, 2001).

It is the Clinical Psychologist's responsibility to generate and keep up to date with ecologically valid evidence. Evidence advocates that a good therapeutic relationship is vital in effective therapy and that specificity in treatments is not. The overarching arms of the medical model and the economic climate for cost-effective evidence-based practice colours the present perception of the evidence (Lavender, 2003). The professional future of Clinical Psychology lies in the hands of Clinical Psychologists. Does the profession want to treat psychological ill health with a medical approach or a psychological approach? If further empirical evidence is needed to show the

efficacy of the therapeutic relationship and inadequacies of manualised treatments then practitioners need to generate research that advocates this. The profession's scientist-practitioner training gives us the skills to do this. The profession can then choose between evidence-based treatments developed by and for practicing psychologist (thus reflecting the realities of therapeutic work) or evidenced-based treatments developed by and for a medical market (Nathan, 2000).

As Wampold et al., (2001) state to coexist medicine and psychology should come to value what each has to offer to the other. In doing this both should recognise that the intervention pathways for medicine and psychology are different. Specificity in medicine is well established as it is for some disorders in psychology (OCD, PTSD, social phobia and panic disorder; Derubeis et al. 2005). However evidently specificity for the vast majority of psychological disorders is not despite the professions' best efforts to try and indicate it. In order to give credibility to the person in a way that values the person as a whole rather than the person as a diagnosis both medicine and psychology must recognise and appreciate the scientific differences between the two professions.

1.5. References

Ahn, H and Wampold B.E. (2001). Where oh where are the specific ingredients? A meta-analysis of component studies in counselling and psychotherapy. *Journal of Counselling Psychology, 48, 251-257.*

Andrews, G., and Harvey, R. (1981). Does psychotherapy benefit neurotic patients: A re-analysis of the Smith, Glass and Miller data. *Archives in General Psychiatry*, **38**, 1203-1208.

Baskin, T.W., Tierney, S.C., Minami, T., and Wampold, B.E. (2003). Establishing specificity in psychotherapy: A meta-analysis of structural equivalence of placebo controls. *Journal of Consulting and Clinical psychology*, **54,** 88-94.

Bennett-Levy, J. (2003). Reflection: a blind spot in psychology? *Clinical Psychology Forum*, **27**, 16-19.

Bergin, A.E., and Lambert, M.J. (1978). The effectiveness of psychotherapy. In S Garfield and A E Bergin (Eds), *Handbook of psychotherapy and behaviour change.* (2nd ed., pp139-190). New York: John Wiley and Sons.

Beutler, L.E. (1979). Toward specific psychological therapies for specific conditions. *Journal of Consulting and Clinical Psychology, 47, 882-897.*

Beutler, L.E. (1991). Have all won and must have prises? Revisiting Luborsky's et al.'s verdict. *Journal of Consulting and Clinical Psychology, 59, 226-232.*

Beutler, L.E., (2000b). Empirically based decisions: A comment. *Prevention and Treatment*, **3,** Article 31.

Bohart, A.C. (2000). Paradigm clash: Empirically supported treatments versus empirically supported psychotherapy practice. *Psychotherapy research*, **10**, 488-493.

British Psychological Society (2001). *Criteria for the accreditation of postgraduate training programmes in clinical psychology*. Leicester: BPS

Butler, S.F. and Strupp, H.H. (1986). Specific and non-specific factors in psychotherapy: A problematic paradigm for psychotherapy research. *Psychotherapy*, **23**, 30-39.

Castel, F. (1985) Moral treatment: mental therapy and social control in the nineteenth century. In S.Cohen and A. Scull (eds) *Social Control and the State*, Oxford: Blackwell.

Catty, J. (2004). "The vehicle of success": Theoretical and empirical perspectives on the therapeutic alliance in psychotherapy and psychiatry. *Psychology and Psychotherapy: Theory, research and practice, 77, 255-272.*

Chambless, D.L., and Hollon, S.D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical psychology, 66, 7-18.*

Corrie, S., and Callahan, M. (2000). A review of the scientist-practitioner model. Britsih *Journal of Medical Psychology*, **73**, 413-427.

Deegear, J and Lawson, D.M. (2003). The Utility of empirically supported treatments. *Professional Psychology: Research and Practice*, **34**, 271-277.

Derubeis, R.J., Brotman, M.A. and Gibbons, C.J. (2005). A conceptual and methodological analysis of the nonspecifics argument. *Clinical Psychology: Science and Practice*, **12**, 174-183.

Digby, A. (1985) Moral treatment at the retreat, 1796-1846, in W.F. Bynum, R. Porter and M. Shepherd (eds) *The Anatomy of Madness*, Volume 2, London: Tavistock.

Donnelly, M. (1979) *Managing the Mind*, London: Tavistock.

Elkin, I., Shea, T., Watkins, J.T., Imber, S.D., Sotsky, S.M., Collins, J.F., Glass, D.R., Pilkonis, P.A., Leber, W.R., Docherty, J.P., Fiester, S.J., and Parloff, M.B. (1989). National Institute of Mental Health treatment of Depression Collaborative Research

Program: General effectiveness of treatments. *Archives of General Psychiatry, 46, 971-982.*

Eysenck, H.J. (1949). Training in Clinical Psychology: an English point of view, *American Psychologist, 4, 173-6.*

Eysenck, H.J. (1952). The effects of psychotherapy: an evaluation. *Journal of Consulting and Clinical Psychology, 16, 319-24.*

Frank, J.D., and Frank, J.B. (1991). *Persuasion and healing: A comparative study of psychotherapy (3rd ed.).* Baltimore: Johns Hopkins University Press.

Freud, S. (1912). *The dynamics of transference. Standard Edition*, 12. London: Hogarth Press (rpr. 1958).

Garfield, S.L. (1998) Some comments on empirically supported treatments. *Journal of Consulting and Clinical psychology*, **66,** 121-125.

Gaston, L., Marmar, C.R., Gallagher, D., and Thompson, L.W. (1991). Alliance prediction of outcome beyond in-treatment symptomatic change as psychotherapy processes. *Psychotherapy Research*, 1,104-113.

Gillmer, B. and Marckus, R. (2003). Personl professional development in clinical psychology training: surveying reflective practice. *Clinical Psychology Forum*, **27**, 20-23.

Goldfried, M.R. and Wolfe, B.E. (1996). Psychotherapy practice and research: Repairing a strained alliance. *American Psychologist*, **51**, 1007-1016.

Grencavage, L.M., and Norcross, J.C. (1990). What are the commonalities among the therapeutic factors? *Professional Psychology: Research and Practice*, **21**, 372-378.

Hall, J. (1993). Clinical Psychology in context. *Clinical Psychology Forum, **61**, pp3-10.*

Heatherington, R. (1981). The changing role of the clinical psychologist. *Bulletin of the British Psychological Society, **34**, 12-14.*

Horvath, A.O. (2005). The therapeutic relationship: Research and theory. An introduction to the special issue. *Psychotherapy Research, **15**, 3-7*

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

Hubble, M.A., Duncan, B.L., and Miller, S.D. (1999). Introduction. In Hubble, M.A., Duncan, B.L., and Miller, S.D. *The Heart and Soul of Change: What Works in Therapy* (pp1-19). Washington D.C. : American Psychological Association.

John, I.D. (1984). Science as a justification for psychology as a social institution. *Australian Psychologist*, **19**, 29-37.

Kennedy, P and Llewelyn, S. (2001). Does the future belong to the scientist practitioner? *The Psychologist*, **14**, 74-78.

Lachmann, F. (1971). A recent development in the technique of psychoanalysis: The therapeutic alliance. *The Clinical Psychologist*, **25**, 10-11.

Lambert, M.J. (1992). Implications of outcome research for psychotherapy integration. In J.C. Norcross and M.R. Goldfried (eds), *Handbook of psychotherapy integration (pp42-129). New York: Basic Books.*

Lambert, M.J., and Barley, D.E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy, 38, 357-361.*

Lambert, M.J., and Bergin, A.E. (1994). The effectiveness of psychotherapy. In A. E. Bergin and S.L. Garfield (eds.), *Handbook of psychotherapy and behaviour change* (4th ed., pp. 143-189). New York: Wiley.

Lambert, M.J. and Ogles, B.M. (2004). The efficacy and effectiveness of psychotherapy in *Bergin's and Garfield's Handbook of Psychotherapy and Behaviour Change* (5th Ed., pp139-193). New York: Wiley.

Landman, J.T., and Dawes, R.M. (1982). Smith and Glasses' conclusions stand up under scrutiny. *American Psychologist, 37, 504-516.*

Lavender, A. (1996). A brief history of the development of clinical psychology in the context of developments in the welfare state in general and the NHS in particular: Unpublished manuscript.

Lavender, T. (2003). Redressing the balance: the place, history and future reflective practice in clinical training. *Clinical Psychology Forum*, **27**, 11-15.

Leeds University (2006). *Clearing House for Postgraduate Courses in Clinical Psychology Handbook 2006 Entry.* LeedsUniversity

Long, C.G. and Hollin, C, R. (1997). The scientist-practitioner model in clinical psychology: A critique. *Clinical Psychology and Psychotherapy*, **4**, 75-83.

Meader, B.D. and Rogers, C.R. (1984). Person-centred therapy. In R. J. Corsini (Ed) *Current Psychotherapies* (3rd Edition, pp. 142-195). Itasca. IL: Peacock.

Messer, S.B. (2004). Evidence-based practice: beyond empirically supported treatments. *Professional Psychology: research and practice*, **35**, 580-588.

Miller, S.D., Hubble, M.A., and Duncan, B.L. (1996). *Psychotherapy is dead, long live psychotherapy*. Workshop presented at the 19th Annual Family Therapy Network Symposium, Washington, DC.

Miller, S.D., Duncan, B.L., and Hubble, M.A. (1997). *Escape from Babel: Toward a unifying language for psychotherapy practice.* New York: W.W. Norton.

Nathan, P.E. (2000). The Boulder Model: A dream deferred – or lost? *American Psychologist*, **55**, 250-252.

Norcross, J.C. (2000). Toward the delineation of empirically based principles in psychotherapy: Commentary on Beutler (2000). *Prevention and Treatment*, **3**, Article 28.

Ogles, B.M., Anderson, T., and Lunnen, K.M., (1999). The contribution of models and techniques to therapeutic efficacy: contradictions between professional trends and clinical research. In Hubble, M.A., Duncan, B.L., and Miller, S.D. *The Heart and Soul of Change: What Works in Therapy* (pp 201 - 225). Washington D.C. :American Psychological Association.

Pilgrim, D and Treacher, A. (2002) *Clinical Psychology Observed.* London: Tavistock.

Rachman, S.J., and Wilson, G.T. (1980). *The effects of psychological therapy* (2nd Ed). New York: Pergamon.

Raven, J. (1950). What is clinical psychology? *Quarterly Bulletin of the British Psychological Society*, **1**, 282-285.

Robinson, L.A., Berman, J., and Neimeyer, R.A. (1990). Psychotherapy for the treatment of depression: A comprehensive review of controlled outcome research. *Psychological Bulletin,* **108,** *30-49.*

Rogers, C. (1957b). A note on the "nature of man". *Journal of Counselling Psychology*, **4**, 199-203.

Rogers, C. (1958). The characteristics of a helping relationship. *Personnel and Guidance Journal*, **37**, 6-16.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy: "At lat the Dodo said, Everybody has won all must have prizes." *American Journal of Orthopsychiatry*, **6**, 412-415.

Shapiro, D. (2002) Renewing the scientist-practitioner model. *The Psychologist, 15, 232-234.*

Shapiro, D.A. and Shapiro, D. (1982). Meta-analysis of comparative therapy outcome studies: A replication and refinement. *Psychological Bulletin, 92, 581-604.*

Silverman, D.K. (2005). What works in Psychotherapy and how do we know? What evidenced-based practice has to offer. *Psychoanalytic Psychology*, **22**, 306-312.

Silverman, L.H. (1979). The unconscious fantasy as therapeutic agent in psychoanalytic treatment. *Journal of American Academy of Psychoanalysis*, 7, 189-213.

Skultans, V. (1979) *English Madness*, London: Routledge and Kegan Paul.

Smith, M.L., and Glass, G.V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist, 32, 752-760.*

Smith, M.L., Glass, G.V. and Miller, T.I. (1980). *The benefits of psychotherapy.* Baltimore, MD: Johns Hopkins University Press.

Stedmon, J., Mitchell, A., Johnstone, L. and Staite, S. (2003) Making Reflective Practice real: problems and solutions in the South West. *Clinical Psychology Forum*, **27**, 30-33.

Stiles, W.B., Shapiro, D.A., and Elliott, R. (1986). Are all psychotherapies equivalent? *American psychologist*, **41**, 165-180.

Task Force on Promotion and Dissemination of Psychological Procedures. (1995). Training in and dissemination of empirically- validated psychological treatments: Report and recommendations. The Clinical psychologist, **48**, 2-23.

Thomas, R. (2004). The person within the professional: Some lessons from psychotherapy? *Clinical Psychology Forum*, **44**, 26-29

Wampold B.E. and Bhati, K.S. (2004). Attending to omissions: A historical examination of Evidenced-based Practice Movements. *Professional Psychology: Research and Practice*, **35**, 563-570.

Wampold, B.E. (2000). Outcomes of individual counselling and psychotherapy: Empirical evidence addressing two fundamental questions. In S.D. Brown and R.W. Lent (Eds), *Handbook of counselling psychology* (4th ed., pp.711-739). New York: Wiley.

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

Wampold, B.E., Ahn, H. and Coleman, H.L.K. (2001). Medical model as metaphor: Old Habits die hard. *Journal of Counselling Psychology*, **48**, 268-273.

Wampold, B.E., Mondin, G.W., Moody, M., Stich, F., Benson, K., and Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "all must have prizes." *Psychological Bulletin, 122, 203-215.*

Weinberger, J. (2002) Short paper, large impact: Rosenzweig's Influence on the Common Factors Movement. *Journal of Psychotherapy Integration*, **12**, 67-76.

Wilson, G.T. (1996). Manual-based treatments: The Clinical application of research findings. Behaviour Research and Therapy, **34**, 295-314.

CHAPTER TWO

Psychological Mindedness and Its Relationship to Adaptive Therapist Attributes

Abstract

Psychological Mindedness (PM) involves an interest in and ability to extract psychological information (thoughts, feelings and behaviours) from a scenario and note patterns or relationships among these concepts in trying to make sense of the experience, be it your own or others'. Psychotherapists are a group shown to be especially psychologically minded. The nature of the psychotherapeutic role and training, demands therapists think about motives, distortions and inner experiences of others. PM is a central aspect of a psychotherapist's life but has not been widely researched in this group. The purpose of this study was to examine empirically the relationships among PM and adaptive therapist attributes; clinician empathy, self understanding and the therapeutic relationship in qualified psychological practitioners. The study also investigated the relationships between age, gender and years of qualified psychotherapy practice on levels of PM. No significant results were found regarding age, gender or years of qualified practice and PM. Significant, positive correlations were found between adaptive therapist attributes; empathy, the therapeutic relationship and level of self-understanding and PM. These results suggested that PM is related in predicted ways to these attributes. The present study should be seen as an initial step in the process of understanding PM in psychotherapists

2.1. Introduction

Psychological Mindedness (PM) has been defined as a "*person's ability to see relationships among thoughts, feelings and actions, with the goal of learning the meanings and causes of his experiences and behavior*" (Applebaum, 1973, p36). This definition was later extended by Farber (1985) to include the thoughts, feelings and behaviours of others as well as self. Following this definition Conte, Plutchik, Jung, Karasu and Lotterman (1990) designed the PM scale and an empirical definition of PM followed; it involves … "*a degree of access to one's feelings that leads, through discussion of one's problems with others, to an ability to acquire insight into meaning and motivation of one's own and others thoughts, feelings and behaviour, and to a capacity for change*" (Conte and Ratto, 1997, p21).

Hence PM involves an interest in and ability to extract psychological information (thoughts, feelings and behaviours) from a scenario and note patterns or relationships among these concepts in trying to make sense of the experience, be it own or others'. Farber (1985) argues such a way of thinking is a cognitive style. The development of PM allows individuals to cope with their environments by understanding the behaviour of themselves and others. Hence PM has been associated positively with psychological well-being (Trudeau and Reich, 1995), as measured by the Scale of Psychological Well Being (Ryff, 1989) and emotional adjustment (Bagby, Taylor and Parker, 1994) in non-clinical populations. Beitel and Cecero (2003) suggest PM does not protect from psychopathology but is an important ingredient in an efficacious therapy. PM is associated with better treatment outcome, session attendance and

engagement in psychotherapy clients (Piper, Joyce, Azim and Rosie, 1994; Conte et al., 1990).

2.1.1. Psychological Mindedness and Psychotherapists

Psychotherapists are a group shown to be especially psychologically minded (Westen, Huebner, Boekamp, Lifton and Silverman, 1991). This makes common sense as PM implies an understanding and appreciation of psychological processes which one would hope is implicit in psychotherapists. The nature of the psychotherapeutic role and training demands therapists think about motives, distortions and inner experiences of others. Indeed therapists should also draw on their own experiences and understandings in trying to understand the experiences of others (Farber, 1985).

Farber and colleagues recently questioned why psychotherapists chose their career and suggest many people become psychotherapists as they have an especially strong need to understand others, are fascinated with human behaviour and enjoy the intellectual stimulation trying to understand people brings (Farber, Manevich, Metzer and Saypol, 2005). They propose many psychotherapists, early in life, begin to think about the "*whys of behaviour*" (Farber et al., 2005, p1016). This skill brings meaning to the psychotherapists' own experiences but also influences their career path into mental health services. Many psychotherapists state that for them this is the one career that is really "ego-syntonic", totally consistent with the way they have understood, behaved and felt all their life (Farber et al., 2005).

Psychological mindedness is a central aspect of a psychotherapist's life but one that has drawn little attention from the therapeutic community (Farber, 1985). PM in psychotherapists has not been widely researched. As part of a wider study looking at the effects of conducting therapy on therapists Farber asked psychotherapists about PM (Farber, 1983b). Farber found that many considered PM to be a double edged sword in that it provides insight and increased self-awareness however at too high a degree PM was seen to interfere with natural, emotionally laden social interactions. As with any way of thinking there is an optimum adaptive level. Maladaptively high levels of PM in postgraduate samples have been associated with lower levels of self-esteem (Farber, 1985) and high levels of self-scrutiny which invariably includes self-criticism (Levinson, Sharaf and Gilbert, 1966).

PM plays an important role in psychotherapy however the psychotherapists' psychologically mindedness role has not been extensively investigated. The focus of this paper is the relationship between PM and desirable therapist attributes. It follows that psychotherapists are psychologically minded however little research looks at this phenomenon or the impact of this on therapeutic practice. A better understanding of PM would help clinicians cultivate PM in themselves and clients so to enhance the therapeutic intervention. To begin to fill this gap the relationships among PM and clinician empathy, the therapeutic relationship and therapists' self-understanding are examined.

2.1.2. Psychological Mindedness and Empathy

Davis (1983) wrote "*..empathy in the broadest sense refers to the reactions of one individual to the observed experiences of another*" (p.113). Empathy provides access to thoughts and feelings of others, once another's psychological processes are observed a psychologically minded person is able to hypothesize about its roots, function and maintenance cycle. Without empathically derived information, a psychological formulation is an educated guess (Beitel, Ferrer and Cecero, 2004).

Hatcher and Hatcher (1997) argue empathy is an important component of PM. Beitel et al., (2004) found empathy was positively associated to PM in an undergraduate sample ($r = .35$, $p < .01$). Empathy is essential in the therapy room as is PM hence it is expected PM will be positively associated with empathy in psychotherapists.

2.1.3. Psychological Mindedness and the Therapeutic Relationship

In the past two decades researchers and practitioners have postulated that the therapeutic alliance, broadly defined as "*the collaborative and affective bond between therapist and client*" is an essential element of the therapeutic process (Martin, Garske and Davis, 2000; p438). To date no empirical evidence exists which looks at the nature of the association between PM and the therapeutic relationship. As PM implies understanding of (others') psychological processes it is hypothesized that this common ground will yield a therapeutic bond and respect that would form the basis of a strong therapeutic relationship.

2.1.4. Psychological Mindedness and Self-Understanding

The nature of the psychotherapeutic role demands that some level of self-understanding is prevalent in psychotherapists. Enhancing self-understanding, through personal therapy or personal development groups is also a prerequisite of many therapy training courses. Studies (Beitel et al., 2004; Trudeau and Reich, 1995) have reported that the PM scale (Conte et al., 1990) and the Private Self-Consciousness Scale (Fenigstein, Scheier and Buss, 1975) are directly related to one another ($r = .45$, $p < .01$; $r = .27$, $p < .05$). Self-consciousness was defined as an awareness of internal mental process rather than understanding. However it follows that a similar relationship between the two concepts PM and self-understanding may also exist.

2.1.5. Goals and Hypotheses

The purpose of this study is to examine the relationships among psychological mindedness and clinician empathy, self understanding and the therapeutic relationship in qualified psychological practitioners. Positive correlations are expected between psychological mindedness and empathy, psychological mindedness and self-understanding and psychological mindedness and the therapeutic relationship. The study will also investigate the relationships between age, gender and years of qualified psychotherapy practice on levels of psychological mindedness. Due to previous research (Hatcher, Hatcher, Berlin, Okla and Richards, 1990; Shill and Lumley, 2002) it is hypothesized that women are more psychologically minded than men. Research regarding PM and age in non psychotherapists are inconclusive

(Hatcher, et al., 1990; Shill and Lumley, 2002) therefore this will be investigated in this sample. The effects of years of qualified practice on PM will also be investigated. Farber (1983) reported therapists become significantly more introspective, reflective and philosophical having embarked on therapeutic practice, a phenomenon he states is likely to increase PM over time. Hence a positive correlation between years of practice and PM is suspected.

2.2. Method

2.2.1. Participants

Participants comprised of 48 qualified therapists who responded to a postal questionnaire distributed by the author (a 22% response rate). All therapists (10 males, 38 females) worked within the Midlands region of the UK. Ages ranged from 28 to 63 years (M=42.9); 69% described themselves as "married or living as married" (n=33), 19% as "single / never married" (n=9), 4% as "separated" (n=2), 4% as "divorced" (n=2) and 4% as "widowed" (n=2). The racial composition of the sample was 98% Caucasian (n=47), 2% Indian (n=1).

The sample had practiced as qualified therapists for between 2 months and 32 years (M=10.75 years); 71% of the sample described their professional role as "Clinical Psychologist" (n=34), 17% as "Counsellor" (n=8), 6% as "Other" (n=3), 4% as "Psychotherapist" (n=2) and 2% as "Counselling Psychologist" (n=1).

2.2.2. Materials

The participant introduction letter (appendix one), participant information sheet (appendix two) and research participant instructions (appendix three) reminded potential participants that involvement in this study was voluntary; these forms also assured anonymity and confidentiality. The questionnaire pack used in this study included five scales. The first (Questionnaire One) was a 34 item demographic questionnaire (appendix four). This measure was designed by the author to collect information about participants' demographics, occupation, professional training, supervision and experiences of personal therapy.

The second scale, the Jefferson Scale of Physician Empathy – Health Professional Version (JSPE - HP), (appendix five) is a 20 item scale measuring practitioners' empathy towards clients (Hojat, Gonnella, Nasca, Mangione, Vergare, et al., 2002b). Hojat argues before this scale; "*there was no empathy scale that was specific enough to capture the essence of empathic care that a clinician renders to his or her client*" (2001; p11). Hojat defines empathy in patient care as "*a cognitive attribute that involves an ability to understand the patient's inner experiences and perspective and a capability to communicate this understanding*" (2001; p4).

The scale is self-administered and designed for use by physicians and other health professionals. Respondents indicate the extent of their agreement or disagreement for each of the 20 items using a 7 point Likert Scale (Strongly Agree = 1....Strongly Disagree = 7), making the possible range of scores 20-140. The empathy score for an

individual is calculated by summing the 20 scores. Half of the items are reversed scored. Higher values indicate a higher degree of empathy. The scale is said to have high construct validity (Hojat et al., 2002b) and is consistent with the notion of the multidimensionality of empathy (Kunyk and Olson, 2001). The scale is said to have high internal consistency and scores that are relatively stable over time (Hojat et al., 2002b).

The third scale, the Psychological Mindedness (PM) Scale (Conte et al., 1990), represents a shortened version of Lotterman's (unpublished 1979 paper) 65-item scale which he used to study client suitability for dynamically orientated psychotherapy. This 45-item scale (appendix six) measures reflection about psychological processes as related to the self and relationships. Items are either self-focused (e.g. "It would be difficult for me to talk about my personal problems with people such as doctors or clergymen") or other-focused (e.g. "I am always curious about the reasons people behave as they do"). Twenty-four items are loaded positively (e.g. "I am always curious about the reasons people behave as they do"). Twenty-one items are loaded negatively, indicating lack of psychological mindedness (e.g. "People sometimes say that I act as if I am having a certain emotion (anger, for example) when I am unaware of it"). Reverse scoring is used for the negatively loaded items. Each item is scored on a 4 point scale that ranges from 1 (strongly agree) to 4 (strongly disagree). The individual's score is obtained by summing all item scores.

Construct validity of the scale was determined by a group of experienced clinicians judging whether the scale encapsulated accurately the concept of psychological mindedness. The clinicians stated that the items in the PM scale captured the construct of PM "*as they understood it clinically and as it is described in the literature*" (Conte et al., 1990; p428). The internal factor structure has been investigated in two studies (Conte, Ratto and Karasu, 1996; Shill and Lumley, 2002). Conceptually factors were replicated but the item content of factors failed to replicate in some instances.

Evidence for the construct validity is given by Bagby, Taylor and Parker (1994) who report a significant negative correlation between the PM scale and a measure of alexithymia.

The internal factor structure has been investigated in two studies (Conte et al., 1996; Shill and Lumley, 2002). In Conte et al's (1996) study, using 256 psychiatric outpatients five factors were identified. They were 1) Willingness to try to understand oneself and others, 2) Openness to new ideas and capacity to change, 3) Access to feelings, 4) Belief in the benefits of discussing one's problems, and 5) Interest in meaning of behaviour.

Shill and Lumley (2002) attempted to replicate Conte et al.'s study, in a sample of 397 undergraduates. They also extracted five factors they were 1) Belief in benefits of discussing one's problems with others 2) Access to feelings 3) Willingness to

discuss one's problems with others 4) Interest in meaning of behaviour, and 5) Openness to change. Conceptually the factors were replicated but the item content of the factors failed to replicate in some instances. Clearly more consideration needs to be given to the factor structure of the PM scale before its factor structure may be considered stable and robust (Beitel, Ferrer, Cecero, 2004).

PM and self-reported psychological well-being (PWB Scale; Ryff, 1989) were positively correlated ($r(87) = 0.31$, $p<0.01$) in a college sample (Trudeau and Reich, 1995) as was extraversion ($r(185) = 0.37$, $p<0.01$) and openness to experience ($r(185) = 0.40$, $p<0.01$) in an undergraduate sample (Beitel and Cecero, 2003). The PM scale also positively correlates with adaptive ego functioning (Conte et al., 1995) and ambiguity tolerance ($r(198) = 0.17$, $p<0.05$) and is inversely related to an external locus of control ($r(198) = -0.30$, $p<0.01$) in an undergraduate sample (Beitel et al., 2004). Beitel and Cecero (2003) found that the PM scale was negatively correlated with the neuroticism subscale of the NEO Five Factor Inventory (NEO-FFI; Costa and McCrae, 1992).

Normative data regarding the Psychological Mindedness Scale is not available in the literature; this is a potential area of research which would the PM scale more meaningful (both clinically and in academia) in future studies.

The fourth scale was the original version of the Self-Understanding of Interpersonal Patterns (SUIP) (Connolly, Crits-Christoph, Kurtz, Butler, Shelton, Hollon et al., 1999). This scale (appendix eight) is a brief self-report inventory designed to operationalise the following definitions of self-understanding and interpersonal patterns; self understanding: "*the understanding of maladaptive interpersonal patterns as described in modern theories of short-term dynamic psychotherapy*", interpersonal patterns; "*the individual's wishes, his or her responses in the interpersonal situation, and the response of others toward the client in these situations*" (Connolly et al., 1999, p473). Connolly et al. further defined self-understanding as being on a continuum from recognition of a problem area to a deeper understanding of the historical origins of the pattern.

The scale comprises of 19 items (interpersonal patterns) selected from 3 sources: 1) problems in self-understanding as reported by clients (Connolly and Strupp, 1996) 2) contributions from students and expert therapists and 3) the Core Conflictual Relationship Theme standard category list (Barber, Crits-Christoph and Luborsky, 1990). Respondents rate whether each of the 19 items is a current problem for them. The problems recognized are then rated on a 4 point scale designed to assess a dimension of self-understanding from mere recognition to a deeper understanding of the origin of the pattern.

Two scores are yielded; the average self-understanding score representing the person's level of self-understanding (scores range from 1-4) and the recognition score which is the sum of the problems recognized by the person (ranges from 0-19).

The SUIP is reported as having good internal consistency (0.79) and test-retest correlation ($r(132) = 0.76$, $p<0.001$) (Connelly et al., 1999). Connelly et al. (1999) report that the SUIP does not correlate with the SCL-90R (Derogatis, 1977), the Inventory of Interpersonal problems (Horowitz, Rosenberg, Baer, Ureno and Villasenor, 1988) or Beck Self-Concept Test (Beck, Steer, Epstein and Brown, 1990) suggesting that the SUIP is measuring a distinct construct (self-understanding) rather than psychiatric severity, interpersonal distress or generally measuring how good a person feels about themselves.

The final scale was the Working Alliance Inventory (WAI) (Form T) (Horvath, 1981) (appendix nine). The WAI is a 36 item, self-report tool designed to measure Bordin's pantheoretical perspective of the working alliance (1979).The scale consists of three subscales: the Bond subscale measures mutual liking and attachment by focusing on tone of voice, empathy, and comfort in exploring intimate issues, the Goal subscale addresses the extent to which therapy goals are important, mutual and capable of being accomplished and the Task subscale focuses on participant's agreement about the steps taken to help improve the client's situation (Fenton, Cecero, Nich, Frankforter and Carroll, 2001).

Horvath and Greenberg state that the reliability of the WAI is "adequate" (1989, p229) and that individual scales appear to be reasonably stable. There are strong associations between the WAI and other inventories designed to measure similar traits, which suggests the WAI has good convergent and discriminate validity

(Horvath and Greenberg, 1989). Three versions of the scale have been developed, therapist, patient and observer-rater; respondents must rate each item on a 7 point scale (1=never, 7=always). The WAI scales are very widely used and are accepted instruments in alliance research (Martin et al., 2000).

2.3. Procedure

A questionnaire pack comprising of the participant introduction sheet, participant information sheet, research participant instructions, written consent forms, Questionnaire One, the JSPE, PM scale, SUIP and WAI was sent to all psychological therapists (n=220) in three National Health Service Trusts in the West Midlands. The correspondence explained that this was an opportunity to participate in research about clinical practice. Interested practitioners were asked to complete the consent forms (appendix ten) and questionnaires and return them in an enclosed stamped, self-addressed envelope to the author.

2.4. Results

In order to address the hypothesis regarding gender differences and PM a two-tailed, independent samples t-test was run. Gender differences were not detected for the PM summed scale score ($F(1,47) = 1.824$, $p>0.05$) or subscales. As no gender differences were found the groups were combined and subsequent analyses were carried out on the whole cohort.

To test the hypothesis, that psychological mindedness is linearly related to; empathy, self-understanding and therapeutic relationship Pearson r correlations were executed. Scale descriptive statistics and intercorrelations are presented in Table 2.1.

Table 2.1. Means, Standard Deviations and Correlations among PM, WAI, JSPE and SUIP Scales.

	Descriptives		Correlations			
Variable	M	SD	PM	JSPE	WAI	SUIP (AV)
PM	143.62	9.918				
JSPE	120.04	9.167	.561**			
WAI	187.38	20.633	.356*	.163		
SUIP (SU)	3.6915	.52315	.401*	.223	.041	
SUIP (RECOG)	5.7917	3.22199	-.371*	.008	-.113	-.154

* Correlation is significant at the 0.05 level (2 tailed)

** Correlation is significant at the 0.01 level (2 tailed)

JSPE – Jefferson Scale of Physician Empathy

PM – Psychological Mindedness Scale

WAI – Working Alliance Inventory

SUIP (SU) – Self Understanding of interpersonal patterns level of self understanding

SUIP (RECOG) – Self Understanding of interpersonal patterns recognition score

Pearson's product moment correlations revealed that PM was significantly and positively associated with empathy, therapeutic relationship and level of self-understanding. PM was significantly and negatively associated with the number of interpersonal patterns recognized on the SUIP as shown in Table 2.1.

Correlations among PM scale subscales and therapist attribute subscales are presented in Table 2.2. PM subscale scores were derived from Shill and Lumley's (2002) factor analysis, as it was conducted in a non-clinical population as is this sample.

Table 2.2. Correlations Among Psychological Mindedness Subscales and Therapist Attributes Variables.

	Descriptives		Therapist Attribute Variables					
PM Subscale a	M	SD	JSPE	WAI b			SUIP	
			-	Bond	Task	Goal	SU	Recog
Benefit	23.56	2.06	.586**	.232	.237	.211	.105	-.197
Feelings	12.88	1.72	.336*	.219	.266	.249	.295*	-.166
Understand	8.79	1.34	.266	.036	.168	.084	.306*	-.465**
Meaning	10.69	1.13	.323*	.138	.214	.171	.340*	-.211
Openness	12.38	1.48	.362*	.334*	.397**	.188	.231	-.068

* correlation is significant at the 0.05 level (2 tailed)

** correlation is significant at the 0.01 level (2 tailed)

Key: a Benefit – belief in the benefit in discussing one's problems, Feelings – access to feelings, Understand – willingness to discuss problems with others, Meaning – interest in meaning of own and others' behaviour, Openness – openness to change.

b Bond – mutual liking and attachment, Task – participant's agreement, Goal – extent to which therapy goals are important, mutual and accomplishable.

As illustrated in Table 2.2. four of the PM subscales related positively and significantly to the JSPE; feelings, meaning, openness and most significantly belief. Significant positive correlations were found between the WAI task and bond

subscales and the openness subscale of the PM scale. The SUIP level of understanding score correlated positively and significantly with three PM scale subscales; feelings, understand and meaning. The understand PM subscale was also inversely correlated with the SUIP recognition score.

Pearson's r was conducted to investigate the nature of the relationship between age and PM. No relationship between age and PM was recorded ($r = -.129$, $p > 0.05$).

The final hypotheses that psychological mindedness increases with years of therapeutic practice was not supported. There was no significant correlation between years of qualified therapeutic practice ($r = .120$, $p > 0.05$) and psychological mindedness.

2.5. Discussion

This study was intended to investigate the empirical association between psychological mindedness and desirable therapist attributes. The results suggest that PM is related in predicted ways to therapist self-understanding, therapeutic relationship and clinician empathy.

Beitel et al., (2004) found empathy was positively associated to PM in an undergraduate sample. The same was true of this sample. Further to this all subscales of the JSPE correlated with the PM scale apart from the "understand" subscale (willingness to discuss problems with others). The absence of a significant

correlation between these two concepts is not surprisingly as one does not have to be empathic to be willing to discuss problems with other people.

Although the full scale scores of the PM scale and WAI correlated in the predicted direction when investigated more closely there was little correlation between subscales of the measures. Items measuring openness to change on the PM scale were positively correlated with the task and bond subscales on the WAI however no other significant correlations were apparent. The goal subscale did not correlate with any PM subscales; this result is unsurprising as the sense that goals are achievable and mutually important in the therapeutic relationship is not something which needs psychological consideration.

The association between self-understanding and PM suggests that more self-understanding is associated with higher levels of psychological mindedness, this result makes intuitive sense. Hence these concepts are directly related to one another yet it is hard to determine which concept facilitates change in the individual; does PM lead to self-understanding or self-understanding lead to PM? Future research in this area could consider this question.

The finding, in this study, that the self-understanding recognition score was inversely related to PM is consistent with other research which suggests PM is associated with better psychological well-being (Trudeau and Reich, 1995) and emotional adjustment (Bagby et al., 1994). Participants with higher PM acknowledged fewer interpersonal

problems in their life. Interestingly "willingness to discuss problems with others" was the only significant intercorrelation between subscales of the PM and self-understanding measures. This finding makes theoretical sense; as willingness to discuss problems with others goes up; the number of perceived interpersonal problems goes down. Thus talking to people about concerns helps resolve them. However, due to the self-report nature of the SUIP it is hard to determine if participants' perceptions of interpersonal problems are accurate.

Contrary to Hatcher et al. (1990) but supporting more recent research (Shill and Lumley, 2002; Beitel et al., 2004) psychological mindedness did not increase with age in this sample. Hatcher et al's (1990) sample comprised of children and young people. When the findings of this paper are considered with other research (Shill and Lumley, 2002; Beitel et al., 2004) one could hypothesize that PM has a window of development that closes in early adulthood, unless psychotherapy is sought by the individual. Future research should explore this idea.

No gender differences were found in this sample. Shill and Lumley (2002) reported females were more psychologically minded than males in a sample of undergraduates. Due to the small sample size and small proportion of males in this paper's sample it is hard to determine whether such differences are likely to occur in psychotherapists. The nature of this sample however reflects the higher proportion of female psychotherapists in the field. If Farber's (2005) "ego-syntonic" comment regarding career choices of highly PM people were true this phenomenon alone

would be evidence of females being more psychologically minded in the general population. The insignificant result found here may suggest that in a highly psychologically minded cohort gender differences are less apparent than those found in the general population. This area warrants further investigation in future research.

Farber's (1985) idea that PM would increase with years of clinical practice was not supported in this investigation. There was no association between years of qualified clinical practice and PM. In Farber's more recent 2005 paper he suggests that psychotherapists come to adopt this cognitive style due to their early childhood experiences. The results from this study might be indicative of a plateau of PM being reached by the time psychotherapists are qualified (further support for this comes from the findings concerning age and PM). It would be interesting to conduct a longitudinal study tracking levels of PM in aspiring psychotherapists. If this cognitive style is developed early in the psychotherapists' life is there any potential to enhance it through personal therapy, clinical practice or training? Does a window of opportunity exist? Research able to answer these questions would have huge implications regarding training courses and selection of trainees.

This study has several limitations that should be noted. Firstly the sample size was small (n=48). The proportion of male practitioners (n=10) and limited professional groups within the sample "Clinical Psychologist" (n=34), "Counsellor" (n=8), "Psychotherapist" (n=2) and "Counselling Psychologist" (n=1) "Other" (n=3) are not adequate to draw conclusions from specifically or generally. Participants in the

present study were also self-selecting in nature; they decided whether to participate to the postal questionnaire or not. Potentially there are many reasons for this such as the length of the research pack and time constraints within the working day. One might also hypothesis that only those with a high level of psychological mindedness would be interested in completing a research pack concerned with "clinical practice" regarding it as "internal supervision"? Such a phenomenon could potentially lead to only measuring the most psychologically minded in the profession. The size and self selecting nature of the sample limits the generalisability of the findings however given the exploratory nature of this study the data yielded is a good starting point for future investigations.

The second limitation is the self-report method of data collection. Obtaining the view from a participant's perspective, as the self-report method does, is a strength and weakness of the design. Such a design does not give an independent perspective of the participants and may be vulnerable to inaccurate reporting from the participant for a variety of conscious (e.g. demand characteristics) or unconscious reasons.

Future research should include a larger number of practitioners containing a more even distribution of therapeutic professions and gender to enhance the generalisability of the findings. Such a sample would also lend itself to exploratory investigations regarding PM and different clinical professions (i.e. Clinical Psychologist, Counsellor) and roles (Cognitive Behavioural practitioner, Person-Centred practitioner). The PM scale should be correlated with other measures desirable in

psychotherapists. It would also be interesting to investigate whether personal therapy and / or personal development in clinicians has the same effect as psychotherapy does in clients on PM (PM increases). It is unclear if engagement in clinicians would yield the similar effects.

Literature suggests there is an optimum level of PM (Farber, 1985) however no "guideline" exists as to what constitutes an adaptive or maladaptive level of PM. Research looking into this phenomenon within a psychotherapist cohort could aid both professional and personal aspects of a clinician's life. Research also suggests that as a cohort psychotherapists are highly psychologically minded, however an empirical expression of what constitutes "high" psychological mindedness does not exist. Research comparing psychotherapists with other generic and health professionals would give rise to this. The present study should be seen as a first step in the process of understanding PM in psychotherapists.

2.6. References

Applebaum, S.A., (1973). The dangerous edge of insight. *Psychotherapy: Theory, Research and Practice,* **13**, 202-206.

Bagby, M.R., Taylor, G.J., and Parker, J.D. (1994). The twenty-item Alexithymia Scale:II. Convergent discriminate and concurrent validity. *Journal of Psychosomatic research*, **38**, 33-40.

Barber, J.P., Crits-Christoph, P., and Luborsky, L. (1990). A guide to the CCRT standard categories and their classification. In L. Luborsky and P. Crits- Christoph (Eds), *Understanding transference: The CCRT method* (pp37-50). New York: Basic Books.

Beck, A.T., Steer, R.A., Epstein, N., and Brown, G. (1990). Beck Self- concept test. *Journal of Consulting and Clinical Psychology, 2,* 191-197.

Beitel, M., and Cecero, J.J., (2003). Predicting Psychological Mindedness from Personality Style and Attachment Security. *Journal of Clinical Psychology.* **59**, 163-172.

Beitel, M., Ferrer, E. and Cecero, J.J. (2004). Psychological Mindedness and Cognitive Style. *Journal of Clinical Psychology*, **60**, 567-582.

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

Connolly, M.B., Crits-Christoph, P., Kurtz, J., Butler, S.F., Shelton, R.C., Hollon, S., Barber, J., Baker, S. and Thase, T.E. (1999). The reliability and validity of a measure of self-understanding of interpersonal patterns. *Journal of counseling psychology*, **46**, 472-482.

Connolly, M.B., and Strupp, H.H. (1996). A cluster analysis of client reported psychotherapy outcomes. *Psychotherapy Research*, **6**, 30-42.

Conte, H.R., Buckley, P., Picard, S., and Karasu, T.B. (1995). Relations between psychological mindedness and personality traits and ego functioning: Validity Studies. *Comprehensive Psychiatry*, **36**, 11-17.

Conte, H.R., Plutchik, R., Jung, B.B., Picard, S., Karasu, T.B. and Lotterman, A. (1990). Psychological Mindedness as a predictor of psychotherapy outcome. A preliminary report. *Comprehensive Psychiatry*, **31**, 426-431.

Conte, H.R., and Ratto, R. (1997). Self-report measures of psychological mindedness. In M. McCallum and W.E. Piper (Eds.), Psychological Mindedness: A contemporary understanding (pp1-26). Mahwah, NJ: Erlbaum.

Conte, H.R., Ratto, R., and Karasu, T.B. (1996). The psychological mindedness scale: Factor structure and relationship to outcome of psychotherapy. *Journal of Psychotherapy research and practice*, **5**, 250-259.

Costa, P.T. and McCrae, R.R. (1992). Revised NEO personality inventory (NEO-PI-R) and NEO five factor inventory (NEO-FFI): Professional manual. Odessa, FL: Psychological Assessment resources.

Davis, M.H. (1983). Measuring individual differences in empathy. *JSAS Catalog of Selected documents in psychology*, **10**, 85.

Derogatis, L.R., (1977). *The SCL-90: Administration scoring and procedures manual – I for revised version.* Baltimore, MD: The Johns Hopkins Hospital.

Farber, B.A., (1983). The effects of psychotherapeutic practice upon psychotherapists. *Psychotherapy: Theory, Research and Practice*, **20**, 174-182.

Farber, B.A., (1983b). The effects of psychotherapeutic role. In B.A. Farber (Ed), *Stress and burnout in the human service professions* (pp97-118). New York: Pergamon.

Farber, B.A., (1985). The genesis, development, and implications of psychological mindedness in psychotherapists. *Psychotherapy*, **22**, 170-177.

Farber, B.A., Manevich, I., Metzer, J., and Saypol, E. (2005). Choosing psychotherapy as a career: Why did we cross that road? *Journal of Clinical Psychology / In Session*, **61**, 1009-1031

Fenton, L.R., Cecero, J.J., Nich, C., Frankforter, T.L and Carroll, K.M., (2001). Perspective is everything. The predictive validity of six working alliance instruments. *Journal of Psychotherapy Practice and Research*, **10**, 262-268.

Fenigstein, A., Scheier, M.F., and Buss, A.H. (1975). Public and private self-consciousness: Assessment and theory. *Journal of Consulting and Clinical Psychology*, **43**, 522-527.

Hatcher, R., Hatcher, S., Berlin, M., Okla, K., and Richards, J. (1990). Psychological mindedness and abstract reasoning in late childhood and adolescence: An exploration using new instruments. *Journal of Youth and Adolescence*, **19**, 307-326.

Hatcher, R.L., and Hatcher, S.L., (1997). Assessing psychological mindedness of children and adolescents. In M. McCallum and W.E. Piper (Eds), *Psychological Mindedness: A Contemporary understanding* (p105-131). Mahwah, N.J: Erlbaum.

Hojat, M. (2001). *User's Guide. The Jefferson Scale of Physician Empathy.* Jefferson Medical College, Philadelphia, PA.

Hojat, M., Gonnella, J.S., Nasca, T.J., Mangione, S., Vergare, M., and Magee, M. (2002b). Physician Empathy: definition, measurement and relationship to gender and specialty. *American Journal of Psychiatry;* **159**, 1563-1569.

Horowitz, L.M., Rosenberg, S.E., Baer, B.A., Ureno G., and Villasenor, V.S. (1988). Inventory of interpersonal problems: Psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology, 56,* 85-892.

Horvath, A.O., (1981). *An exploratory study of the concept of therapeutic alliance and its measurement.* Unpublished doctoral dissertation, University of British Columbia, Vancouver, Canada.

Horvath, A.O., and Greenberg, L.S., (1989). Development and validation of the Working Alliance Inventory. *Journal of Counselling Psychology*, **36**, 223-233.

Kunyk, D. and Olson, J.K. (2001). Clarification of conceptualizations of empathy. *Journal of Advanced Nursing*, **35**, 317-325.

Levinson, D.J., Sharaf, M.R., and Gilbert, D.C. (1966). Intraception: Evolution of a concept. In G.J. DiRenzo (Ed.) *Concepts, Theory and Explanation in the Behavioural Sciences* (pp 116-135). New York: Random House.

Lotterman, A.C. (1979). *A questionnaire measure of psychological mindedness and the capacity to benefit from psychotherapy.* Unpublished manuscript.

Martin, D.J., Garske, J.P., and Davis, M.K., (2000). Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. *Journal of Consulting and Clinical Psychology,* **68**, 438-450.

Piper, W.E., Joyce, A.S., Azim, H.H., and Rosie, J.S. (1994). Patient characteristics and success in day treatment. *Journal of Nervous and Mental Disease*, **182**, 381-386.

Ryff, C.D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology*, **57**, 1069-1081.

Shill, M.A. and Lumley, M.A. (2002). The Psychological Mindedness Scale: Factor structure, convergent validity and gender in a non-psychiatric sample. *Psychology and Psychotherapy: Theory, research and Practice*, **75**, 131-150.

Trudeau, K.J. and Reich, R. (1995). Correlates of psychological mindedness. *Personality and Individual Differences*, **19**, 699-704.

Westen, D., Huebner, D., Boekamp, J., Lifton, N., and Silverman, M. (1991). Assessing complexity of representations of people and understanding of social causity: A comparison of natural science and clinical psychology graduate students. *Journal of Social and Clinical Psychology,* **10**, 448-458.

CHAPTER THREE

A Survey Investigating the Experience of Personal Therapy in Qualified Therapists.

Abstract

The interest in personal therapy in therapists has a longstanding history which can be traced back through the development of the profession worldwide. Prevalence rates of psychotherapists in personal therapy show that personal therapy is popular. This research addressed a gap in the field regarding personal therapy in British qualified therapists. This study used quantitative and qualitative methods to begin to understand personal therapy in qualified clinicians in this country. The results showed two thirds of the therapists had engaged in personal therapy which is consistent with previous American research. The two most frequently cited reasons for personal therapy were "personal growth" and "personal distress". Interpretative Phenomenological Analysis (IPA) yielded two broad processes containing six themes when therapists' were asked to comment on their personal therapy experiences. Participants saw their own personal therapy as a valuable way to address, manage and take for themselves professionally and personally. Participants also expressed they learnt experientially whilst engaged in therapy, acquiring deeper understandings about theories, models and therapeutic processes. Similarly experiencing the client role had yielded deeper empathy and respect for their clients. A limitation of the present study was the low response rate (n=48). It is argued that this phenomenon reflects the reluctance of practitioners in this country to engage in discourse about personal therapy. This research finding in itself highlights a huge under researched area in qualified psychotherapists and specifically Clinical Psychologists in this country.

3.1 Introduction

The interest in personal therapy in therapists has a longstanding narrative which can be traced back through the development of the profession of psychoanalysis and later psychotherapy (Wiseman and Shefler, 2001).

3.1.1. Potential contributions of Personal Therapy on Clinical Practice

Norcross, Strausser-Kirtland and Missar (1988) identified six recurring tenets to the potential contributions of personal therapy on clinical practice when reviewing literature concerning personal therapy in psychotherapists. The tenets were;

> "*1) by improving the emotional and mental functioning of the psychotherapist: it makes the clinician's life less neurotic and more gratifying in a profession where one's personal health is an indispensable foundation; 2) by providing the therapist-patient with a more complete understanding of personal dynamics, interpersonal elicitations and conflictual issues: the therapist will thereby conduct treatment with clearer perception, les contaminated reactions, and reduced countertransference potential; 3) by alleviating the emotional stresses and burdens inherent in this "impossible profession": it enables a practitioner to deal more successfully with the special problems imposed by our craft; 4) by serving as a profound socialisation experience: it establishes a sense of conviction about the validity of psychotherapy, demonstrates its transformational power in their own lives and facilitates the internalisation of the healer role; 5)by placing therapists in the role of the client and thus sensitising them to the interpersonal reactions*

and needs of their own clients; and 6) by providing a firsthand intensive opportunity to observe clinical methods: the therapist's therapist models interpersonal and technical skills"

(in Orlinsky, Norcross, Ronnestad and Wiseman, 2005; p225-226).

3.1.2. Personal Therapy and Treatment Outcome

Previous research has tried to ascertain whether the benefits of personal therapy impact on the efficacy of patient-therapists' sessions (treatment outcome). Conflicting evidence exists supporting (Norcross et al., 1988) and refuting (Macaskill, 1998; Macran and Shapiro, 1998) this position. In a recent review of literature Orlinsky et al., (2005) reiterated the poor quality of studies concerned with personal therapy and treatment outcome to date. They stated none of the studies were randomised or controlled, all involved comparatively small samples and crude assessments of patient outcomes. Further to this Beutler, Machado and Neufeldt (1994) argue no relationship is found between personal therapy and treatment outcome as reasons for engaging in therapy are too diverse. As such this leads to complex interactions between personal therapy and therapist efficacy.

3.1.3. Personal Therapy and Process Studies

More encouraging findings suggest personal therapy does positively impact on in-therapy process; centrality of warmth, empathy and the personal relationship; the importance of transference and countertransference (Orlinsky et al., 2005). Hence evidence supports the notion that personal therapy aids the therapists' ability to

provide clients with a good therapeutic relationship which is central to psychotherapy outcome (Lambert and Bergin, 1994).

3.1.4. Prevalence of Personal Therapy

Prevalence of personal therapy in psychotherapists shows that personal therapy is popular. It is estimated that in America and the UK, between two thirds and three fourths of therapists have received some form of personal therapy (Macran, Stiles and Smith, 1999). In Norcross's most recent review of literature he estimates the prevalence is approximately three quarters of all mental health professionals (Norcross, 2005). Research from America states prevalence of personal therapy varies with theoretical orientation; Psychoanalytic clinicians have the highest rates and Behaviour therapists the lowest (Norcross, 2005).

3.1.5. Therapists' Experience of Personal Therapy

Therapists' self-reports of experience of personal therapy indicate that the majority benefited considerably professionally and personally (Macran et al., 1999; Wiseman and Shefler, 2001; Norcross, 2005). Across six studies cited in Orlinsky et al.'s recent chapter (2005; p214-230) 90% or more psychotherapists were satisfied with their treatment. They state "*even accounting for cognitive dissonance and rosy memories, the vast majority of therapists seem to have had very positive experiences*" (Orlinsky et al., 2005; p215). Psychotherapists state improvement in multiple areas: self-esteem, work functioning, social life, emotional expression and symptom severity (Norcross, 2005). The majority of psychotherapists also strongly valued the

experiential learning personal therapy brought to their professional practice (Norcross, 2005). In two studies asking Psychologists what they had learnt from their experience of personal therapy; one using an American sample (Norcross et al., 1988) the other asking Psychologists in the UK (Norcross, Dryden, DeMichele, 1992) the most frequent responses concerned the interpersonal relationships and dynamics of psychotherapy. These included centrality of warmth, empathy, and the personal relationship; knowing what it's like to be a client; the importance of transference and countertransference; the need for personal treatment amongst therapists; the inevitable "human-ness" of the therapist; and the need for more client tolerance in psychotherapy (Norcross, 2005).

3.1.6. The Present Study

In 1992 Norcross et al. stated that "*to their knowledge their study was the first to focus on British Clinical Psychologists personal therapy experiences*" (1992; p30). Research regarding British clinicians' personal therapy has developed since this time however the majority is concerned with therapists in training. It is hoped that this research will address a gap in the field regarding British qualified therapists. By beginning to understand and document the personal therapy experiences of therapists in this country it is hoped a more general understanding of such experiences in the UK will prevail. The aims of the present study are 1) to quantify, through a postal survey, the personal therapy experiences of qualified therapists in this country. 2) Contribute to the understanding of personal therapy in therapists in the UK via an interpretative relationship with transcripts regarding their experiences.

3.2. Method

3.2.1. Participants

Participants comprised of 48 qualified therapists who responded to a postal questionnaire distributed by the author (a 22% response rate). All therapists (10 males, 38 females) worked within the Midlands region of the UK. Ages ranged from 28 to 63 years (M=42.9); 69% described themselves as "married or living as married" (n=33), 19% as "single / never married" (n=9), 4% as "separated" (n=2), 4% as "divorced" (n=2) and 4% as "widowed" (n=2). The racial composition of the sample was 98% Caucasian (n=47), 2% Indian (n=1).

The sample had practiced as qualified therapists for between 2 months and 32 years (M= 10.75 years); 71% of the sample described their professional role as "Clinical Psychologist" (n=34), 17% as "Counsellor" (n=8), 6% as "Other" (n=3), 4% as "Psychotherapist" (n=2) and 2% as "Counselling Psychologist" (n=1).

3.2.2. Materials

The participant introduction letter (appendix one), participant information sheet (appendix two) and research participant instructions (appendix three) informed potential participants that involvement in this study was voluntary; these forms also assured anonymity and confidentiality. Participants were asked to complete a 34-item questionnaire; "Questionnaire One" (appendix four).

Questionnaire One

This measure was designed by the author to collect information regarding the participants' demographic status, occupation, professional training, supervision and experiences of personal therapy. The questionnaire was piloted on a number of qualified clinicians before the current version was included in this study (version 5).

The "About Your Personal Therapy" section, which is this paper's main concern, asked participants about their experience(s) of personal therapy. Participants were asked if they had ever engaged in personal therapy (QU 28), if they would consider personal therapy (QU 29) and how many sessions of personal therapy they have engaged in (QU 30). Participants were then asked to tick each purpose that applied to them regarding the purpose of previous and current episodes of personal therapy. Categories regarding the "purpose of personal therapy" (questions 31 and 33) were generated from the research findings of Macran et al., (1999; p420). Finally participants were invited to comment on their experience of personal therapy.

3.3. Procedure

A questionnaire pack comprising of the material outlined previously and a number of other questionnaires (as part of a larger study) was sent to all qualified psychological therapists (N= 220) in three National Health Service Trusts in the Midlands. The correspondence explained that this was an opportunity to participate in research about clinical practice. Interested practitioners were asked to complete the consent forms

(appendix ten) and questionnaires and return them, in an enclosed stamped, self-addressed envelope to the author.

3.3.1. Qualitative Analysis

Responses to QU 34 "Please comment on your experience of Personal Therapy" was analysed following the procedure documented by Smith (2003; Smith and Osborn, 2003), which he described as interpretative phenomenological analysis (IPA). For a full description of the IPA process please see appendix eleven. The IPA process allowed the researchers to gain an understanding regarding therapists' experience of personal therapy via a bottom-up approach. The researchers started from responses and moved towards concepts that organized and integrated what was observed in the responses.

3.3.1.1. The Researchers

The responses to QU 34 were transposed and initially analysed by the author, who is a 30 year old white British woman currently in the final stages of Clinical Psychology Doctorate training with an additional 3 years of postgraduate psychological research experience. Her colleague, Maxine Richards is a 32 year old mixed white British and black Caribbean woman experienced in qualitative research methods. The supervisor of the project, Stephen Joseph, is a psychotherapist with extensive experience of personal therapy and qualitative methods. One researcher had engaged in personal therapy and had found it valuable and beneficial; the other had no strong views about personal therapy.

3.4. Results

3.4.1. Quantitative Analysis

Descriptive and frequency data was obtained from SPSS version 12 regarding participants' responses (n=48) to the personal therapy section of Questionnaire One.

Have you ever engaged in personal therapy?

66.7% (n=32) participants stated they had engaged in personal therapy, 33.3% (n=16) stated they had not.

Would you consider personal therapy?

The majority of the sample had engaged in personal therapy (n=32). Of the remaining clinicians 81.25% (n=13) stated they would consider personal therapy, 4.2% (n=2) did not respond to the question and 2.1% (n=1) stated they would not consider personal therapy.

How many sessions of personal therapy have you engaged in?

The number of personal therapy sessions clinicians had engaged in ranged from 5 to 728. The mean number of sessions was 153.72 (SD 207.98). The median number of sessions was 47.5, mode number of sessions 50.

Purpose of previous episodes of personal therapy.

Table 3.1 shows the purpose(s) of engaging in previous episodes of personal therapy in the sample (respondents marked all categories that applied).

Table 3.1. A Frequency Table Illustrating Purpose(s) of Engaging in Previous Episodes of Personal Therapy.

	N	%
Purpose of engaging in personal therapy		
Personal Growth	26	81.25
Personal Distress	24	75
Training Requirement	19	59.38
To prevent burn-out	10	31.25
Self- reflection as a practitioner	11	34.38
Other	3	9.38

Three reasons for engaging in personal therapy were given most often (n=13). In these instances "personal growth" was always given as a reason to engage in personal therapy. When just one purpose for engaging in personal therapy was given (n=7) the predominant reason reported was "personal distress" (n=6) followed by "personal growth" (n=1).

Are you currently receiving personal therapy?

14.6% (n=7) of respondents reported that they are currently engaged in personal therapy.

Purpose of current episodes of personal therapy.

Table 3.2. shows the purpose(s) of current personal therapy in the sample (respondents marked all categories that applied).

Table 3.2. A Frequency Table to Illustrate the Purpose(s) of Engaging in Current Personal Therapy.

	N	%
Purpose of engaging in personal therapy		
Personal Growth	6	85.71
Personal Distress	2	28.57
Training Requirement	0	0
To prevent burn-out	3	42.86
Self- reflection as a practitioner	1	14.29
Other	0	0

3.4.2. Qualitative Analysis

A consistent pattern of themes emerged from the participants responses to "Please comment on your experience of Personal Therapy" (n=29). The analysis yielded 6 salient themes (one apparent theme that seemed idiosyncratic to one or two participants have been excluded because of space constraints) which were grouped into two broad domains, as shown in Table 3.3.

Table 3.3. A Table showing Themes and Domains derived from responses to "Please comment on your experiences of Personal Therapy".

Domain and Theme	No of participants with theme
Impact on the "person"	
1. Therapist takes care of self	8
2. Therapists develops as a person	10
3. Enriching experience	13
Impact on the "professional"	
4. Therapist learns from therapy	6
5. Therapist learns from client role	10
6. Maintains working relationships	5

Each theme is considered in turn, with excerpts to illustrate each one.

3.4.2.1. Impact on the "Person"

This domain concerned the impact of personal therapy on the participants' "person"; the person who works as a therapist. It encompassed the participants' subjective, positive, experience of personal therapy as potentially very challenging but worthwhile (enriching experience). This domain also encompasses the therapists' awareness of personal growth facilitated through personal therapy (therapist develops as a person) and acknowledges the importance of taking care of the person "in" the therapist (therapist takes care of self).

Theme 1: Therapist takes care of self.

Participants described their personal therapy as a key way of taking care of themselves both professionally and personally. Therapists' stated personal therapy helped to contain, work through or even off-load issues that arose due to the nature of their clinical caseload.

> "I have engaged in therapy for a number of reasons since qualifying. On occasion this has been to deal with distress following major life events. More generally I value the time to separate my own issues from client's which is vital to me given that I use reflection and transference, counter transference with clients. I also work with those who have been sexually abused and who inflict significant trauma to others. I find therapy provides a helpful place to ensure that work does not get taken home and prevents me from losing empathy because I have not processed my reaction to such issues. Some of this can be addressed in supervision but when it relates to ones own personal issues then it needs to be reflected on in a therapeutic space".
>
> (Participant 14)

> "The nature of my work means I often deal with complex emotions with clients that have a personal bearing on myself as a person - personal therapy assists with this process and is a good way to grow personally and deal with the distress of the feelings generated through client work and external personal experiences". (Participant 42)

Both participants talk of the benefits of having their own therapeutic space to process and reflect upon the impact of their clients' stories, emotions and behaviours. Both extracts also acknowledge that therapists need to take care of themselves psychologically so that safe, effective clinical work can take place. They also

recognize that they bring dynamics to the therapeutic relationship which warrants a separate space to clinical supervision.

In taking care of themselves, therapists also accepted personal therapy could help alleviate personal distress separate from that generated by the nature of the profession:

> "Felt better able to cope with personal distress". (Participant 12).

> "Very helpful in recognising patterns from childhood and in supporting me through a very difficult time". (Participant 45).

Hence therapists acknowledge that personal therapy is a useful and valuable space to address and work through personal issues that arise through clinical work or personal experiences.

<u>Theme 2: Therapist develops as a person.</u>

This theme encapsulates the concept of personal growth and insight into personal vulnerabilities and drives. Many therapists described how personal therapy helped facilitate change in them personally.

> "I found personal therapy enabled me to grow as a person. It gave me insight into factors that drive me. I was able to understand what it feels like to be a client. I have gained as a person and am able to see clearer about the motivations that drive me as a therapist". (Participant 21)

> "My experience has been very positive. The therapist is a good listener and her reflections are very helpful. Through my experience of therapy I have been able to recognise patterns which have been unhelpful and start to change these in my life". (Participant 41)

Hence the therapists acknowledge that personal therapy is useful in developing a better psychological understanding of their own internal processes and imply that this leads to personal gains.

Theme 3: Enriching experience.

All of the respondents talked of the actual experience and gains of personal therapy in a positive light. Some, as illustrated by participant 22, described the challenge of engaging in the therapy process initially but this was always counterbalanced with a positive stance regarding the overall process and experience in general.

> "Frightening. Initially hated vulnerability and having to be a client! Exceptionally challenging and huge struggle to get to sessions some weeks but ultimately hugely rewarding" (Participant 22).

Some participants commented on their experience using just one or two words. In each case the message was a clear, positive one;

> "I have valued it" (Participant 6)
>
> "Tough, stimulating, life giving" (Participant 35)
>
> "Invaluable on a number of levels, personally, professionally and as a member of a wider clinical team and network" (Participant 43)

3.4.2.2. Impact on the "Professional"

Therapists stipulated their clinical practice was more informed since engaging in personal therapy. They learnt experientially from being the client rather than the therapist in the relationship (therapist learns from client role) and they felt they had a deeper understanding of process issues, models and techniques through actually experiencing these rather than merely reading about them (therapist learns from therapy). Finally therapists acknowledged engaging in personal therapy helped them maintain working relationships with clients thus reduced the likelihood of becoming "burnt out" or less empathic in the clinical setting. Hence personal therapy had helped maintain their humane approach to clinical work (maintains working relationships).

Theme 4: Therapist learns from therapy.

Respondents stated they experientially learnt about the therapy process. Many advocated that such an experience was essential in really understanding the nature of this work:

> ".....professionally it helped me understand the importance of boundaries, regular times and appts, the power of summarising and reflecting and a patients positive feelings towards their therapist" (Participant 8)

> "Personal therapy was a very positive experience in the sense of understanding a model in much more detail..." (Participant 27)

"Absolutely essential to understand the craft of psychotherapeutic treatment from within myself rather than books…….. Working in depth with my own therapy allowed me to develop ways of working in depth with clients…"

(Participant 28)

Theme 5: Therapist learns from client role.

Therapists articulated that experiencing the client role had shaped their therapeutic practice.

"Sitting in the other chair" and experiencing what it feels like to be a client has significantly improved my practice (I believe)". (Participant 4)

"It was a very helpful experience professionally in that I understood the experience of being in the receiving end……" (Participant 24)

"Personal therapy was a very positive experience….Also to experience being the client - how I felt when challenged, the relationship with a therapist, how one feels after therapy and so on". (Participant 27)

"PT made me realise how frightening it can be to go to a therapist. My respect for my clients has increased as a result." (Participant 28)

It is implied that experiencing the client role has led to more personable or empathic practice towards clients in the therapists' own clinical work.

Theme 6: Maintains working relationships.

The final concept participants described was personal therapy's role in maintaining effective therapeutic practices. Participants described how personal or professional

issues could affect them which in turn would invariably impact on their clinical practice. Hence by engaging in personal therapy they avoided "burn out" and were able to work with clients they could not have otherwise.

"...I find therapy provides a helpful place to ensure that work does not get taken home and prevents me from losing empathy because I have not processed my reaction to such issues. Some of this can be addressed in supervision but when it relates to ones own personal issues then it needs to be reflected on in a therapeutic space. I personally think that anyone working long term with severe trauma and or offending behaviour and or personality disorders would benefit from ongoing therapy!" (Participant 14)

"...and to ensure that my professional practice does not suffer due to very challenging personal experiences over the past couple of years".
(Participant 29)

3.4. Discussion

The quantitative results show two thirds of the sample have engaged in personal therapy. This finding is consistent with previous American research stating the vast majority of mental health professionals have undergone personal treatment (Norcross, 2005); and shows a considerably higher proportion than that quoted in Norcross et al.'s (1992) survey of British Clinical Psychologists but mirrors the prevalence (between two thirds and three fourths) quoted by Macran et al., (1999; p419). Unfortunately the size of the sample in this study did not allow exploration of the impact of theoretical orientation on prevalence of personal therapy however this would be interesting to consider in further research

The most frequently stated reasons for engaging in therapy were "personal growth" and "personal distress" this also mirrors recent results regarding American practitioners' motivations to engage in therapy (Norcross, 2005). Not all respondents who engaged in personal therapy commented on it (n = 4). Reasons for this can only be inferred. The overall consensus of those who did comment was personal therapy was a positive experience which helped them in their personal and professional lives. This finding reflects robust findings in American (Norcross, 2005), British (Macran et al., 1999; Norcross et al., 1992; Orlinsky et al., 2005) and European samples (Orlinsky, Ronnestad, Willutki, Wiseman and Botermans, 2005; Orlinsky and Ronnestad, 2005). This may not have been the case for the four participants who chose not to comment and this should be kept in mind.

The fact that the large majority of practitioners contacted (n=220) did not complete and return questionnaires (n=172) should also be given consideration. Potentially there are many reasons for this such as the length of the research pack and time constraints within the working day. Guy and Liaboe (1986) highlighted "*...the puzzling silence among mental health professionals concerning the need for periodic or ongoing psychotherapy for experienced psychotherapists*" (p20). Norcross et al., (1992) stated "*The silence is deafening*" (p30) when trying to review literature regarding personal therapy in British Clinical Psychologists. One could hypothesise that the poor response rate of practitioners in this study is due to this trend. Questionnaires were predominately sent to Clinical Psychologists, perhaps the silence inferred in this research reflects the reluctance to discuss personal therapy in this

professional group, in this country. Possibly the non respondents in this study did not want to engage in a dialogue about personal therapy thus reflecting a long standing, well documented phenomenon within the profession as a whole (Norcross et al., 1992). This research finding in itself highlights a huge under researched area in qualified psychotherapists and specifically Clinical Psychologists in this country. Further research should try and understand "*the silence*" (Norcross et al., 1992; p30) in the profession.

The respondents' overwhelmingly positive reflections on personal therapy could be due to another skew in the sample. Therapists who have had positive personal therapy experiences (rather than negative ones) may have been more willing to participate. Hence those with lesser experiences of personal therapy chose not to respond to the questionnaire. Investigating these experiences would also be another valid area for further research. It is also plausible that negative feelings about therapy diminish with hindsight. Since the questionnaire did not ask participants to comment on all treatment episodes participants may have chosen to comment on their most positive experience. It is hoped respondents in this enquiry do make up a representative sample; a cross section of qualified practitioners in the Midlands, from which findings can be generalised. With such a poor response rate and small sample this cannot be guaranteed however quantitative findings have mirrored those of larger studies which is promising.

Although in depth interviews were not conducted in order to research personal therapy in qualified therapists the main themes were still apparent in the communication. Each of the six themes appeared in the responses of five or six participants and half appeared in ten or more of them (as shown in Table 3.3.). The goal of this research was to begin to build an up-to-date understanding of personal therapy in qualified practitioners in the UK, it is hoped this has been achieved.

What understandings did therapists convey about their personal therapy? The findings suggest two broad processes (the domains illustrated in Table 3.3.). First, the participants acknowledged their part in the therapy process and saw their own personal therapy as a useful and valuable way to address, manage and take care of that presence. In every instance this was understood to be a positive experience. Challenges in this process were often inferred or expressed however the overwhelming sense was that the process had, on the whole, been an enriching experience. The final domain emphasised how personal therapy impacted on the therapists' professional practice. Through personal therapy therapists had experientially learnt more and felt they had deeper understandings about theories, models and therapeutic processes. Similarly experiencing the client role had yielded deeper empathy and respect for their clients. Finally therapists recognised the impact of the person in the professional role and used personal therapy as a way of maintaining healthy working relationships with clients. This piece of research reinforces the notion proposed by Orlinsky et al. (2005) which states "*It seems virtually impossible to have undergone personal therapy oneself without emerging*

with heightened appreciation of the interpersonal relationship and the vulnerability felt by patients" (p223).

Within each domain there appeared to be particular ways in which aspects of personal healing or growth contributed to aspects of participants' later effectiveness as therapists. More generally, it seemed therapists who had come to terms with his or her own vulnerabilities; anxieties, "humanities" and other personal problems were presumably able to work more effectively. Norcross et al., (1992) wrote "*The goal of the psychotherapist's personal treatment is to alter the nature of subsequent therapeutic work in ways that enhance its effectiveness*" (p29) this goal was not always explicit in this sample however many deduced their therapeutic practice was enhanced as a result of their experience of personal therapy. Further still Norcross et al.'s (1988) six potential contributions of personal therapy to clinical work were recognised in this sample.

The domains elicited in this research were not completely separate or independent: Experiences in one domain sometimes appeared to influence translations in another. Macran et al (1999) suggest this reflects the integrated, interconnected way in which individuals organise their thoughts, feelings and experiences. I would suggest this illustrates how it is difficult to separate the person from the professional (and vice versa) in this vocation. To paraphrase Freud, psychotherapists possess a special skill, but beyond that, we are inescapably human.

As in most qualitative studies, the interpretations made must be considered as tentative and limited by the context of the work – including the analysts' own biases. The small analyst team in this study did however consist of people with and without personal therapy experience. Nevertheless a larger group of people analysing the qualitative material would have increased confidence in consensus (Hill, Thompson and Williams, 1997). As previously discussed the sample in this study was small and not necessarily representative of therapists generally. Different themes may have been found in a different cohort of therapists. However the strong commonalities of themes within the group and the broad parallels with the results of previous research (Norcross et al., 1988; Norcross et al, 1992; Norcross, 2005) offer some assurance that many of the themes would appear in other samples.

The results of this study are also subject to limitations due to the self-report nature of Questionnaire One. The questionnaire is only capable of accessing retrospective self-perceptions of the experience of personal therapy. An opportunity to speak to the therapists' therapists would be very enlightening and would make for a fascinating piece of research although the pragmatics of conducting such a study would be near impossible.

A further problem with this research is that it assumes uniformity as "qualified therapists" whereas the sample comprised of professionals from different occupational and theoretical backgrounds. Unfortunately the sample was too small to conduct analysis on the basis of gender, age range, years of clinical practice,

theoretical orientation or professional role. Such analysis may have shown discrepancies (or indeed similarities) between these groups.

This research is just a starting point. Possible future work would entail conducting similar research strategies with larger samples or carrying out more in-depth interviews with therapists, with a larger team of analysts thus building on what has been achieved. Future research could look in detail as to whether personal therapy does in fact bring gains to therapists that are not readily available in supervision, training courses or reading. Just as the therapist needs to consider the fit between client and intervention, therapists may have a preference as to how the gains of personal therapy are sought (if a choice exists). The nature of personal therapy at different stages in the therapists' career would also be interesting to investigate as would interviewing those who have chosen not to engage in personal therapy or have had negative experiences.

In conclusion, Kottler (1986) stated if therapists did not believe that they themselves could benefit from the therapeutic tools of their profession, they have no business practising them on others. It is unclear from this investigation if this sample embarked on personal therapy because of their trust in their profession or if the sample is representative of the profession in the UK due to its size. Nevertheless what is clear is this sample came to see personal therapy as an essential tool for learning about therapeutic practice further reiterating previous research findings (Macran et al., 1999; Norcross, 2005, Orlinsky et al., 2005; Wiseman and Shelfer,

2001). Future research should continue this work and try to establish the findings of the present paper within a representative sample of UK psychotherapists.

3.5. References

Beutler, L.E., Machado, P.P., and Neufeldt, S.A. (1994). Therapist variables. In A.E. Bergin and S.L. Garfield (Eds), *Handbook of psychotherapy and behaviour change* (4th ed., pp229-269). New York: John Wiley.

Guy, J.D., and Liaboe, G.P., (1986). Personal therapy for the experienced psychotherapist: A discussion of its usefulness and utilization. *The Clinical Psychologist*, **39**, 20-23.

Hill, C.E., Thompson, B.J., and Williams, E.N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist*, **25**, 517-572.

Kottler, J.A. (1986). *On being a therapist.* London: Jossey-Bass

Lambert, M. J., and Bergin, A.E., (1994). The effectiveness of psychotherapy. In A.E. Bergin and S.L. Garfield (Eds), *Handbook of psychotherapy and behaviour change* (4th Ed., pp143-189). New York: John Wiley.

Macaskill, N.D. (1998). Personal therapy in the training of the psychotherapist: Is it effective? *British Journal of Psychotherapy*, **43**, 219-226.

Macran, S. and Shapiro, D. (1998). The role of personal therapy for therapists: A review. *British Journal of Medical Psychology*, **71**, 13-25.

Macran, S., Stiles, W.B., and Smith, J.A., (1999). How does personal therapy affect therapist's practice? *Journal of Counselling Psychology*, **46**, 419-431.

Norcross, J.C., (2005). The Psychotherapist's Own Psychotherapy: Educating and Developing Psychologists. *American Psychologist*, **60**, 840-850.

Norcross, J.C., Dryden, W and DeMichele, J.T., (1992). British Clinical Psychologists and personal therapy: III. What's good for the goose? *Clinical Psychology Forum*, **44**, 29-33.

Norcross, J.C., Strausser-Kirtland, D., and Missar, C.D. (1988). The process and outcomes of psychotherapists' personal treatment experiences. *Psychotherapy: Theory, Research, Practice, Training*, **25**, 36-43.

Orlinsky, D.E., Norcross, J.C., Ronnestad, M, H., and Wiseman, H. (2005). Outcomes and impacts of psychotherapists' personal therapy: A research review. In J.D. Geller, J.C. Norcross, and D.E. Orlinsky (Eds), *The psychotherapist's own psychotherapy: Patient and clinician perspectives* (pp214-230). New York: Oxford University Press.

Orlinsky, D.E., and Ronnestad, M.H. (2005). *How psychotherapists develop: A study of therapeutic work and professional growth.* Washington, DC: American Psychological Association.

Orlinsky, D.E., Ronnestad, M.H., Willutki, U., Wiseman, H., and Botermans, J.F. (2005). The prevalence and parameters of personal therapy in Europe and elsewhere. In J.D. Geller, J,C. Norcross, and D.E. Orlinsky (Eds.), *The psychotherapist's own psychotherapy: Patient and clinician perspectives* (pp177-191). New York: Oxford University Press.

Smith, J.A., (2003). *Qualitative Psychology: A Practical Guide to Research Methods.* London: Sage Publications.

Smith, J.A., and Osborn, M. (2003). Interpretative phenomenological analysis in Smith, J.A., (2003). *Qualitative Psychology: A Practical Guide to Research Methods.* London: Sage Publications (pp51- 80)

Wiseman, H., and Shelfer, G. (2001). Experienced Psychoanalytically Orientated Therapists' Narrative Accounts of Their Personal Therapy: Impacts on Professional and Personal Development. *Psychotherapy: Theory, Research, Practice, Training*, **38**, 129-141.

CHAPTER FOUR

Changing Perspectives of a Trainee Clinical Psychologist

4.1. Introduction

In this reflective review I hope to encapsulate and comment on changes within me whilst training to become a Clinical Psychologist. My perspectives regarding what constitutes effective therapy and thus facilitates therapeutic change have altered dramatically. This review will reflect upon the perspectives I had prior to the course, outline changes in these perspectives and discuss the experiences that facilitated change over the course's duration.

4.1.1. In The Beginning. Before the journey began

Preceding the training course I worked within two psychology academic departments as a research assistant where my focus was directed towards manualised psychological interventions. My remit was to work within multi-disciplinary teams developing and evaluating manualised psychological interventions (based on a Cognitive Behavioural approach). The manuals, developed in the medical model context, were for specific clinical populations with specific psychological problems. As with the majority of treatment manuals developed within the NHS and academic departments the manuals were: written by "expert" psychologists who identified a specific problem to treat, in a specific population, using specific well defined interventions. The manuals were promoted and marketed as the "gold standard treatments" as advocated by the National Health Service and the Home Office (who funded the projects) and the medical profession in general. I took on board this medical model approach to psychological problems 110%.

My limited clinical experience prior to starting training came from an assistant psychologist post in Adult Mental Health. The department I worked in was very pro Cognitive Behavioural Therapy (CBT) I was presented with numerous book chapters and manuals giving detailed descriptions of clinical interventions. Psycho-educational and behavioural interventions such as systematic desensitization and anxiety management courses were presented as the treatment of choice in the field. Although aware of some other models of working within the service I completed the post believing 1) Cognitive Behavioural Therapy was the intervention of choice in Clinical Psychology and 2) Therapeutic gain was a result of psychological techniques. This perspective was reinforced and thus strengthened in the (positive) outcomes of my clinical practice.

4.1.2. Embarking on the Training Course

It is subsequently no surprise that having worked within these contexts I started the course looking forward to the prospect of learning more therapeutic techniques (CBT); an intervention the medical profession hold in high esteem. I wanted to be introduced to, "brush-up" on and widen my knowledge base on more "active" therapy techniques. I had learnt from my professional communications, that this knowledge would equip me for my career as a clinician. Furthermore I believed it was these skills which would shape me into a competent practitioner rather than any other. I was not disappointed as this is what the course delivered. Specific techniques, interventions and psychological theories for an array of presenting problems were taught and Cognitive Behavioural Therapy predominated the teaching.

Questioning my knowledge

When I think back to the beginning of the training course I am gracious enough to be able to laugh at myself – how naïve I had been. In my opinion, coming straight from contexts which subscribed heavily to a more medical way of working, rather than a more diverse clinical background had a lot to do with this. Although the research I was involved in was "real life" research some elements did not truly reflect the idiosyncrasies of the everyday clinical work. For example when recruiting participants in the studies only those participants who attended regularly for appointments were approached. Obviously this needed to be the case in order for the therapy to have any chance of illustrating its potential. However in the populations the research programmes were examining (probation and substance misuse services) regular attendance occurs in the minority. Therefore manipulating this factor alone hugely skews the evidence base for this type of therapy with these populations. Manipulating such parameters made CBT look like a "wonder drug"; here was something which could be utilisable by many professionals (the manuals gave step by step guides to delivery) with little prior psychological knowledge which seemed to be effective with the clients (within the research parameters) over a relatively short period of time.

Then the clinical implications of such parameters were not discussed. As an academic the perils of confounding variables outweighed clinical idiosyncrasies. Now, as a practitioner, when I consider this experience I realise how near impossible it is to conduct worthwhile research that is reflective of true clinical practice. The

research method that best reflects true clinical practice is perhaps the single case experimental design. This unfortunately is not recognised by the medical profession, on the whole, as reliable and valid empirical evidence. Thus more medicalised research methods such as the randomised control trials (RCTs) I was involved in, inform practice and define what works in psychotherapy. However having witnessed the fundamental flaws in this approach in finding effective evidence based practice I am more cynical about conclusions generated from RCTs generally.

My work in adult mental health, prior to the course, was limited. In hindsight I understand that clients were vetted to be deemed appropriate for an assistant to work with. I appreciate this had to happened however I realise that this experience left me naïve to the professions' potential therapeutic repertoire.

My introduction to clinical practice through the medical model moulded my perspectives regarding what constitutes effective psychological interventions. I embarked on the course regarding clinical psychologists to primarily deliver CBT. As in my previous fields CBT was proclaimed as the gold standard treatment for the majority of psychological problems. I have come to question this position. The course has not enlightened me; experiences whilst on the course have opened my eyes.

4.1.3. My Perspective Now

The perspectives I have now regarding the clinical psychologist's role, good clinical practice and competence could not be anymore removed from where I started. Now I see the value in bringing firstly myself, then my counselling skills followed by my psychological knowledge to the therapeutic interaction. The "active" psychological approaches are used if appropriate and required not as a matter of course. I now believe the catalyst of therapeutic change is the interaction / space between practitioner and client, the process rather than anything that is overtly done. My clinical practice these days is more about giving somebody the opportunity to talk and be heard; experience validation, rather than educating the client in psychological models or techniques.

The "interviewing and counselling" workshops on the training course introduced "active listening" skills. However as the workshop title suggests these fundamentals were introduced as a way of facilitating speech in order to produce a formulation. The therapeutic value of counselling skills was not made explicit and so its potential disguised. I have come to appreciate what "common factors" of all therapies can offer for myself. A process the next section describes.

4.2. The Vehicles of Change Within Me

The change in my perspectives has come about due to a number of personal and professional experiences over the last three years; my doctorate research, specialist placement, personal therapy and therapeutic work with non "textbook" clients.

4.2.1. Doctorate Research

The theme of my doctorate research came about as I realised the potential limitations of "active therapies" in my clinical practice. An interest in the process of therapy grew as I started to question the applicability of the techniques with my caseload. I became interested in looking at the people in therapy (therapist and client), something that manualised approaches tend not to do, and started to question and acknowledge what I brought to the therapeutic interaction. The literature I reviewed for my research talked about the efficacy of "common factors" in the therapeutic exchange and acknowledged the impact of the "people" in therapy. For the first time I was presented with empirical evidence concerning what I was questioning in my clinical work. Un-be-known to me this radical break through was common knowledge in Humanistic, Rogerian and Psychoanalytic circles it seemed that everyone knew about this phenomenon apart from me. I was left wondering why I was not aware of this evidence. Was it kept from me or had I ignored this information?

I am still not sure how to answer those questions. Haven spoken to fellow trainees about their beliefs many of them have the same ideas as me. It seems those who had more clinical experience before embarking on the course held this belief when they started training but ignored it in order to succeed at the task in hand; to illustrate proficiency in the active therapies – something it seems the training course (and profession?) admires. Like me, they perceived the course as wanting them to be proficient in techniques rather than valuing the process of being with a client in the room.

The doctorate research process allowed me the time and space to consider and explore the evidence and issues regarding effective clinical practice. It didn't seem enough to just read about this process, I would have felt a fraud not having tried it out for myself, so over the past six months my therapeutic work has focussed on integrating and utilising these new theories (new to me) with my clinical practice. Thus I chose a specialist placement which allowed me to develop and explore my skills in this therapeutic field.

4.2.2. Specialist Placement

I worked as a clinician in a local counselling service requesting that I develop my skills in working with the therapeutic process. Although I considered myself to be doing this more so in my practice I still found it very hard to fully engage in this process myself. I struggled with feeling that I wasn't "doing" anything in the interactions. I wasn't sure I could stick with this approach; it went against everything I had come to understand in my training. I felt I was outside my clinical comfort zone. I had to rely on me in the therapy room now, not the session plans and techniques I would have drawn on previously. This position felt daunting as a trainee I did not value me in the room; my faith was in the techniques.

I'm pleased to say after time I began to feel more comfortable in this new zone. As I observed the therapeutic gains in the clients I worked with, my confidence in my own abilities grew. Therapeutic change in this work was attributed to the relationship the client and I had built and so I felt more able to take some credit for this. (Previously

I'd attribute change to implemented techniques). I had space to explore my part in the therapeutic interaction in supervision and eventually acknowledged that stripped bare of any active techniques I am a resource that can be relied upon in clinical practice.

4.2.3. Personal Therapy

Having acknowledged that I play a part in all my therapeutic interactions it deemed appropriate that I engage in personal therapy to gain insight into what I bring to an exchange. I accessed the therapy network and engaged in twelve sessions of therapy. I approached the service wanting to understand myself better so to inform my clinical practice. Whilst engaged in therapy the goals changed as I experienced a succession of personal losses. I left subsequent sessions wondering when the therapist was going to do something to help or direct me a little regarding my distress and became quite frustrated with her lack of clinical skills or tools. The psychologist had used a humanistic approach and although I was beginning to advocate the usefulness of this approach as a clinician I found it hard to ascribe to this position as a client. Eventually I realised, through my own therapy experience, how therapeutic and validating it was to be given the space to talk and really be heard.

Of course now I have come to appreciate the approach the psychologist was using. My personal distress alleviated without receiving any explicit direction or education. The therapist allowed me to foster my own management and understanding of my reaction to loss. These experiences had also brought "live" material into the sessions

which aided my understanding of me. Thus the therapeutic intervention of an "insight therapy" was the catalyst of the positive therapeutic gains and insight in me.

Despite this personal positive experience I initially still questioned this stance and struggled with not "doing" in sessions. I continued to want to introduce techniques, coping mechanisms and psychological models in my therapeutic work. I held off and as mentioned earlier my clients' therapeutic gains and my personal insight highlighted to me this was my need not a therapeutic need of my clients.

4.2.4. Non Textbook Clients

As I worked through my clinical placements I realised that clients who fit into neat treatment packages are few and far between. More often than not clients present to a service with a problem which is associated with a "straight forward" treatment package by the referrer. However after a thorough assessment of the client's presenting problem and wider experiences I often advocated that the neat treatment packages would not suffice in many cases. Clients who only converse about their presenting problem or experiences associated with their presenting problem are few and far between. A client enters as a person with a complex life, of which the problem is part, and so brings to the clinical setting their life of which the clinical intervention is a part. It seems silly to leave "the life" outside the clinical setting when this where the client operates.

My eclectic practice tentatively began. I saw the value in tailoring treatment approaches to meet the needs of the person in the room rather than the person's problem. I found myself incorporating a more humanistic approach in my clinical work. I came to realise that having accessed the service most clients valued the initial opportunity to express the discomfort and distress associated with their presenting problem. They valued the time to talk without fear of being judged or ridiculed. They valued a good listener. Once the client was engaged and the therapeutic relationship established I tailored my approach to their insight and style. Being an active listener initially facilitated feelings of validation in the client and empathy in me, this in turn developed the therapeutic relationship between us. With this foundation I felt able to bring other approaches, techniques or stances to the interaction, if deemed appropriate, in order to meet the clients' therapeutic goals and needs.

These non textbook clients have taught me the most valuable practitioner lessons. These clients encouraged me to think more about the person in the room rather than the diagnosis. When I first practiced therapeutic work I felt I needed to know everything about the disorder and its' subsequent treatment, before I could begin to intervene. Now I acknowledge that it is useful to have knowledge about disorders, and treatments of course, but believe it is more useful to take to sessions a non-judgemental stance, a congruent approach and genuine interest. In other words these clients taught me that psychologists work with people, and should focus on the person in the room rather than the diagnosis. This seems so obvious but as a novice

practitioner this stance has evolved over the course of my training. This was not implicit in me to begin with.

4.3. Conclusion

I have experienced huge changes professionally and personally over the last three years. Training to become a clinical psychologist has been the hardest thing I have ever done. I never expected this journey to be so personally challenging. The training has left me with more questions about myself than answers. However these challenges have led me to a place I feel content in. I would not change any experiences I have had on the course as I'm happy to be the practitioner (and person) it has shaped me into.

I came to the course aspiring to bring about change in clients through the information, knowledge and techniques. I believed to be a good practitioner I needed to explicitly share my psychological expertise with clients. The research process gave me the opportunity to explore this premise and question ideas I had regarding what constituted effective therapy. The research process allowed me the time to read around, reflect and think over ideas. Given this opportunity I developed more rounded, informed opinions and arguments which in turn shaped my therapeutic work and ideas about effective therapy. I'm leaving the course recognising there is place for techniques and models in the therapy room but that place isn't paramount. The person in the room is paramount to me now, then the presenting problem and everything else; well I'll just see what happens.

APPENDICES

APPENDIX 1

Participant Introduction Letter

Programme Director
Doctorate Course in Clinical Psychology
Dr Delia Cushway
BA (Hons) MSc PhD AFBPS CPsychol (Clin Foren)

School of Health and Social Sciences
Coventry University
Priory Street Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8300

THE UNIVERSITY OF WARWICK

COVENTRY UNIVERSITY

Our ref

Your ref

Date

December 2005

Dear.....

Research Study: Therapists' experience of Therapeutic Alliance

I am writing to you to let you know about the research I am undertaking as part of my clinical training and seek your help with this. My name is Becky Daw and I am studying for a Doctorate in Clinical Psychology at the universities of Coventry and Warwick. I am interested in hearing about your training experiences and clinical work and ask for your participation in completing 5 questionnaires.

The following people are involved in this research:

Becky Daw
Clinical Psychologist in Training at the Universities of Coventry and Warwick.
Telephone number: 02476 888 328
E mail: r.daw@warwick.ac.uk

Dean of School of Health and Social Sciences Dr Linda Merriman Mphil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Telephone 024 7679 5805
Chair of Department of Psychology Professor Koen Lamberts BA BSc MSc PhD University of Warwick Coventry CV4 7AL Telephone 024 7652 3096

Stephen Joseph
Chartered Health Psychologist, Reader In Health Psychology, University of Warwick, Coventry
Telephone number: 02476 528 182

Please find enclosed a participant information letter and consent forms. Please ensure you read the participant information letter and consent forms fully before deciding whether or not to take part in this study.

If you decide to take part in this study then please sign and return the consent forms and completed questionnaires in the stamp-addressed envelope provided.

I would be happy to answer any questions you may have regarding the study. If you do have any questions then please e mail me or call me on the phone number listed above.

I would like to take this opportunity to thank you for reading this letter.

Yours sincerely

Becky Daw
Clinical Psychologist in Training

APPENDIX 2

Participant Information Sheet

PAGE

NUMBERING

AS ORIGINAL

Programme Director
Doctorate Course in Clinical Psychology
Dr Delia Cushway
BA (Hons) MSc PhD AFBPS CPsychol (Clin Foren)

School of Health and Social Sciences
Coventry University
Priory Street Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8300

THE UNIVERSITY OF WARWICK

COVENTRY UNIVERSITY

Our ref

Participant information sheet

Your ref

Date

Study Title:

Therapists' experience of Therapeutic Alliance (the relationship between therapist and client).

Invitation to take part in the study

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

The aim of the study is to investigate how your training experience has impacted on your clinical practice.

Why have I been chosen?

I have contacted all qualified practising psychological therapists who work for Hereford, South Worcester, North Warwickshire and Coventry PCTs.

Do I have to take part?

Participation is completely voluntary but would be very much appreciated. It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect you in any way.

What will happen to me if I take part?

Participation would entail completing 5 questionnaires (enclosed within this correspondence) which will take no longer than 25 minutes to complete.

What do I have to do?

I simply require you to complete one questionnaire asking a little information about you (such as your training route and current professional role) and four other standardised questionnaires which ask about concepts I am interested in investigating in this research, concepts such as empathy.

I then ask that you send the completed questionnaires and consent form back to me within one calendar month to enable me to collate the information efficiently.

NB Please keep this information sheet and a copy of the consent form, for your information, if you do decide to participate.

What are the possible disadvantages and risks of taking part?

There are no foreseeable risks in taking part in this study. Participation in this study will involve completing questionnaires which will take up approximately 25 minutes of your time.

What are the possible benefits of taking part?

Completing the enclosed questionnaires will lead you to reflect on your clinical practice which may be beneficial to your clinical work.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you which leaves the University will have your name removed so that you cannot be recognised from it.

Questionnaires will be anonymous but will carry a code number linking them to your signed consent form. The key to the code numbers will only be privy to the chief investigator.

Signed consent forms and questionnaires will be kept separately at the University of Warwick, Psychology Department in a secure filing cabinet.

What will happen to the results of the research study?

The study forms the research component of a Doctorate in Clinical Psychology, and thus a copy of the research will be kept at both Coventry and Warwick Universities. In addition, it is anticipated that the findings of the research will be published in relevant journals.

Participants who would like to receive a copy of the research findings will be asked to e mail me with their contact details so that they can be forwarded in due course.

No participants will be identified in any reports or publications which come out of the data collated as part of this research.

Who is organising and funding the research?

The research is being partly funded by the Universities of Coventry and Warwick. This funding is to cover the costs of printing and inter library loans. None of the research team will receive any monetary payment in addition to their regular salary for taking part in the research. The study forms the research component of a Doctorate in Clinical Psychology for myself.

Who has reviewed the study?

Warwickshire Local Research Ethics Committee has reviewed this study and given it ethical approval. In addition, the study has received ethics approval from the Research Subcommittee of the Doctoral Course in Clinical Psychology at Coventry University and Warwick Research Ethics Committee.

Contact for further information

If you have any questions or queries regarding this study please do not hesitate to contact me. My contact details are:

Contact in the first instance:

Chief Investigator

Becky Daw

Clinical Psychology Doctorate Course,

School of Health and Social Sciences

Coventry University.

Priory Street

Coventry

CV1 5FB

Telephone 02476 888 328

E mail: r.daw@warwick.ac.uk

Contact in the second instance:

Supervisor

Stephen Joseph

Department of Psychology,

University of Warwick,

Coventry.

CV4 7AL

Telephone (work) 02476 528 182

s.joseph@warwick.ac.uk

Thank you for taking the time to read this information sheet. If you would like to participate in this study please turn overleaf for instructions on what to do next.

Thank you in anticipation,

Becky Daw

Trainee Clinical Psychologist

Universities of Coventry and Warwick

Please keep this information sheet for your information

APPENDIX 3

Research Participant Instructions

Research Participation Instructions

Thank you for agreeing to participate in this investigation.

Please follow these simple steps which will guide you through the participation procedure.

1 Once you decide you are happy to participate in this study please complete and sign the two written consent forms enclosed (one for you to keep and one for you to return).

2 Complete the first questionnaire in the pack: Questionnaire One.

3 Continue to complete questionnaires Two – Five

4 Please look over each questionnaire to ensure you have answered all items on each questionnaire.

5 Having ensured all items are answered please place your completed questionnaires and signed written consent form in the pre-paid envelope.

6 Return the questionnaires to the chief investigator in the post.

7 If you would like to receive a copy of the findings of this research please send an e mail to (e mail address) and details of where the findings are published will be forwarded to you as they become available.

8 If at any point you wish to withdraw from the study please send an email to (e mail address) with the subject heading as "WITHDRAW" and your questionnaires will be removed from the cohort.

Thank you for your participation in the study, it is much appreciated.

APPENDIX 4

Questionnaire One

Questionnaire One

ALL INFORMATION GIVEN IN THIS QUESTIONNAIRE WILL BE DEALT WITH IN THE STRICTEST CONFIDENCE

About you

1. Gender

   M [] F []

2. Age [ ][ ]

3. Marital Status

Single / never married	[]	Widowed	[]
Separated	[]	Married / living as married	[]
Divorced	[]	Other	[]

4. Ethnicity

White	[]	Indian	[]
Black Caribbean	[]	Pakistani	[]
Black African	[]	Bangladeshi	[]
Black other	[]	Chinese	[]
Other (Please specify)	[]		

_____

About your occupation

5. Your qualification(s) as a practitioner

Certificate	[]	Diploma	[]
MA/MSC	[]	Clinical Psych. Doctorate	[]
Other (Please specify)	[]	_____	

6. Please give details of each training course;

Name of training course: _____

Duration of training course: _____

Name of training course: _____

Duration of training course: _____

Name of training course: _____

Duration of training course: _____

7. How would you describe your professional role? E.g. Counsellor, Clinical Psychologist (TICK ONE BOX)

Counsellor	[]	Clinical Psychologist	[]
Counselling Psychologist	[]	Other (Please specify)	[]
Psychotherapist	[]	_____	

8 Why did you decide to pursue this profession?

.....

.....

.....

.....

.....

.....

.....

9 How long have you been practicing since initially qualifying?
(in years and months) [ ][ ]years [ ][ ]months

10 Do you currently work full time [] part time []

11 How much time is spent engaged in therapeutic work during an average week

up to a day [] 1-2 days [] 3-4days [] more than 4 days []

12 How much does your current practice draw on the following approaches:

	I don't use this approach	I occasionally use this approach	I use this approach often	This is my main approach
Client-centred / humanistic	[]	[]	[]	[]
Psychodynamic	[]	[]	[]	[]
Cognitive-Behavioural	[]	[]	[]	[]
Integrative	[]	[]	[]	[]
Systemic	[]	[]	[]	[]
Transpersonal / spiritual	[]	[]	[]	[]

13 What as a practitioner do you bring (metaphorically) to a clinical session?

.....

.....

.....

.....

About your Training

14 How much did your training focus on each of the following approaches;
In teaching the theoretical background?

	None of training	**Very little**	**Most of training**	**All of training**
Client-centred / humanistic	[]	[]	[]	[]
Psychodynamic	[]	[]	[]	[]
Cognitive-Behavioural	[]	[]	[]	[]
Integrative	[]	[]	[]	[]
Systemic	[]	[]	[]	[]
Transpersonal / spiritual	[]	[]	[]	[]

15 How much did your training focus on each of the following approaches;

When allowing practice of these approaches?

	Not at all (less than half a day)	**A little** (between 0.5 and 7 days)	**Moderately** (between 7 and 14 days)	**A lot** (more than 14 days)
Client-centred / humanistic	[]	[]	[]	[]
Psychodynamic	[]	[]	[]	[]
Cognitive-Behavioural	[]	[]	[]	[]
Integrative	[]	[]	[]	[]
Systemic	[]	[]	[]	[]
Transpersonal / spiritual	[]	[]	[]	[]

16 Did your training introduce reflective practice?

Yes [] No []

17 Did your training actively encourage reflective practice?

Yes [] No []

18 Was personal development a requirement of your training course?

Yes [] No [] (got to Q20)

19 Was personal development an optional or compulsory element of the course?

Optional [] Compulsory []

20 Please comment on your experience of Personal Development:

.....

.....

.....

.....

.....

.....

About your SUPERVISION

21 Do you receive formal supervision?

Yes [] No []

22 How many hours of formal supervision do you have a week?

[ ] [ ] hours

23 Is your supervision;

1:1 [] group [] both []

24 is your supervision with;

peers [] a higher grade clinician [] both []

25 What percentage of time is dedicated to you as a reflective practitioner in supervision?

100% [] 75% [] 50%[] 25%[] no time[]

26 Are you satisfied with the amount of supervision you receive?

Yes [] No []

27 Are you satisfied with the quality of supervision you receive?

Yes [] No []

About PERSONAL THERAPY

28 Have you ever engaged in personal therapy?

Yes [] (go to Q30) No []

29 Would you consider personal therapy?

Yes []

No []

STOP HERE. THANK YOU FOR COMPLETEING THIS QUESTIONNAIRE

30 How many sessions of personal therapy have you engaged in?

[ ] [ ] sessions

31 Please tick each purpose that applies as to why you engaged in personal therapy.

Purpose	
Personal Growth	[]
Personal distress	[]
Training requirement	[]
To prevent burn-out	[]
Self-reflection as a practitioner	[]
Other (please specify)	
.....	[]

32 Are you currently receiving personal therapy?

Yes [] No []

33 What is the purpose of this current episode of personal therapy?

Purpose	
Personal Growth	[ ]
Personal distress	[ ]
Training requirement	[ ]
To prevent burn-out	[ ]
Other (please specify)	
.....	[ ]

34 Please comment on your experience of Personal Therapy:

.....

.....

.....

.....

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

APPENDIX 5

Jefferson Scale of Physician Empathy (Health Professional Version)

Questionnaire Two

Please indicate the extent of your agreement or disagreement with each of the following statements by writing the appropriate rating number on the underlined space provided before each statement. Please use the following 7 point scale (a higher number on the scale indicates more agreement):

1 2 3 4 5 6 7

strongly disagree — strongly agree

1 — My understanding of how my clients and their families feel does not influence my treatment

2 — My clients feel better when I understand their feelings

3 — It is difficult for me to view things from my clients' perspective

4 — I consider understanding my clients' body language as important as verbal communication in therapist-client relationships.

5 — I have a good sense of humour that I think contributes to a better clinical outcome.

6 — Because people are different, it is difficult for me to see things from my clients' perspectives.

7 — I try not to pay attention to my clients' emotions in history taking

8 — Attentiveness to my clients' personal experiences does not influence treatment outcomes.

9 — I try to imagine myself in my clients' shoes when providing care to them.

10 — My clients value my understanding of their feelings which is therapeutic in its own right.

11 — Clients' illnesses can be cured only by pharmacological treatment; therefore, emotional ties to my clients do not have a significant influence on treatment outcomes.

12 — Asking clients about what is happening in their personal lives is not helpful in understanding their complaints.

13 — I try to understand what is going on in my clients' minds by paying attention to their non-verbal cues and body language.

14 — I believe that emotion has no place in the treatment of an illness.

15 — Empathy is a therapeutic skill without which my success in treatment is limited.

16 — An important component of the relationship with my clients is my understanding of their emotional status, as well as that of their families.

17 — I try to think like my clients in order to render better care.

18 — I do not allow myself to be influenced by strong personal bonds between my clients and their family members.

19 — I do not enjoy reading non-medical literature or the arts.

20 — I believe that empathy is an important therapeutic factor in treatment.

APPENDIX 6

Psychological Mindedness Scale

	Strongly agree	Agree	Disagree	Strongly disagree
1 I would be willing to talk about my personal problems if I thought it might help me or a member of my family.	4	3	2	1
2 I am always curious about the reasons people behave as they do.	4	3	2	1
3 I think that most people who are mentally ill have something physically wrong with their brain.	4	3	2	1
4 when I have a problem, if I talk about it with a friend, I feel a lot better.	4	3	2	1
5 Often I don't know what I'm feeling.	4	3	2	1
6 I am willing to change old habits to try a new way of doing things	4	3	2	1
7 there are certain problems which I could not discuss outside my immediate family.	4	3	2	1
8 I often find myself thinking about what made me act in a certain way	4	3	2	1
9 emotional problems can sometimes make you physically sick.	4	3	2	1
10 when you have problems, talking about them with other people just makes them worse.	4	3	2	1
11 usually, if I feel an emotion, I can identify it	4	3	2	1
12 if a friend gave me advice about how to do something better, I'd try it out.	4	3	2	1
13 I am annoyed by someone, whether he is a doctor or not, who wants to know about my personal problems.	4	3	2	1
14 I find that once I have developed a habit, it is hard to change, even if I know there is another way of doing things that might be better.	4	3	2	1
15 I think that people who are mentally ill often have problems which began in their childhood.	4	3	2	1
16 letting off steam by talking to someone about your problems often makes you feel a lot better.	4	3	2	1
17 people sometimes say that I act as if I am having a certain emotion (anger, for example) when I am unaware of it.	4	3	2	1
18 I get annoyed when people give me advice about changing the way I do things.	4	3	2	1
19 it would not be difficult for me to talk about personal problems with people such as doctors or clergymen.	4	3	2	1

	Strongly agree	Agree	Disagree	Strongly disagree
20 if a good friend of mine suddenly started to insult me, my first reaction might be to try and understand why he was so angry.	4	3	2	1
21 I think that when a person has crazy thoughts, it is often because he is very anxious or upset.	4	3	2	1
22 I've never found that talking to people about my worries helps much.	4	3	2	1
23 often, even though I know that I'm having an emotion, I don't know what it is.	4	3	2	1
24 I like to do things the way I've done them in the past. I don't like to try to change my behaviour much.	4	3	2	1
25 there are some things in my life I would not discuss with anyone	4	3	2	1
26 Understanding the reasons you have deep down for acting in certain ways is important.	4	3	2	1
27 at work, if someone suggested a different way of doing a job that might be better, I'd give it a try.	4	3	2	1
28 I've found that when I talk about my problems to someone else, I come up with ways to solve them that I hadn't thought of before.	4	3	2	1
29 I am sensitive to the changes in my own feelings.	4	3	2	1
30 when I learn a new way of doing something, I like to try it out to see if it would work better than what I had been doing before.	4	3	2	1
31 it is important to be open and honest when you talk about your troubles with someone you trust.	4	3	2	1
32 I really enjoy trying to figure other people out.	4	3	2	1
33 I think that most people with mental problems have probably received some kind of injury to their head.	4	3	2	1
34 talking about your worries to another person helps you to understand problems better.	4	3	2	1
35 I'm usually in touch with my feelings.	4	3	2	1
36 I like to try new things, even if it involves taking risks.	4	3	2	1
37 It would be very difficult for me to discuss upsetting or embarrassing aspects of my personal life with people, even if I trust them.	4	3	2	1
38 if I suddenly lost my temper with someone, without knowing exactly why, my first impulse would be to forget about it.	4	3	2	1

	Strongly agree	Agree	Disagree	Strongly disagree
39 I think that what a person's environment (family etc) is like has little to do with whether he develops mental problems.	4	3	2	1
40 when you have troubles, talking about them to someone else just makes you more confused.	4	3	2	1
41 I frequently don't want to delve too deeply into what I'm feeling.	4	3	2	1
42 I don't like doing things if there is a chance that they won't work out.	4	3	2	1
43 I think that no matter how hard you try, you'll never really understand what makes people tick.	4	3	2	1
44 I think that what goes on deep down in a person's mind is important in determining whether he will have a mental illness.	4	3	2	1
45 fear of embarrassment or failure doesn't stop me from trying something new.	4	3	2	1

APPENDIX 7

Self-Understanding of Interpersonal Patterns Scale

Read each item and circle "yes" or "no" to indicate whether the statement is relevant to your current life.

For those statements you answered "yes" please complete the rating scale.

Rating Scale:	
a)	I recognise that I feel and act this way with a significant person in my life, but I don't know why.
b)	I can see that this experience has become a pattern with multiple people in my life, but don't know why.
c)	I am beginning to see a link between these experiences and past relationship experiences, but the connection is not yet clear.
d)	I can clearly see that I feel and act this way because of past relationship experiences.

			Rating
1 I feel the need to "save" others when I see them having a tough time and therefore try to solve their problems for them.	Yes	No	
2 I feel the need to guide others when I see them about to make a mistake and wind up telling them what to do.	Yes	No	
3 I feel the need to please others and let them push me to do something I don't want to do.	Yes	No	
4 I need someone to truly understand me, and feel hurt when he / she cannot relate to my feelings.	Yes	No	
5 I feel the need to keep someone close, and do whatever is necessary to keep him / her with me even when they need to leave me.	Yes	No	
6 I feel the need to change someone, and wind up helping him / her to think more like me even when he / she has beliefs of values different from mine.	Yes	No	
7 I feel the need to be understood by others, and get defensive or angry when others are not able to see things like I see them.	Yes	No	
8 I feel the need to be close to someone and have difficulty letting them have the space they need.	Yes	No	
9 I am very dependent on others for approval, and feel hurt when they reject me.	Yes	No	
10 I need to be trusted by someone, and feel rejected when they do not trust me.	Yes	No	
11 I need to trust someone, yet I distance myself from that person when they act in a dishonest way.	Yes	No	
12 I feel the need to be accepted by someone, and feel bad about myself when he / she doesn't like me.	Yes	No	

Rating Scale:

a) I recognise that I feel and act this way with a significant person in my life, but I don't know why.

b) I can see that this experience has become a pattern with multiple people in my life, but don't know why.

c) I am beginning to see a link between these experiences and past relationship experiences, but the connection is not yet clear.

d) I can clearly see that I feel and act this way because of past relationship experiences.

			Rating
13 I need someone to take care of me, and feel abandoned when he / she is not helpful.	Yes	No	
14 I need someone to be reliable, and I feel disappointed when he / she lets me down.	Yes	No	
15 I need to feel accepted by others, and I feel bad when they oppose what I want to do.	Yes	No	
16 I need to feel free of responsibility, and I distance myself from someone I care about because they are too dependent on me.	Yes	No	
17 I need to be respected by someone, and I feel hurt when he / she does not approve of me.	Yes	No	
18 I want to accept someone else, but I am forced to distance myself when they do not live up to my expectations.	Yes	No	
19 I feel the need to avoid conflict, and keep quiet even when someone else mistreats me.	Yes	No	

APPENDIX 8

The Working Alliance Inventory (Therapist Version)

Working Alliance Inventory

Form T

Instructions

On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her client As you read the sentences mentally insert the name of your client in place of _____in the text.

Below each statement inside there is a seven point scale:

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you ***always*** feel (or think) circle the number 7; if it ***never*** applies to you circle the number 1. Use the numbers in between to describe the variations between these extremes.

This questionnaire is **CONFIDENTIAL**; neither your therapist nor the agency will see your answers.

Work fast, your first impressions are the ones we would like to see.
(PLEASE DON'T FORGET TO RESPOND TO ***EVERY*** *ITEM.*)

Thank you for your cooperation.

1. I feel uncomfortable with _____.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

2. _____ and I agree about the steps to be taken to improve his/her situation.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

3. I have some concerns about the outcome of these sessions.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

4. My client and I both feel confident about the usefulness of our current activity in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

5. I feel I really understand _____.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

6. _____ and I have a common perception of her/his goals..

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

7. _____ finds what we are doing in therapy confusing.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

8. I believe _____ likes me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

9. I sense a need to clarify the purpose of our session(s) for _____.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

10. I have some disagreements with _____ about the goals of these sessions.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

11. I believe the time _____ and I are spending together is not spent efficiently.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

12. I have doubts about what we are trying to accomplish in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

13. I am clear and explicit about what _____'s responsibilities are in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

14. The current goals of these sessions are important for _____.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

15. I find what _____ and I are doing in therapy is unrelated to her/his current concerns.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

16. I feel confident that the things we do in therapy will help _____ to accomplish the changes that he/she desires.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

17. I am genuinely concerned for _____'s welfare.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

18. I am clear as to what I expect _____ to do in these sessions.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

19. _____ and I respect each other.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

20. I feel that I am not totally honest about my feelings toward _____.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

21. I am confident in my ability to help _____.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

22. We are working towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

23. I appreciate _____ as a person.						
1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
24. We agree on what is important for _____ to work on.						
1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
25. As a result of these sessions _____ is clearer as to how she/he might be able to change.						
1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
26. _____ and I have built a mutual trust.						
1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
27. _____ and I have different ideas on what his/her real problems are.						
1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
28. Our relationship is important to _____.						
1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
29. _____ has some fears that if she/he says or does the wrong things, I will stop working with him/her.						
1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
30. _____ and I have collaborated in setting goals for these session(s).						
1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
31. _____ is frustrated by what I am asking her/him to do in therapy.						
1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
32. We have established a good understanding between us of the kind of changes that would be good for _____.						
1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
33. The things that we are doing in therapy don't make much sense to _____.						
1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always

34. _____ doesn't know what to expect as the result of therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

35. _____ believes the way we are working with her/his problem is correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

36. I respect _____ even when he/she does things that I do not approve of.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

APPENDIX 9

Written Consent Forms

PAGE

NUMBERING

AS ORIGINAL

Programme Director
Doctorate Course in Clinical Psychology
Dr Delia Cushway
BA (Hons) MSc PhD AFBPS CPsychol (Clin Foren)

School of Health and Social Sciences
Coventry University
Priory Street Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8300

THE UNIVERSITY OF WARWICK

COVENTRY UNIVERSITY

Our ref

Your ref

Participant Identification number for this trial:

Date

Written Consent Form

Please complete and return to the chief investigator

Title of project: Therapists' experience of Therapeutic Alliance

Name of researcher: Becky Daw

Please initial box

1 I confirm that I have read and understand the participant information sheet date 08/11/05 (version 2) for the above study and have had the opportunity to ask questions ☐

2 I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason, without my medical care or legal rights being affected. ☐

3 I agree that documents submitted to the chief investigator may be looked at by responsible individuals within the research team where it is relevant to my taking part in research. I give permission for these individuals to have access to my documents. ☐

4 I agree to take part in the above study ☐

.....	.....	.....
Name (Please print):	Date	Signature

.....	.....	.....
Name of person taking consent (if different from researcher)	Date	Signature

.....	.....	.....
Researcher	Date	Signature

Copies:
1 for participant, 1 for researcher

Programme Director
Doctorate Course in Clinical Psychology
Dr Delia Cushway
BA (Hons) MSc PhD AFBPS CPsychol (Clin Foren)

School of Health and Social Sciences
Coventry University
Priory Street Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8300

THE UNIVERSITY OF WARWICK

COVENTRY UNIVERSITY

Our ref

Your ref

Date

Participant Identification number for this trial:

Written Consent Form

Please complete and keep for your information

Title of project: Therapists' experience of Therapeutic Alliance

Name of researcher: Becky Daw

Please initial box

1 I confirm that I have read and understand the participant information sheet date 08/11/05 (version 2) for the above study and have had the opportunity to ask questions ☐

2 I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason, without my medical care or legal rights being affected. ☐

3 I agree that documents submitted to the chief investigator may be looked at by responsible individuals within the research team where it is relevant to my taking part in research. I give permission for these individuals to have access to my documents. ☐

4 I agree to take part in the above study ☐

.....	.....	.....
Name (Please print):	Date	Signature

.....	.....	.....
Name of person taking consent (if different from researcher)	Date	Signature

.....	.....	.....
Researcher	Date	Signature

Copies:
1 for participant, 1 for researcher

APPENDIX 10

Procedure for Interpretative Phenomenological Analysis (IPA)

Procedure for Interpretative Phenomenological Analysis (IPA)

(Smith and Osborn, 2003)

Each response to QU 34 was transposed (appendix twelve).

1. The transcripts were read and re read several times by the author. The left – hand margin was used to annotate anything that was interesting or significant about what the respondent said with respect to participants' experience of personal therapy and how their experiences influenced their clinical practice (refer to appendix twelve).

Worked Examples

Participant number	Comments	Original response
12	Purpose - able to deal with personal distress and so continue working professionally	Felt better able to cope with personal distress, reflection on own personal distress allowed me to work with similarly affected clients without personal distress
4	Valuable experience personally and professionally, see what it's like to be a client, improved practice	Very valuable both personally and professionally "sitting in the other chair" and experiencing what it feels like to be a client has significantly improved my practice (I believe)

2. This process was worked through the whole data set.

3. The right hand margin was then used to document emerging theme titles.

   The comments of each participant were grouped together to represent what seemed to the author to be salient themes. This level involves a slightly higher level of abstraction. Any apparent clustering was compared back to the transcript, to ensure the new cluster description fitted with what the participant actually said. As this process was repeated new understandings

and themes emerged. The initial notes are transformed into concise phrases to try and capture the essence of what was found in the text.

Worked examples

Participant Number	Comments	Original response	Emerging Theme titles
12	Purpose - able to deal with personal distress and so continue working professionally	Felt better able to cope with personal distress, reflection on own personal distress allowed me to work with similarly affected clients without personal distress	1-function, to cope with personal distress 2-function, maintain good working relationships with clients
4	Valuable experience personally and professionally, see what it's like to be a client, improved practice	Very valuable both personally and professionally "sitting in the other chair" and experiencing what it feels like to be a client has significantly improved my practice (I believe)	1-postive experience professionally and personally 2) experience being a client 3)improved practice

4. The transformation of initial notes into themes is continued through the whole data set. At this stage no attempt is made to select or omit particular responses for special attention. The number of emerging themes reflects the richness of particular responses (refer to appendix twelve)
5. The emergent themes were then listed on a sheet of paper in chronological order. (appendix thirteen)
6. Emerging theme titles were then ordered as the author tried to make sense of the connections between the themes which were emerging. Clusters of themes are put together. As clusters and super-ordinate concepts emerge, it was checked with the original primary source material to make sure the

connections were valid. A document was produced summarizing the identified themes for the sample (appendix fourteen). This document also contained illustrative excerpts from the respondents and frequencies.

7. As a validity check on the analytic process, a colleague repeated the above procedures (appendix fifteen).

8. In the next stage of the analysis the researchers considered the themes identified in order to produce a new, consolidated list of themes for the group. Each list of themes was examined for commonalities and difference. Themes that appeared to cluster into new themes were checked against the original transcript. The consolidated list was examined by the two raters to see how the themes might be meaningfully grouped into broader domains (appendix sixteen).

9. Excerpts from the original responses were then added to the consolidation list (appendix seventeen).

10. A final consolidation list was produced defining the broad domains and 6 themes and their frequencies, which emerged from the data (appendix eighteen).

APPENDIX 11

QUALITATIVE RESPONSES AND RATER ONE IPA PROCESS

CASE NO	COMMENTS	PLEASE COMMENT ON YOUR EXPERIENCE OF PERSONAL THERAPY	EMERGING THEME TITLES
1	IMP TO SEE WHAT IT FEELS LIKE	IT SEEMS ESSENTIAL TO KNOW WHAT PSYCHOTHERAPY FEELS LIKE BEFORE INFLICTING IT UPON OTHERS	1-EXPERIENCE BEING A CLIENT
2	GOOD EXPERIENCE. PURPOSE SPIRITUAL ISSUES AND GROWTH, CONNECTION TO WIDER EXPERIENCE	I FOUND PERSONAL THERAPY TO BE A SUPERB EXPERIENCE. I DO HAVE PERSONAL THERAPY FROM TIME TO TIME BUT I AM NOT HAVING IT AT THE MOMENT. WHEN I DO IT IS FOCUSED ON SPIRITUAL ISSUES, PARTICULARLY GROWTH, CONNECTION TO A WIDER EXPERIENCE OUTSIDE THE TRADITIONAL THERAPEUTIC MILIEU	1-POSITIVE EXPERIENCE, 2-FUNCTION RE PERSONAL GROWTH
3			
4	VALUABLE EXPERIENCE PERSONALLY AND PROFESSIONALLY, SEE WHAT IT'S LIKE TO BE A CLIENT, IMPROVED PRACTICE	VERY VALUABLE BOTH PERSONALLY AND PROFESSIONALLY "SITTING IN THE OTHER CHAIR" AND EXPERIENCING WHAT IT FEELS LIKE TO BE A CLIENT HAS SIGNIFICANTLY IMPROVED MY PRACTICE (I BELIEVE)	1-POSTIVE EXPERIENCE PROFESSIONALLY AND PERSONALLY 2) EXPERIENCE BEING A CLIENT 3)IMPROVED PRACTICE
5	BENEFICIAL, SORTED OUT PERSONAL ISSUES, SEE WHAT IT'S LIKE TO BE A CLIENT	VERY BENEFICIAL HELPED ME SORT THINGS OUT FOR MYSELF HELPED ME UNDERSTAND WHAT IT IS LIKE TO BE A CLIENT	1- POSITIVE EXPERIENCE 2-EXPERIENCE BEING A CLIENT 3- FUNCTION: TO COPE WITH PERSONAL ISSUES
6	VALUED EXPERIENCE	I HAVE VALUED IT	1- VALUED
7			
8	BENEFICIAL PERSONALLY AND PROFESSIONALLY, UNDERSTAND IMP OF BOUNDARIES, REGULAR APPTS, POWER OF SUMMARIES, REFLECTING AND FEELINGS TOWARDS THERAPIST	EXTREMELY BENEFICIAL PERSONALLY, BUT PROFESSIONALLY IT HELPED ME UNDERSTAND THE IMPORTANCE OF BOUNDARIES, REGULAR TIMES AND APPTS, THE POWER OF SUMMARISING AND REFLECTING AND A PATIENTS POSITIVE FEELINGS TOWARDS THEIR THERAPIST	1- POSITIVE EXPERIENCE PROFESSIONALLY AND PERSONALLY 2-EXPERIENTIAL LEARNING RE PROCESS ISSUES
9			

CASE NO	COMMENTS	PLEASE COMMENT ON YOUR EXPERIENCE OF PERSONAL THERAPY	EMERGING THEME TITLES
10	USEFUL FOR SPECIFIC ISSUES	USEFUL TO ADDRESS SPECIFIC ISSUES	1- USEFUL TO ADDRESS SPECIFIC ISSUES
11			
12	PURPOSE - ABLE TO DEAL WITH PERSONAL DISTRESS AND SO CONTINUE WORKING PROFESSIONALLY	FELT BETTER ABLE TO COPE WITH PERSONAL DISTRESS, REFLECTION ON OWN PERSONAL DISTRESS ALLOWED ME TO WORK WITH SIMILARLY AFFECTED CLIENTS WITHOUT PERSONAL DISTRESS	1-FUNCTION, TO COPE WITH PERSONAL DISTRESS 2-FUNCTION, MAINTAIN GOOD WORKING RELATIONSHIPS WITH CLIENTS
13			
14	PURPOSE, DEAL WITH PERSONAL DISTRESS, SEPARATE OWN ISSUES FROM CLIENTS'. ENSURES WORK DOESN'T GET TAKEN HOME, PREVENTS ME LOOSING EMPATHY, ANYONE WORKING WITH SEVERE AND ENDURING MH CLIENTS SHOULD ENGAGE IN ONGOING THERAPY	I HAVE ENGAGED IN THERAPY FOR A NUMBER OF REASONS SINCE QUALIFYING. ON OCCASION THIS HAS BEEN TO DEAL WITH DISTRESS FOLLOWING MAJOR LIFE EVENTS. MORE GENERALLY I VALUE THE TIME TO SEPARATE MY OWN ISSUES FROM CLIENT'S WHICH IS VITAL TO ME GIVEN THAT I USE REFLECTION AND TRANSFERENCE, COUNTER TRANSFERENCE WITH CLIENTS. I ALSO WORK WITH THOSE WHO HAVE BEEN SEXUALLY ABUSED AND WHO INFLICT SIGNIFICANT TRAUMA TO OTHERS. I FIND THERAPY PROVIDES A HELPFUL PLACE TO ENSURE THAT WORK DOES NOT GET TAKEN HOME AND PREVENTS ME FROM LOSING EMPATHY BECAUSE I HAVE NOT PROCESSED MY REACTION TO SUCH ISSUES. SOME OF THIS CAN BE ADDRESSED IN SUPERVISION BUT WHEN IT RELATES TO ONES OWN PERSONAL ISSUES THEN IT NEEDS TO BE REFLECTED ON IN A THERAPEUTIC SPACE. I PERSONALLY THINK THAT ANYONE WORKING LONG TERM WITH SEVERE TRAUMA AND OR OFFENDING BEHAVIOUR AND OR PERSONALITY DISORDERS WOULD BENEFIT FROM ONGOING THERAPY!	1-FUNCTION, TO ALLEVIATE PERSONAL DISTRESS 2-FUNCTION, MAINTAIN GOOD WORKING RELATIONSHIPS WITH CLIENTS 3- FUNCTION TO WORK ON OWN ISSUES 4 FUNCTION: PREVENTS BURN OUT
15			
16	IMP TO SEE WHAT IT FEELS LIKE	IT'S IMPORTANT TO KNOW WHAT IT'S LIKE TO BE IN THE OTHER CHAIR.	1 - EXPERIENCE BEING A CLIENT
17	IMP TO SEE WHAT IT FEELS LIKE, PURPOSE SELF HELP AND CONTINUAL DEVELOPMENT, CHALLENGING	INSIGHTFUL IN REGARDS TO "BEING IN THE OTHER CHAIR". CHALLENGING IN POSITIVE WAYS. VERY SUPPORTIVE AND RESPECTFUL. FELT LISTENED TO AND GUIDED IN DIRECTIONS TO DEVELOP SELF-HELP AND CONTINUAL DEVELOPMENT.	1-CHALLENEGING, 2-EXPERIENCE BEING A CLIENT, 3 POSITIVE EXP, 4 FUNC - SELF-HELP

CASE NO	COMMENTS	PLEASE COMMENT ON YOUR EXPERIENCE OF PERSONAL THERAPY	EMERGING THEME TITLES
18			
19	HELPED ME DEVELOP AS A PERSON, UNDERSTAND THE THERAPEUTIC PROCESS	I FEEL IT HELPED ME UNDERSTAND THE THERAPEUTIC PROCESS AS WELL AS HELPING ME DEVELOP AS A PERSON	1 FUNCTION: PERSONAL GROWTH, 2 FUNCTION: UNDERSTAND TH. PROCESS
20			
21	GROWTH AS A PERSON, INSIGHT INTO FACTORS THAT DRIVE ME, SEE WHAT IT FEELS LIKE TO BE A CLIENT, GAINED AS A PERSON, CLEARER INSIGHT INTO DRIVE OF BECOMING A THERAPIST	I FOUND PERSONAL THERAPY ENABLED ME TO GROW AS A PERSON. IT GAVE ME INSIGHT INTO FACTORS THAT DRIVE ME. I WAS ABLE TO UNDERSTAND WHAT IT FEELS LIKE TO BE A CLIENT. I HAVE GAINED AS A PERSON AND AM ABLE TO SEE CLEARER ABOUT THE MOTIVATIONS THAT DRIVE ME AS A THERAPIST.	1 FUNCTION: PERSONAL GROWTH, 2 EXPERIENCE BEING A CLIENT, 3 INSIGHT INTO PROFESSIONAL AND PERSONAL DRIVES
22	FRIGHTENING, HATED VULNERABILITY, HAVING TO BE A CLIENT, STRUGGLE TO GET THERE, HUGELY REWARDING	FRIGHTENING. INITIALLY HATED VULNERABILITY AND HAVING TO BE A CLIENT! EXCEPTIONALLY CHALLENGING AND HUGE STRUGGLE TO GET TO SESSIONS SOME WEEKS BUT ULTIMATELY HUGELY REWARDING	1 CHALLENGING 2 POSITIVE, 3REWARDING 4 SEE WHAT IT'S LIKE TO BE A CLIENT 5 FRIGHTENING
23	PURPOSE: PRESERVING OF SANITY, ENLIGHTENMENT, SELF-MONITORING. IMPORTANT, EXPENSIVE, INDULGENT, FUN, STIMULATING	I FIND MY PT A MIXTURE OF STIMULATING, IMPORTANT, EXPENSIVE, IRRITATING, FUN, INDULGENT, ENLIGHTENING, SELF MONITORING, PRESERVING OF MY SANITY AND VERY USEFUL!	1 FUNCTION; PERSONAL GROWTH
24	HELPFUL EXPERIENCE PROFESSIONALLY; SEE WHAT IT FEELS LIKE, SEE TECHNIQUES, PERSONALLY; GROWTH.	IT WAS A VERY HELPFUL EXPERIENCE PROFESSIONALLY IN THAT I UNDERSTOOD THE EXPERIENCE OF BEING IN THE RECEIVING END. SOME CONCEPTS AND TECHNIQUES STILL PROVE USEFUL. PERSONALLY IN TERMS OF MY OWN GROWTH, MEDITATION BASED TECHNIQUES AND YOGIC CONTINUOUS CONSCIOUS BREATHING OF REBIRTHING HAVE BEEN MOST USEFUL THAN ALL THE THERAPIES PUT TOGETHER.	1 EXPERIENCE BEING A CLIENT 2 EXPERIENTIAL LEARNING RE TECHNIQUES 3 FUNCTION: PERSONAL GROWTH
25			
26			

CASE NO	COMMENTS	PLEASE COMMENT ON YOUR EXPERIENCE OF PERSONAL THERAPY	EMERGING THEME TITLES
27	POSITIVE EXP AS UNDERSTAND A MODEL IN MORE DETAIL, SEE WHAT IT FEELS LIKE, R'SHIP WITH THERAPIST, AFTER THERAPY ETC	PERSONAL THERAPY WAS A VERY POSITIVE EXPERIENCE IN THE SENSE OF UNDERSTANDING A MODEL IN MUCH MORE DETAIL. ALSO TO EXPERIENCE BEING THE CLIENT - HOW I FELT WHEN CHALLENGED, THE RELATIONSHIP WITH A THERAPIST, HOW ONE FEELS AFTER THERAPY AND SO ON	1 EXPERIENTIAL LEARNING RE MODEL, 2 EXP BEING A CLIENT, 3 EXPERIENTIAL LEARNING RE PROCESS ISSUES
28	ESSENTIAL TO EXPERIENTIALLY LEARN, LOOK AFTER SELF, UNDERSTAND MOTIVATION OF BECOMING A THERAPIST, DEVELOPED PRACTICE (SEE TECHNIQUES?). RESPECT FOR CLIENTS, SEE HOW FRIGHTENING IT CAN BE	ABSOLUTELY ESSENTIAL TO UNDERSTAND THE CRAFT OF PSYCHOTHERAPEUTIC TREATMENT FROM WITHIN MYSELF RATHER THAN BOOKS. WORKING WITH DEEPLY DISTRESSED AND DAMAGED CLIENTS LEAVES AN IMPACT ON THE THERAPIST IT IS IMPERATIVE I FIND WAYS TO SUSTAIN MYSELF IN THE FACE OF THIS. IT HELPED ME UNDERSTAND WHY I NEEDED TO BE A THERAPIST. WORKING IN DEPTH WITH MY OWN THERAPY ALLOWED ME TO DEVELOP WAYS OF WORKING IN DEPTH WITH CLIENTS. PT MADE ME REALISE HOW FRIGHTENING IT CAN BE TO GO TO A THERAPIST. MY RESPECT FOR MY CLIENTS HAS INCREASED AS A RESULT.	1 EXPERIENTIAL LEARNING RE MODEL AND TECHNIQUES, 2 EXPERIENCE BEING THE CLIENT, 3 FUNCTION: MAINTAIN GOOD WORKING RELATIONSHIPS WITH CLIENTS, 4 INSIGHT INTO PROFESSIONAL DRIVES 5 - FUNCTION PREVENT BURN OUT 6 FRIGHTENING
29	TO ENSURE PRO. PRACTICE DOESN'T SUFFER DUE TO PERSONAL DISTRESS	AS BEFORE AND TO ENSURE THAT MY PROFESSIONAL PRACTICE DOES NOT SUFFER DUE TO VERY CHALLENGING PERSONAL EXPERIENCES OVER THE PAST COUPLE OF YEARS.	1 FUNCTION: MAINTAIN GOOD WORKING RELATIONSHIPS WITH CLIENTS 2 FUNCTION ALLEVIATE PERSONAL DISTRESS
30			
31	MIXED EXPERIENCE, HELPFUL.	IT HAS BEEN MIXED. WHILST IT HAS ALWAYS BEEN HELPFUL, I HAVE BEEN SURPRISED THAT THE THERAPY I AM CURRENTLY ENGAGED IN (LAST 18MONTHS- OPEN ENDED) HAS BEEN THE MOST HELPFUL. BEFORE THIS I HAD SEEN IT A "RATIONED" (BY MYSELF) GROUP OF SESSIONS ENTERED INTO TO ADDRESS A PARTICULAR ISSUE, PROBLEM. "ALLOWING" MYSELF TO WORK MORE LONG TERM HAS BEEN INVALUABLE.	1 HELPFUL
32			
33			

CASE NO	COMMENTS	PLEASE COMMENT ON YOUR EXPERIENCE OF PERSONAL THERAPY	EMERGING THEME TITLES
34	PATCHY EXPERIENCE	PATCHY. I DID NOT FEEL I MADE MUCH PROGRESS IN MY FIRST THERAPY (PSYCHOANALYTIC) THE SECOND (INTEGRATIVE) SEEMED MORE PRODUCTIVE - GREATER WARMTH FROM THERAPIST.	1 PATCHY
35	TOUGH, STIMULATING, LIFE GIVING	TOUGH, STIMULATING, LIFE GIVING	1 CHALLENGING, 2 POSITIVE
36			
37			
38	HELPFUL EXPERIENCE BUT TIME MONEY COULDN'T ALLOW	FOUND IT HELPFUL ON OCCASION HOWEVER THE MODEL (JUNGIAN ANALYTIC) DEMANDED MORE THAN 1 SESSION PER WEEK WHICH I DID NOT HAVE THE TIME OR FINANCE TO SUPPORT SO THERAPY ENDED.	1 HELPFUL
39	EXCELLENT EXPERIENCE, GROWTH, PERSONAL DISTRESS	EXCELLENT MY PURPOSE CHANGED FROM BEREAVEMENT TO PERSONAL GROWTH OVER THE SESSIONS- THE EXPERIENCE WAS GOOD IN EVERY WAY.	1 FUNCTION PERSONAL GROWTH 2 FUNCTION ALLEVIATE PERSONAL DISTRESS 3 POSITIVE EXPERIENCE
40			
41	POSITIVE EXPERIENCE, ENLIGHTENMENT RE PATTERNS OF BEHAVIOUR	MY EXPERIENCE HAS BEEN VERY POSITIVE. THE THERAPIST IS A GOOD LISTENER AND HER REFLECTIONS ARE VERY HELPFUL. THROUGH MY EXPERIENCE OF THERAPY I HAVE BEEN ABLE TO RECOGNISE PATTERNS WHICH HAVE BEEN UNHELPFUL AND START TO CHANGE THESE IN MY LIFE.	1 POSITIVE, 2 FUNCTION: PERSONAL GROWTH
42	HELP FUNCTION PROFESSIONALLY DUE TO IMPACT OF CLIENT WORK, PERSONAL GROWTH, DEAL WITH PROFESSIONAL AND PERSONAL DISTRESS,	THE NATURE OF MY WORK MEANS I OFTEN DEAL WITH COMPLEX EMOTIONS WITH CLIENTS THAT HAVE A PERSONAL BARING ON MYSELF AS A PERSON - PERSONAL THERAPY ASSISTS WITH THIS PROCESS AND IS A GOOD WAY TO GROW PERSONALLY AND DEAL WITH THE DISTRESS OF THE FEELINGS GENERATED THROUGH CLIENT WORK AND EXTERNAL PERSONAL EXPERIENCES.	1 MAINTAIN GOOD WORKING RELATIONSHIP WITH CLIENTS, 2 FUNCTION PERSONAL GROWTH, 3 FUNCTION ALLEVIATE PERSONAL DISTRESS, 4 PREVENT BURN OUT

CASE NO	COMMENTS	PLEASE COMMENT ON YOUR EXPERIENCE OF PERSONAL THERAPY	EMERGING THEME TITLES
43	INVALUABLE, PROFESSIONALLY AND PERSONALLY	INVALUABLE ON A NUMBER OF LEVELS, PERSONALLY, PROFESSIONALLY AND AS A MEMBER OF A WIDER CLINICAL TEAM AND NETWORK.	1 VALUABLE PERSONALLY AND PROFESSIONALLY
44			
45	HELPFUL RE RECOGNISING PERSONAL PATTERNS, AND PERSONAL DISTRESS	VERY HELPFUL IN RECOGNISING PATTERNS FROM CHILDHOOD AND IN SUPPORTIVE ME THROUGH A VERY DIFFICULT TIME.	1 FUNCTION PERSONAL GROWTH, 2 FUNC ALLEVIATE PERSONAL GROWTH
46			
47			
48	POWERFUL RE PROCESS ISSUES	IT WAS VERY POWERFUL IN FORMING MY UNDERSTANDING OF DYNAMIC ISSUES IN THERAPY.	1 EXPERIENTIAL LEARNING RE PROCESS ISSUES

APPENDIX 12

Rater One Emerging Theme Titles (chronological order)

Rater One Emerging Theme Titles (chronological order)

EXPERIENCE BEING A CLIENT

POSITIVE EXPERIENCE,

FUNCTION RE PERSONAL GROWTH

POSTIVE EXPERIENCE PROFESSIONALLY AND PERSONALLY

EXPERIENCE BEING A CLIENT

IMPROVED PRACTICE

POSITIVE EXPERIENCE

EXPERIENCE BEING A CLIENT

FUNCTION: TO COPE WITH PERSONAL ISSUES

VALUED

POSITIVE EXPERIENCE PROFESSIONALLY AND PERSONALLY

EXPERIENTIAL LEARNING RE PROCESS ISSUES

USEFUL TO ADDRESS SPECIFIC ISSUES

FUNCTION, TO COPE WITH PERSONAL DISTRESS

FUNCTION, MAINTAIN GOOD WORKING RELATIONSHIPS WITH CLIENTS

FUNCTION, TO ALLEVIATE PERSONAL DISTRESS

FUNCTION, MAINTAIN GOOD WORKING RELATIONSHIPS WITH CLIENTS

FUNCTION TO WORK ON OWN ISSUES

FUNCTION: PREVENTS BURN OUT

EXPERIENCE BEING A CLIENT

CHALLENEGING,

EXPERIENCE BEING A CLIENT,

POSITIVE EXPERIENCE,

FUNCTION - SELF-HELP

FUNCTION: PERSONAL GROWTH,

FUNCTION: UNDERSTAND THERAPEUTIC PROCESS

FUNCTION: PERSONAL GROWTH,

EXPERIENCE BEING A CLIENT,

INSIGHT INTO PROFESSIONAL AND PERSONAL DRIVES

CHALLENGING

POSITIVE, 3REWARDING

FUNCTION; PERSONAL GROWTH

EXPERIENCE BEING A CLIENT

EXPERIENTIAL LEARNING RE TECHNIQUES

FUNCTION: PERSONAL GROWTH

EXPERIENTIAL LEARNING RE MODEL,

EXPERIENCE BEING A CLIENT,

EXPERIENTIAL LEARNING RE PROCESS ISSUES

EXPERIENTIAL LEARNING RE MODEL AND TECHNIQUES,

EXPERIENCE BEING THE CLIENT,

FUNCTION: MAINTAIN GOOD WORKING RELATIONSHIPS WITH

CLIENTS,

INSIGHT INTO PROFESSIONAL DRIVES

FUNCTION PREVENT BURN OUT

FUNCTION: MAINTAIN GOOD WORKING RELATIONSHIPS WITH CLIENTS

FUNCTION ALLEVIATE PERSONAL DISTRESS

HELPFUL EXPERIENCE

PATCHY

CHALLENGING,

POSITIVE

HELPFUL

FUNCTION PERSONAL GROWTH

FUNCTION ALLEVIATE PERSONAL DISTRESS

POSITIVE EXPERIENCE

POSITIVE,

FUNCTION: PERSONAL GROWTH

MAINTAIN GOOD WORKING RELATIONSHIP WITH CLIENTS,

FUNCTION PERSONAL GROWTH,

FUNCTION ALLEVIATE PERSONAL DISTRESS,

PREVENT BURN OUT

VALUABLE PERSONALLY AND PROFESSIONALLY

FUNCTION PERSONAL DISTRESS,

FUNCTION ALLEVIATE PERSONAL GROWTH

EXPERIENTIAL LEARNING RE PROCESS ISSUES

APPENDIX 13

Rater One Summary of Identified Themes

EXPERIENCE OF PT

POSITIVE EXPERIENCE, 9

1. S2 I FOUND PERSONAL THERAPY TO BE A SUPERB EXPERIENCE
2. S4 VERY VALUABLE BOTH PERSONALLY AND PROFESSIONALY
3. S5 VERY BENEFICIAL
4. S8 EXTREMELY BENEFICIAL PERSONALLY
5. S17 VERY SUPPORTIVE AND RESPECTFUL. FELT LISTENED TO AND GUIDED IN DIRECTIONS TO DEVELOP SELF-HELP AND CONTINUAL DEVELOPMENT.
6. S22 EXCEPTIONALLY CHALLENGING AND HUGE STRUGGLE TO GET TO SESSIONS SOME WEEKS BUT ULTIMATELY HUGELY REWARDING
7. S35 TOUGH, STIMULATING, LIFE GIVING
8. S39 EXCELLENT MY PURPOSE CHANGED FROM BEREAVEMENT TO PERSONAL GROWTH OVER THE SESSIONS- THE EXPERIENCE WAS GOOD IN EVERY WAY
9. S41 MY EXPERIENCE HAS BEEN VERY POSITIVE.

VALUED 3

1. S4 VERY VALUABLE BOTH PERSONALLY AND PROFESSIONALLY
2. S6 I HAVE VALUED IT
3. S43 INVALUABLE ON A NUMBER OF LEVELS, PERSONALLY, PROFESSIONALLY AND AS A MEMBER OF A WIDER CLINICAL TEAM AND NETWORK.

CHALLENEGING, 3

1. S17 CHALLENGING IN POSITIVE WAYS

2. S22 EXCEPTIONALLY CHALLENGING AND HUGE STRUGGLE TO GET TO SESSIONS SOME WEEKS BUT ULTIMATELY HUGELY REWARDING
3. S35 TOUGH, STIMULATING, LIFE GIVING

REWARDING 1

1. S22 EXCEPTIONALLY CHALLENGING AND HUGE STRUGGLE TO GET TO SESSIONS SOME WEEKS BUT ULTIMATELY HUGELY REWARDING

HELPFUL EXPERIENCE 2

1. S31 WHILST IT HAS ALWAYS BEEN HELPFUL, I HAVE BEEN SURPRISED THAT THE THERAPY I AM CURRENTLY ENGAGED IN (LAST 18MONTHS- OPEN ENDED) HAS BEEN THE MOST HELPFUL
2. S38 FOUND IT HELPFUL ON OCCASION HOWEVER THE MODEL (JUNGIAN ANALYTIC) DEMANDED MORE THAN 1 SESSION PER WEEK WHICH I DID NOT HAVE THE TIME OR FINANCE TO SUPPORT SO THERAPY ENDED.

PATCHY 1

1. S34 PATCHY. I DID NOT FEEL I MADE MUCH PROGRESS IN MY FIRST THERAPY (PSYCHOANALYTIC) THE SECOND (INTEGRATIVE) SEEMED MORE PRODUCTIVE - GREATER WARMTH FROM THERAPIST

FRIGHTENING 2

1. S22 FRIGHTENING. INITIALLY HATED VULNERABILITY AND HAVING TO BE A CLIENT!
2. S 28 PT MADE ME REALISE HOW FRIGHTENING IT CAN BE TO GO TO A THERAPIST. MY RESPECT FOR MY CLIENTS HAS INCREASED AS A RESULT.

PERSONAL DEVELOPMENT

FUNCTION: TO WORK WITH PERSONAL ISSUES 1

1. S14 MORE GENERALLY I VALUE THE TIME TO SEPARATE MY OWN ISSUES FROM CLIENT'S WHICH IS VITAL TO ME GIVEN THAT I USE REFLECTION AND TRANSFERENCE, COUNTER TRANSFERENCE WITH CLIENTS. I ALSO WORK WITH THOSE WHO HAVE BEEN SEXUALLY ABUSED AND WHO INFLICT SIG. TRAUMA TO OTHERS. I FIND THERAPY PROVIDES A HELPFUL PLACE TO ENSURE THAT WORK DOES NOT GET TAKEN HOME AND PREVENTS ME FROM LOSING EMPATHY BECAUSE I HAVE NOT PROCESSED MY REACTION TO SUCH ISSUES.

FUNCTION, TO COPE WITH PERSONAL DISTRESS 7

1. S5 HELPED ME SORT THINGS OUT FOR MYSELF
2. S12 FELT BETTER ABLE TO COPE WITH PERSONAL DISTRESS
3. S14 ON OCCASION THIS HAS BEEN TO DEAL WITH DISTRESS FOLLOWING MAJOR LIFE EVENTS
4. S29 TO ENSURE THAT MY PROFESSIONAL PRACTICE DOES NOT SUFFER DUE TO VERY CHALLENGING PERSONAL EXPERIENCES OVER THE PAST COUPLE OF YEARS.
5. S39 EXCELLENT MY PURPOSE CHANGED FROM BEREAVEMENT TO PERSONAL GROWTH OVER THE SESSIONS- THE EXPERIENCE WAS GOOD IN EVERY WAY
6. S42 THE NATURE OF MY WORK MEANS I OFTEN DEAL WITH COMPLEX EMOTIONS WITH CLIENTS THAT HAVE A PERSONAL BARING ON MYSELF AS A PERSON - PERSONAL THERAPY ASSISTS WITH THIS PROCESS AND IS A GOOD WAY TO GROW PERSONALLY AND DEAL WITH THE

DISTRESS OF THE FEELINGS GENERATED THROUGH CLIENT WORK AND EXTERNAL PERSONAL EXPERIENCES

7. S45 VERY HELPFUL IN RECOGNISING PATTERNS FROM CHILDHOOD AND IN SUPPORTIVE ME THROUGH A VERY DIFFICULT TIME.

FUNCTION - SELF-HELP 1

1. S17 VERY SUPPORTIVE AND RESPECTFUL. FELT LISTENED TO AND GUIDED IN DIRECTIONS TO DEVELOP SELF-HELP AND CONTINUAL DEVELOPMENT.

FUNCTION PERSONAL GROWTH, 9

1. S2 WHEN I DO IT IS FOCUSED ON SPIRITUAL ISSUES, PARTICULARLY GROWTH, CONNECTION TO A WIDER EXPERIENCE OUTSIDE THE TRADITIONAL THERAPEUTIC MILIEU
2. S19 I FEEL IT HELPED ME UNDERSTAND THE THERAPEUTIC PROCESS AS WELL AS HELPING ME DEVELOP AS A PERSON
3. S21 I FOUND PERSONAL THERAPY ENABLED ME TO GROW AS A PERSON
4. S23 I FIND MY PT A MIXTURE OF STIMULATING, IMPORTANT, EXPENSIVE, IRRITATING, FUN, INDULGENT, ENLIGHTENING, SELF MONITORING, PRESERVING OF MY SANITY AND VERY USEFUL!
5. S24 PERSONALLY IN TERMS OF MY OWN GROWTH, MEDITATION BASED TECHNIQUES AND YOGIC CONTINUOUS CONSCIOUS BREATHING OF REBIRTHING HAVE BEEN MOST USEFUL THAN ALL THE THERAPIES PUT TOGETHER

6. S39 EXCELLENT MY PURPOSE CHANGED FROM BEREAVEMENT TO PERSONAL GROWTH OVER THE SESSIONS- THE EXPERIENCE WAS GOOD IN EVERY WAY
7. S41 THE THERAPIST IS A GOOD LISTENER AND HER REFLECTIONS ARE VERY HELPFUL. THROUGH MY EXPERIENCE OF THERAPY I HAVE BEEN ABLE TO RECOGNISE PATTERNS WHICH HAVE BEEN UNHELPFUL AND START TO CHANGE THESE IN MY LIFE.
8. S42 THE NATURE OF MY WORK MEANS I OFTEN DEAL WITH COMPLEX EMOTIONS WITH CLIENTS THAT HAVE A PERSONAL BARING ON MYSELF AS A PERSON - PERSONAL THERAPY ASSISTS WITH THIS PROCESS AND IS A GOOD WAY TO GROW PERSONALLY AND DEAL WITH THE DISTRESS OF THE FEELINGS GENERATED THROUGH CLIENT WORK AND EXTERNAL PERSONAL EXPERIENCES
9. S45 VERY HELPFUL IN RECOGNISING PATTERNS FROM CHILDHOOD AND IN SUPPORTIVE ME THROUGH A VERY DIFFICULT TIME.

PROFESSIONAL DEVELOPMENT	
EXPERIENTIAL LEARNING RE PROCESS ISSUES	4

1. S8 PROFESSIONALLY IT HELPED ME UNDERSTAND THE IMPORTANCE OF BOUNDARIES, REGULAR TIMES AND APPTS, THE POWER OF SUMMARISING AND REFLECTING AND A PATIENTS POSITIVE FEELINGS TOWARDS THEIR THERAPIST
2. S19 I FEEL IT HELPED ME UNDERSTAND THE THERAPEUTIC PROCESS AS WELL AS HELPING ME DEVELOP AS A PERSON
3. S27 PERSONAL THERAPY WAS A VERY POSITIVE EXPERIENCE IN THE SENSE OF UNDERSTANDING A MODEL

IN MUCH MORE DETAIL. ALSO TO EXPERIENCE BEING THE CLIENT - HOW I FELT WHEN CHALLENGED, THE RELATIONSHIP WITH A THERAPIST, HOW ONE FEELS AFTER THERAPY AND SO ON

4. S48 IT WAS VERY POWERFUL IN FORMING MY UNDERSTANDING OF DYNAMIC ISSUES IN THERAPY.

EXPERIENTIAL LEARNING RE MODEL AND TECHNIQUES, 3

1. S24 IT WAS A VERY HELPFUL EXPERIENCE PROFESSIONALLY IN THAT I UNDERSTOOD THE EXPERIENCE OF BEING IN THE RECEIVING END SOME CONCEPTS AND TECHNIQUES STILL PROVE USEFUL
2. S27 PERSONAL THERAPY WAS A VERY POSITIVE EXPERIENCE IN THE SENSE OF UNDERSTANDING A MODEL IN MUCH MORE DETAIL
3. S28 ABSOLUTELY ESSENTIAL TO UNDERSTAND THE CRAFT OF PSYCHOTHERAPEUTIC TREATMENT FROM WITHIN MYSELF RATHER THAN BOOKS..... WORKING IN DEPTH WITH MY OWN THERAPY ALLOWED ME TO DEVELOP WAYS OF WORKING IN DEPTH WITH CLIENTS

INSIGHT INTO PROFESSIONAL AND PERSONAL DRIVES 1

1. S21 IT GAVE ME INSIGHT INTO FACTORS THAT DRIVE ME.. I HAVE GAINED AS A PERSON AND AM ABLE TO SEE CLEARER ABOUT THE MOTIVATIONS THAT DRIVE ME AS A THERAPIST

INSIGHT INTO PROFESSIONAL DRIVES 1

1. S28 IT HELPED ME UNDERSTAND WHY I NEEDED TO BE A THERAPIST

1. S4 "SITTING IN THE OTHER CHAIR" AND EXPERIENCING WHAT IT FEELS LIKE TO BE A CLIENT HAS SIGNIFICANTLY IMPROVED MY PRACTICE (I BELIEVE)
2. S5 HELPED ME UNDERSTAND WHAT IT IS LIKE TO BE A CLIENT
3. S1 IT SEEMS ESSENTIAL TO KNOW WHAT PSYCHOTHERAPY FEELS LIKE BEFORE INFLICTING IT UPON OTHERS
4. S16 IT'S IMPORTANT TO KNOW WHAT IT'S LIKE TO BE IN THE OTHER CHAIR.
5. S17 INSIGHTFUL IN REGARDS TO "BEING IN THE OTHER CHAIR"
6. S21 I WAS ABLE TO UNDERSTAND WHAT IT FEELS LIKE TO BE A CLIENT
7. S22 FRIGHTENING. INITIALLY HATED VULNERABILITY AND HAVING TO BE A CLIENT!
8. S24 IT WAS A VERY HELPFUL EXPERIENCE PROFESSIONALLY IN THAT I UNDERSTOOD THE EXPERIENCE OF BEING IN THE RECEIVING END
9. S27 PERSONAL THERAPY WAS A VERY POSITIVE EXPERIENCE IN THE SENSE OF UNDERSTANDING A MODEL IN MUCH MORE DETAIL. ALSO TO EXPERIENCE BEING THE CLIENT - HOW I FELT WHEN CHALLENGED, THE RELATIONSHIP WITH A THERAPIST, HOW ONE FEELS AFTER THERAPY AND SO ON
10. S28 PT MADE ME REALISE HOW FRIGHTENING IT CAN BE TO GO TO A THERAPIST. MY RESPECT FOR MY CLIENTS HAS INCREASED AS A RESULT.

DIRECT IMPACT ON CLINICAL WORK

FUNCTION: MAINTAIN GOOD WORKING RELATIONSHIPS WITH CLIENTS

5

1. S12 REFLECTION ON OWN PERSONAL DISTRESS ALLOWED ME TO WORK WITH SIMILARLY AFFECTED CLIENTS WITHOUT PERSONAL DISTRESS
2. S14 MORE GENERALLY I VALUE THE TIME TO SEPARATE MY OWN ISSUES FROM CLIENT'S WHICH IS VITAL TO ME GIVEN THAT I USE REFLECTION AND TRANSFERENCE, COUNTER TRANSFERENCE WITH CLIENTS. I ALSO WORK WITH THOSE WHO HAVE BEEN SEXUALLY ABUSED AND WHO INFLICT SIG. TRAUMA TO OTHERS. I FIND THERAPY PROVIDES A HELPFUL PLACE TO ENSURE THAT WORK DOES NOT GET TAKEN HOME AND PREVENTS ME FROM LOSING EMPATHY BECAUSE I HAVE NOT PROCESSED MY REACTION TO SUCH ISSUES.
3. S28 WORKING WITH DEEPLY DISTRESSED AND DAMAGED CLIENTS LEAVES AN IMPACT ON THE THERAPIST IT IS IMPERATIVE I FIND WAYS TO SUSTAIN MYSELF IN THE FACE OF THIS
4. S29 TO ENSURE THAT MY PROFESSIONAL PRACTICE DOES NOT SUFFER DUE TO VERY CHALLENGING PERSONAL EXPERIENCES OVER THE PAST COUPLE OF YEARS.
5. S42 THE NATURE OF MY WORK MEANS I OFTEN DEAL WITH COMPLEX EMOTIONS WITH CLIENTS THAT HAVE A PERSONAL BARING ON MYSELF AS A PERSON - PERSONAL THERAPY ASSISTS WITH THIS PROCESS AND IS A GOOD WAY TO GROW PERSONALLY AND DEAL WITH THE DISTRESS OF THE FEELINGS GENERATED THROUGH CLIENT WORK AND EXTERNAL PERSONAL EXPERIENCES

APPENDIX 14

RATER TWO IPA PROCESS

CASE NO	COMMENTS	PLEASE COMMENT ON YOUR EXPERIENCE OF PERSONAL THERAPY	EMERGING THEME TITLES
1	importance of self experience before practice, informs real empathy for clients, how it feels to be a client	IT SEEMS ESSENTIAL TO KNOW WHAT PSYCHOTHERAPY FEELS LIKE BEFORE INFLICTING IT UPON OTHERS	insight into how it feels to be a client informs practice ,importance of being a client to be effective therapist enhances empathy for clients
2	very positive, ongoing part of personal development and spiritual growth, beneficial not only for crises	I FOUND PERSONAL THERAPY TO BE A SUPERB EXPERIENCE. I DO HAVE PERSONAL THERAPY FROM TIME TO TIME BUT I AM NOT HAVING IT AT THE MOMENT. WHEN I DO IT IS FOCUSED ON SPIRITUAL ISSUES, PARTICULARLY GROWTH, CONNECTION TO A WIDER EXPERIENCE OUTSIDE THE TRADITIONAL THERAPEUTIC MILIEU	important for continued personal development not just crisis management very positive experience
3			
4	very valuable to inform practice and for personal development. Importance of self experience to inform real empathy for clients, how it feels to be a client	VERY VALUABLE BOTH PERSONALLY AND PROFESSIONALLY "SITTING IN THE OTHER CHAIR" AND EXPERIENCING WHAT IT FEELS LIKE TO BE A CLIENT HAS SIGNIFICANTLY IMPROVED MY PRACTICE (I BELIEVE)	insight into how it feels to be a client informs practice importance of being a client to be an effective therapist enhances empathy for clients
5	very helpful personally resolved difficulties informs real empathy for clients	VERY BENEFICIAL HELPED ME SORT THINGS OUT FOR MYSELF HELPED ME UNDERSTAND WHAT IT IS LIKE TO BE A CLIENT	enhances empathy for clients benefit in resolving personal difficulties
6	valued	I HAVE VALUED IT	valued
7			
8	v beneficial personally. helped inform practice in terms of method of relating to clients, clients positive connection to therapist, practical issues-importance of continuity/regularity regarding schedule of sessions	EXTREMELY BENEFICIAL PERSONALLY, BUT PROFESSIONALLY IT HELPED ME UNDERSTAND THE IMPORTANCE OF BOUNDARIES, REGULAR TIMES AND APPTS, THE POWER OF SUMMARISING AND REFLECTING AND A PATIENTS POSITIVE FEELINGS TOWARDS THEIR THERAPIST	benefit in resolving personal difficulties insight into how it feels to be a client informs practice

CASE NO	COMMENTS	PLEASE COMMENT ON YOUR EXPERIENCE OF PERSONAL THERAPY	EMERGING THEME TITLES
9			
10	useful for personal issues	USEFUL TO ADDRESS SPECIFIC ISSUES	benefit in resolving personal difficulties
11			
12	faciliated personal coping skills, gave personal insight which transferred to dealing with clients with similar issues without negative impact on self, enhanced practice	FELT BETTER ABLE TO COPE WITH PERSONAL DISTRESS, REFLECTION ON OWN PERSONAL DISTRESS ALLOWED ME TO WORK WITH SIMILARLY AFFECTED CLIENTS WITHOUT PERSONAL DISTRESS	benefit in resolving personal difficulties facilitates personal coping skills insight into how it feels to be a client informs practice facilitates coping with impact clients issues may personally have on therapist
13			
14	numerous benefits. provides protection from burnout. allows separation of work from personal life. Ongoing therapy as practitioner useful for personal difficulties. helps personal coping skills. buffer against transference issues in therapeutic relationship. Necessary in addition to supervision when dealing with clients with severe and enduring difficulties. gives time and space for reflection. allows processing of effects clients have on you	I HAVE ENGAGED IN THERAPY FOR A NUMBER OF REASONS SINCE QUALIFYING. ON OCCASION THIS HAS BEEN TO DEAL WITH DISTRESS FOLLOWING MAJOR LIFE EVENTS. MORE GENERALLY I VALUE THE TIME TO SEPARATE MY OWN ISSUES FROM CLIENT'S WHICH IS VITAL TO ME GIVEN THAT I USE REFLECTION AND TRANSFERENCE, COUNTER TRANSFERENCE WITH CLIENTS. I ALSO WORK WITH THOSE WHO HAVE BEEN SEXUALLY ABUSED AND WHO INFLICT SIGNIFICANT TRAUMA TO OTHERS. I FIND THERAPY PROVIDES A HELPFUL PLACE TO ENSURE THAT WORK DOES NOT GET TAKEN HOME AND PREVENTS ME FROM LOSING EMPATHY BECAUSE I HAVE NOT PROCESSED MY REACTION TO SUCH ISSUES. SOME OF THIS CAN BE ADDRESSED IN SUPERVISION BUT WHEN IT RELATES TO ONES OWN PERSONAL ISSUES THEN IT NEEDS TO BE REFLECTED ON IN A THERAPEUTIC SPACE. I PERSONALLY THINK THAT ANYONE WORKING LONG TERM WITH SEVERE TRAUMA AND OR OFFENDING BEHAVIOUR AND OR PERSONALITY DISORDERS WOULD BENEFIT FROM ONGOING THERAPY!	facilitates coping with impact clients issues may personally have on therapist buffer from empathy burnout buffer from transference issues enhances reflective practice supervisory effects benefit in resolving personal difficulties facilitates personal coping skills

CASE NO	COMMENTS	PLEASE COMMENT ON YOUR EXPERIENCE OF PERSONAL THERAPY	EMERGING THEME TITLES
15			
16	importance of true empathy- how it feels to be a client.	IT'S IMPORTANT TO KNOW WHAT IT'S LIKE TO BE IN THE OTHER CHAIR.	insight into how it feels to be a client informs practice importance of being a client to be an effective therapist enhances empathy for clients
17	provides insight into how it feels to be a client-true empathy. Positively challenging. Supportive and respectful. Benefits of being listened to and guidance. Facilitates self help-coping skills? And ongoing development (personal?)	INSIGHTFUL IN REGARDS TO "BEING IN THE OTHER CHAIR". CHALLENGING IN POSITIVE WAYS. VERY SUPPORTIVE AND RESPECTFUL. FELT LISTENED TO AND GUIDED IN DIRECTIONS TO DEVELOP SELF-HELP AND CONTINUAL DEVELOPMENT.	insight into how it feels to be a client informs practice importance of being a client to be an effective therapist enhances empathy for clients facilitates personal coping skills important for continued personal development positive valued experiences in therapy positively challenging supportive respectful guidance being listened to
18			
19	increased understanding of therapeutic process through experience as a client. Facilitated personal development	I FEEL IT HELPED ME UNDERSTAND THE THERAPEUTIC PROCESS AS WELL AS HELPING ME DEVELOP AS A PERSON	facilitates personal development increased understanding of therapeutic process importance of being a client to be an effective therapist
20			
21	Facilitated personal growth. Facilitated insight into personal motivation. gives true empathy for clients through being a client. Benefit personally. Facilitated insight into mot as a therapist	I FOUND PERSONAL THERAPY ENABLED ME TO GROW AS A PERSON. IT GAVE ME INSIGHT INTO FACTORS THAT DRIVE ME. I WAS ABLE TO UNDERSTAND WHAT IT FEELS LIKE TO BE A CLIENT. I HAVE GAINED AS A PERSON AND AM ABLE TO SEE CLEARER ABOUT THE MOTIVATIONS THAT DRIVE ME AS A THERAPIST.	facilitates personal development increased personal insight increased understanding of reasons for being a therapist importance of being a client to be an effective therapist beneficial personally

CASE NO	COMMENTS	PLEASE COMMENT ON YOUR EXPERIENCE OF PERSONAL THERAPY	EMERGING THEME TITLES
22	Scary. Strong dislike of vulnerability as client. Resentment at having had to be a client. Difficulty attending sessions- psychologically? but seen as positive	FRIGHTENING. INITIALLY HATED VULNERABILITY AND HAVING TO BE A CLIENT! EXCEPTIONALLY CHALLENGING AND HUGE STRUGGLE TO GET TO SESSIONS SOME WEEKS BUT ULTIMATELY HUGELY REWARDING	awareness of potentially uncomfortable element of therapy for client enhanced empathy for clients increased awareness of vulnerabilty of client increased awareness of attrition increased awareness of frightening element of therapy
23	Positive and negative elements. stimulating important beneficial fun helps monitor self preserves sanity expensive irritating indulgent (paradox? Useful yet indulgent)	I FIND MY PT A MIXTURE OF STIMULATING, IMPORTANT, EXPENSIVE, IRRITATING, FUN, INDULGENT, ENLIGHTENING, SELF MONITORING, PRESERVING OF MY SANITY AND VERY USEFUL!	positive and negative elements overall beneficial importance of being a client positive experience positively challenging stimulating facilitates self monitoring expense irritation indulgent
24	very beneficial professionally, aided client empathy having being a client. particular techniques and concepts exposed to personally useful for personal growth, seen as of more benefit than all combined therapies	IT WAS A VERY HELPFUL EXPERIENCE PROFESSIONALLY IN THAT I UNDERSTOOD THE EXPERIENCE OF BEING IN THE RECEIVING END. SOME CONCEPTS AND TECHNIQUES STILL PROVE USEFUL. PERSONALLY IN TERMS OF MY OWN GROWTH, MEDITATION BASED TECHNIQUES AND YOGIC CONTINUOUS CONSCIOUS BREATHING OF REBIRTHING HAVE BEEN MOST USEFUL THAN ALL THE THERAPIES PUT TOGETHER.	facilitates personal development increased understanding of therapeutic process importance of being a client to be an effective therapist facilitates professional development enhances empathy for clients
25			
26			

CASE NO	COMMENTS	PLEASE COMMENT ON YOUR EXPERIENCE OF PERSONAL THERAPY	EMERGING THEME TITLES
27	aided understanding of a therapeutic model when on receiving end as a client. provided true client empathy, experience of being challenged, relation to therapist, emotional aftermath of therapy- possibly made more aware of uncomfortable elements of being a client?	PERSONAL THERAPY WAS A VERY POSITIVE EXPERIENCE IN THE SENSE OF UNDERSTANDING A MODEL IN MUCH MORE DETAIL. ALSO TO EXPERIENCE BEING THE CLIENT - HOW I FELT WHEN CHALLENGED, THE RELATIONSHIP WITH A THERAPIST, HOW ONE FEELS AFTER THERAPY AND SO ON	aids understanding of therapeutic model awareness of potentially uncomfortable element of therapy for client enhanced empathy for clients increased awareness of emotional aftermath of therapy increased awareness of impact of being challenged
28	Personal experience essential for understanding treatment rather than theoretical knowledge. Useful as protection from impact working with deeply distressed and damaged clients. Gave insight into motives for being a therapist. experience as a client informed and enriched deepened therapy with clients. gave awareness that therapy can be frightening for clients, thus increasing respect for clients	ABSOLUTELY ESSENTIAL TO UNDERSTAND THE CRAFT OF PSYCHOTHERAPEUTIC TREATMENT FROM WITHIN MYSELF RATHER THAN BOOKS. WORKING WITH DEEPLY DISTRESSED AND DAMAGED CLIENTS LEAVES AN IMPACT ON THE THERAPIST IT IS IMPERATIVE I FIND WAYS TO SUSTAIN MYSELF IN THE FACE OF THIS. IT HELPED ME UNDERSTAND WHY I NEEDED TO BE A THERAPIST. WORKING IN DEPTH WITH MY OWN THERAPY ALLOWED ME TO TO DEVELOP WAYS OF WORKING IN DEPTH WITH CLIENTS. PT MADE ME REALISE HOW FRIGHTENING IT CAN BE TO GO TO A THERAPIST. MY RESPECT FOR MY CLIENTS HAS INCREASED AS A RESULT.	aids understanding of therapeutic model increased understanding of reasons for being a therapist enriched practice-deepened therapy increased awareness of frightening element of therapy enhanced empathy for clients increased respect for clients facilitates coping with impact clients issues may personally have on therapist

CASE NO	COMMENTS	PLEASE COMMENT ON YOUR EXPERIENCE OF PERSONAL THERAPY	EMERGING THEME TITLES
29	ensures personal problems do not impact upon professional practice-acts as a buffer	AS BEFORE AND TO ENSURE THAT MY PROFESSIONAL PRACTICE DOES NOT SUFFER DUE TO VERY CHALLENGING PERSONAL EXPERIENCES OVER THE PAST COUPLE OF YEARS.	facilitates coping with impact personal issues may have on professional practice
30			
31	Mixed experiences but always helpful. fixed number of sessions for specific problem less beneficial than long term open ended approach	IT HAS BEEN MIXED. WHILST IT HAS ALWAYS BEEN HELPFUL, I HAVE BEEN SURPRISED THAT THE THERAPY I AM CURRENTLY ENGAGED IN (LAST 18MONTHS- OPEN ENDED) HAS BEEN THE MOST HELPFUL. BEFORE THIS I HAD SEEN IT A "RATIONED" (BY MYSELF) GROUP OF SESSIONS ENTERED INTO TO ADDRESS A PARTICULAR ISSUE, PROBLEM. "ALLOWING" MYSELF TO WORK MORE LONG TERM HAS BEEN INVALUABLE.	positive and negative elements overall beneficial
32			
33			
34	different approaches different results. Therapist warmth more useful. More personal progress from Integrative than psychoanalytic approach	PATCHY. I DID NOT FEEL I MADE MUCH PROGRESS IN MY FIRST THERAPY (PSYCHOANALYTIC) THE SECOND (INTEGRATIVE) SEEMED MORE PRODUCTIVE - GREATER WARMTH FROM THERAPIST.	therapist warmth beneficial personal development
35		TOUGH, STIMULATING, LIFE GIVING	
36			
37			
38	Helpful sometimes. Model too demanding in terms of finances and time barrier to continuing therapy	FOUND IT HELPFUL ON OCCASION HOWEVER THE MODEL (JUNGIAN ANALYTIC) DEMANDED MORE THAN 1 SESSION PER WEEK WHICH I DID NOT HAVE THE TIME OR FINANCE TO SUPPORT SO THERAPY ENDED.	awareness finances and time commitment barriers to continued therapy
39	Beneficial. Negative transformed into positive through therapy	EXCELLENT MY PURPOSE CHANGED FROM BEREAVEMENT TO PERSONAL GROWTH OVER THE SESSIONS- THE EXPERIENCE WAS GOOD IN EVERY WAY.	

CASE NO	COMMENTS	PLEASE COMMENT ON YOUR EXPERIENCE OF PERSONAL THERAPY	EMERGING THEME TITLES
40			
41	Very positive. Gained insight which translated into action of changing unhelpful patterns. Therapist qualities-good listener and reflector helpful	MY EXPERIENCE HAS BEEN VERY POSITIVE. THE THERAPIST IS A GOOD LISTENER AND HER REFLECTIONS ARE VERY HELPFUL. THROUGH MY EXPERIENCE OF THERAPY I HAVE BEEN ABLE TO RECOGNISE PATTERNS WHICH HAVE BEEN UNHELPFUL AND START TO CHANGE THESE IN MY LIFE.	gained personal insight facilitated personal change therapist qualities listening reflecting beneficial
42	Helpful professionally as clients difficulties impact upon therapist, therapy assists dealing with effects of exposure to clients complex emotions. Helpful personally	THE NATURE OF MY WORK MEANS I OFTEN DEAL WITH COMPLEX EMOTIONS WITH CLIENTS THAT HAVE A PERSONAL BARING ON MYSELF AS A PERSON - PERSONAL THERAPY ASSISTS WITH THIS PROCESS AND IS A GOOD WAY TO GROW PERSONALLY AND DEAL WITH THE DISTRESS OF THE FEELINGS GENERATED THROUGH CLIENT WORK AND EXTERNAL PERSONAL EXPERIENCES.	facilitates coping with impact clients issues may personally have on therapist benefit in resolving personal difficulties
43	Invaluable personally professionally. Wider effects on clinical team and network	INVALUABLE ON A NUMBER OF LEVELS, PERSONALLY, PROFESSIONALLY AND AS A MEMBER OF A WIDER CLINICAL TEAM AND NETWORK.	facilitates personal development facilitates professional development
44			
45	Helpful personally. Supportive through difficult time. gained insight into patterns from childhood	VERY HELPFUL IN RECOGNISING PATTERNS FROM CHILDHOOD AND IN SUPPORTIVE ME THROUGH A VERY DIFFICULT TIME.	facilitates personal development benefit in resolving personal difficulties gained personal insight
46			
47			
48	being a client powerful in assisting understanding dynamics of therapy	IT WAS VERY POWERFUL IN FORMING MY UNDERSTANDING OF DYNAMIC ISSUES IN THERAPY.	insight into how it feels to be a client informs practice assists understanding therapy dynamics

Rater Two

Initial list of Themes

insight into how it feels to be a client informs practice

importance of being a client to be effective therapist enhances empathy for clients

important for continued personal development not just crisis management very

positive experience

insight into how it feels to be a client informs practice importance of being a client

to be an effective therapist enhances empathy for clients

enhances empathy for clients benefit in resolving personal difficulties

valued

benefit in resolving personal difficulties insight into how it feels to be a client

informs practice

benefit in resolving personal difficulties

benefit in resolving personal difficulties facilitates personal coping skills

insight into how it feels to be a client informs practice

facilitates coping with impact clients issues may personally have on therapist

facilitates coping with impact clients issues may personally have on therapist

buffer from empathy burnout

buffer from transference issues

enhances reflective practice

supervisory effects

benefit in resolving personal difficulties

facilitates personal coping skills

insight into how it feels to be a client informs practice importance of being a client to be an effective therapist enhances empathy for clients

insight into how it feels to be a client informs practice

importance of being a client to be an effective therapist

enhances empathy for clients

facilitates personal coping skills

important for continued personal development

positive valued experiences in therapy positively challenging supportive respectful guidance being listened to

facilitates personal development

increased understanding of therapeutic process

importance of being a client to be an effective therapist

facilitates personal development increased personal insight

increased understanding of reasons for being a therapist

importance of being a client to be an effective therapist beneficial personally awareness of potentially uncomfortable element of therapy for client enhanced empathy for clients increased awareness of vulnerability of client increased awareness of attrition increased awareness of frightening element of therapy positive and negative elements overall beneficial

importance of being a client positive experience positively challenging stimulating facilitates self monitoring

expense irritation indulgent

facilitates personal development

increased understanding of therapeutic process

importance of being a client to be an effective therapist

facilitates professional development enhances empathy for clients

aids understanding of therapeutic model awareness of potentially uncomfortable

element of therapy for client

enhanced empathy for clients

increased awareness of emotional aftermath of therapy

increased awareness of impact of being challenged

aids understanding of therapeutic model

increased understanding of reasons for being a therapist

enriched practice-deepened therapy increased awareness of frightening element of

therapy enhanced empathy for clients increased respect for clients

facilitates coping with impact clients issues may personally have on therapist

facilitates coping with impact personal issues may have on professional practice

Positive and negative elements overall beneficial

therapist warmth beneficial personal development

awareness finances and time commitment barriers to continued therapy

gained personal insight

facilitated personal change

therapist qualities listening reflecting beneficial

facilitates coping with impact clients issues may personally have on therapist

benefit in resolving personal difficulties

facilitates personal development

facilitates professional development

facilitates personal development

benefit in resolving personal difficulties gained personal insight

insight into how it feels to be a client informs practice assists understanding therapy dynamics

Rater Two

Clustering of Themes

POSITIVE PERSONAL IMPACT

Positive highly valued personal experience

positive experience

benefit in resolving personal difficulties (crisis management)

valued

positively challenging

stimulating

Personal development

facilitates personal coping skills

facilitates ongoing personal development not just crisis management

facilitates self monitoring

facilitated personal change

Increased self awareness/insight

POSITIVE PROFESSIONAL IMPACT

Enhanced client empathy informs and improves therapeutic practice

increases understanding of therapeutic processes and dynamics

enriched practice-deepened therapy

insight into how it feels to be a client informs practice

understanding therapy dynamics

insight into how it feels to be a client informs practice

importance of being a client to be effective therapist

enhances empathy for clients

Improved therapeutic relationship with clients

increased respect for clients

Potentially uncomfortable elements of therapy for client highlighted

increased awareness of vulnerability of client

increased awareness of attrition

increased awareness of frightening element of therapy

awareness finances and time commitment barriers to continued therapy expense

irritation

indulgent

increased awareness of emotional aftermath of therapy

increased awareness of impact of being challenged

Buffer against negative impact of client issues on therapist

coping with impact clients issues may personally have on therapist

buffer from empathy burnout

buffer from transference issues

supervisory effects

Buffer against negative impact of therapist issues on therapy/client

facilitates coping with / impact of personal issues may have on professional practice

Professional development

Increased understanding of reasons for being a therapist

facilitates professional development

Therapist qualities important

therapist warmth

support

reflecting

respect

guidance

listening

APPENDIX 15

IPA Consolidation List – Rater One and Two Themes

IPA Consolidation List – Rater One and Two Themes

		Frequency
Impact on the "Person"		
1	Therapist takes care of self	9
	Rater One – function to work with personal issues	
	Rater One – function to come with personal distress	
	Rater One – function of self-help	
	Rater Two – Buffer against negative impact of client issues on therapist	
2	Therapist develops as a person	10
	Rater One – Function personal growth	
	Rater Two – Personal development	
	Rater One – insight into personal and professional drives	
3	Enriching experience	13
	Rater One – Experience of PT	
	Rater Two – positive highly valued personal experience	
Impact on the "Professional"		
4	Therapist learns from therapy	6
	Rater One – experiential learning re process issues	
	Rater one – experiential learning re model and techniques	
5	Therapist learns from client role	10
	Rater One – experience being a client	
	Rater Two – potentially uncomfortable elements of therapy for client highlighted	
	Rater Two – enhanced client empathy informs and improves therapeutic practice	

6	Insight into professional drives	2
	Rater One – insight into professional and personal drives	
	Rater One – Insight into professional drives	
	Rater Two – professional development	
7	Maintains working relationships	5
	Rater One – Function: Maintain good working relationships with clients	
	Rater One – Function Prevents burn out	
	Rater Two – Buffer against negative impact of therapist issues on therapy / client	
	Rater Two – Buffer against negative impact of client issues on therapist	

APPENDIX 16

IPA Consolidation List with Excerpts

IPA Consolidation List with Excerpts

Frequency

Impact on the "Person"

8 **Therapist takes care of self** 8

- S14 ON OCCASION THIS HAS BEEN TO DEAL WITH DISTRESS FOLLOWING MAJOR LIFE EVENTS. MORE GENERALLY I VALUE THE TIME TO SEPARATE MY OWN ISSUES FROM CLIENT'S WHICH IS VITAL TO ME GIVEN THAT I USE REFLECTION AND TRANSFERENCE, COUNTER TRANSFERENCE WITH CLIENTS. I ALSO WORK WITH THOSE WHO HAVE BEEN SEXUALLY ABUSED AND WHO INFLICT SIG. TRAUMA TO OTHERS. I FIND THERAPY PROVIDES A HELPFUL PLACE TO ENSURE THAT WORK DOES NOT GET TAKEN HOME AND PREVENTS ME FROM LOSING EMPATHY BECAUSE I HAVE NOT PROCESSED MY REACTION TO SUCH ISSUES
- S5 HELPED ME SORT THINGS OUT FOR MYSELF
- S12 FELT BETTER ABLE TO COPE WITH PERSONAL DISTRESS
- S29 TO ENSURE THAT MY PROFESSIONAL PRACTICE DOES NOT SUFFER DUE TO VERY CHALLENGING PERSONAL EXPERIENCES OVER THE PAST COUPLE OF YEARS.
- S39 EXCELLENT MY PURPOSE CHANGED FROM BEREAVEMENT TO PERSONAL GROWTH OVER THE SESSIONS- THE EXPERIENCE WAS GOOD IN EVERY WAY
- S42 THE NATURE OF MY WORK MEANS I OFTEN DEAL WITH COMPLEX EMOTIONS WITH CLIENTS THAT HAVE A PERSONAL BARING ON MYSELF AS A PERSON - PERSONAL THERAPY ASSISTS WITH THIS PROCESS AND IS A GOOD WAY TO GROW PERSONALLY AND DEAL WITH THE DISTRESS OF THE FEELINGS GENERATED THROUGH CLIENT WORK AND EXTERNAL PERSONAL EXPERIENCES
- S45 VERY HELPFUL IN RECOGNISING PATTERNS FROM CHILDHOOD AND IN SUPPORTING ME THROUGH A VERY DIFFICULT TIME

- S17 VERY SUPPORTIVE AND RESPECTFUL. FELT LISTENED TO AND GUIDED IN DIRECTIONS TO DEVELOP SELF-HELP AND CONTINUAL DEVELOPMENT

- S2 WHEN I DO IT IS FOCUSED ON SPIRITUAL ISSUES, PARTICULARLY GROWTH, CONNECTION TO A WIDER EXPERIENCE OUTSIDE THE TRADITIONAL THERAPEUTIC MILIEU
- S19 I FEEL IT HELPED ME UNDERSTAND THE THERAPEUTIC PROCESS AS WELL AS HELPING ME DEVELOP AS A PERSON
- S21 I FOUND PERSONAL THERAPY ENABLED ME TO GROW AS A PERSON. IT GAVE ME INSIGHT INTO FACTORS THAT DRIVE ME. . I HAVE GAINED AS A PERSON AND AM ABLE TO SEE CLEARER ABOUT THE MOTIVATIONS THAT DRIVE ME AS A THERAPIST
- S23 I FIND MY PT A MIXTURE OF STIMULATING, IMPORTANT, EXPENSIVE, IRRITATING, FUN, INDULGENT, ENLIGHTENING, SELF MONITORING, PRESERVING OF MY SANITY AND VERY USEFUL!
- S24 PERSONALLY IN TERMS OF MY OWN GROWTH, MEDITATION BASED TECHNIQUES AND YOGIC CONTINUOUS CONSCIOUS BREATHING OF REBIRTHING HAVE BEEN MOST USEFUL THAN ALL THE THERAPIES PUT TOGETHER
- S39 EXCELLENT MY PURPOSE CHANGED FROM BEREAVEMENT TO PERSONAL GROWTH OVER THE SESSIONS- THE EXPERIENCE WAS GOOD IN EVERY WAY
- S41 THE THERAPIST IS A GOOD LISTENER AND HER REFLECTIONS ARE VERY HELPFUL. THROUGH MY EXPERIENCE OF THERAPY I HAVE BEEN ABLE TO RECOGNISE PATTERNS WHICH HAVE BEEN UNHELPFUL AND START TO CHANGE THESE IN MY LIFE.
- S42 THE NATURE OF MY WORK MEANS I OFTEN DEAL WITH COMPLEX EMOTIONS WITH CLIENTS THAT HAVE A PERSONAL BARING ON MYSELF AS A PERSON - PERSONAL THERAPY ASSISTS

WITH THIS PROCESS AND IS A GOOD WAY TO GROW PERSONALLY AND DEAL WITH THE DISTRESS OF THE FEELINGS GENERATED THROUGH CLIENT WORK AND EXTERNAL PERSONAL EXPERIENCES

- S45 VERY HELPFUL IN RECOGNISING PATTERNS FROM CHILDHOOD AND IN SUPPORTIVE ME THROUGH A VERY DIFFICULT TIME.

10 Enriching experience 13

- S2 I FOUND PERSONAL THERAPY TO BE A SUPERB EXPERIENCE
- S4 VERY VALUABLE BOTH PERSONALLY AND PROFESSIONALY
- S5 VERY BENEFICIAL
- S8 EXTREMELY BENEFICIAL PERSONALLY
- S17 VERY SUPPORTIVE AND RESPECTFUL. FELT LISTENED TO AND GUIDED IN DIRECTIONS TO DEVELOP SELF-HELP AND CONTINUAL DEVELOPMENT. CHALLENGING IN POSITIVE WAYS
- S22 EXCEPTIONALLY CHALLENGING AND HUGE STRUGGLE TO GET TO SESSIONS SOME WEEKS BUT ULTIMATELY HUGELY REWARDING
- S35 TOUGH, STIMULATING, LIFE GIVING
- S39 EXCELLENT MY PURPOSE CHANGED FROM BEREAVEMENT TO PERSONAL GROWTH OVER THE SESSIONS- THE EXPERIENCE WAS GOOD IN EVERY WAY
- S41 MY EXPERIENCE HAS BEEN VERY POSITIVE.
- S6 I HAVE VALUED IT
- S43 INVALUABLE ON A NUMBER OF LEVELS, PERSONALLY, PROFESSIONALLY AND AS A MEMBER OF A WIDER CLINICAL TEAM AND NETWORK.
- S31 WHILST IT HAS ALWAYS BEEN HELPFUL, I HAVE BEEN SURPRISED THAT THE THERAPY I AM CURRENTLY ENGAGED IN (LAST 18MONTHS- OPEN ENDED) HAS BEEN THE MOST HELPFUL
- S38 FOUND IT HELPFUL ON OCCASION HOWEVER THE MODEL (JUNGIAN ANALYTIC) DEMANDED MORE THAN 1 SESSION PER

WEEK WHICH I DID NOT HAVE THE TIME OR FINANCE TO SUPPORT SO THERAPY ENDED.

•

Impact on the "Professional"

11 Therapist learns from therapy 6

- S8 PROFESSIONALLY IT HELPED ME UNDERSTAND THE IMPORTANCE OF BOUNDARIES, REGULAR TIMES AND APPTS, THE POWER OF SUMMARISING AND REFLECTING AND A PATIENTS POSITIVE FEELINGS TOWARDS THEIR THERAPIST
- S19 I FEEL IT HELPED ME UNDERSTAND THE THERAPEUTIC PROCESS AS WELL AS HELPING ME DEVELOP AS A PERSON
- S27 PERSONAL THERAPY WAS A VERY POSITIVE EXPERIENCE IN THE SENSE OF UNDERSTANDING A MODEL IN MUCH MORE DETAIL. ALSO TO EXPERIENCE BEING THE CLIENT - HOW I FELT WHEN CHALLENGED, THE RELATIONSHIP WITH A THERAPIST, HOW ONE FEELS AFTER THERAPY AND SO ON
- S48 IT WAS VERY POWERFUL IN FORMING MY UNDERSTANDING OF DYNAMIC ISSUES IN THERAPY.
- S24 IT WAS A VERY HELPFUL EXPERIENCE PROFESSIONALLY IN THAT I UNDERSTOOD THE EXPERIENCE OF BEING IN THE RECEIVING END SOME CONCEPTS AND TECHNIQUES STILL PROVE USEFUL
- S28 ABSOLUTELY ESSENTIAL TO UNDERSTAND THE CRAFT OF PSYCHOTHERAPEUTIC TREATMENT FROM WITHIN MYSELF RATHER THAN BOOKS..... WORKING IN DEPTH WITH MY OWN THERAPY ALLOWED ME TO DEVELOP WAYS OF WORKING IN DEPTH WITH CLIENTS

12 Therapist learns from client role 10

- S4 "SITTING IN THE OTHER CHAIR" AND EXPERIENCING WHAT IT FEELS LIKE TO BE A CLIENT HAS SIGNIFICANTLY IMPROVED MY PRACTICE (I BELIEVE)
- S5 HELPED ME UNDERSTAND WHAT IT IS LIKE TO BE A CLIENT
- S1 IT SEEMS ESSENTIAL TO KNOW WHAT PSYCHOTHERAPY FEELS LIKE BEFORE INFLICTING IT UPON OTHERS
- S16 IT'S IMPORTANT TO KNOW WHAT IT'S LIKE TO BE IN THE OTHER CHAIR.
- S17 INSIGHTFUL IN REGARDS TO "BEING IN THE OTHER CHAIR"
- S21 I WAS ABLE TO UNDERSTAND WHAT IT FEELS LIKE TO BE A CLIENT
- S22 FRIGHTENING. INITIALLY HATED VULNERABILITY AND HAVING TO BE A CLIENT!
- S24 IT WAS A VERY HELPFUL EXPERIENCE PROFESSIONALLY IN THAT I UNDERSTOOD THE EXPERIENCE OF BEING IN THE RECEIVING END
- S27 PERSONAL THERAPY WAS A VERY POSITIVE EXPERIENCE IN THE SENSE OF UNDERSTANDING A MODEL IN MUCH MORE DETAIL. ALSO TO EXPERIENCE BEING THE CLIENT - HOW I FELT WHEN CHALLENGED, THE RELATIONSHIP WITH A THERAPIST, HOW ONE FEELS AFTER THERAPY AND SO ON
- S28 PT MADE ME REALISE HOW FRIGHTENING IT CAN BE TO GO TO A THERAPIST. MY RESPECT FOR MY CLIENTS HAS INCREASED AS A RESULT.

13 Insight into professional drives 2

- S21 IT GAVE ME INSIGHT INTO FACTORS THAT DRIVE ME. . I HAVE GAINED AS A PERSON AND AM ABLE TO SEE CLEARER ABOUT THE MOTIVATIONS THAT DRIVE ME AS A THERAPIST

- S28 IT HELPED ME UNDERSTAND WHY I NEEDED TO BE A THERAPIST

14 Maintains working relationships **5**

- S12 REFLECTION ON OWN PERSONAL DISTRESS ALLOWED ME TO WORK WITH SIMILARLY AFFECTED CLIENTS WITHOUT PERSONAL DISTRESS
- S14 MORE GENERALLY I VALUE THE TIME TO SEPARATE MY OWN ISSUES FROM CLIENT'S WHICH IS VITAL TO ME GIVEN THAT I USE REFLECTION AND TRANSFERENCE, COUNTER TRANSFERENCE WITH CLIENTS. I ALSO WORK WITH THOSE WHO HAVE BEEN SEXUALLY ABUSED AND WHO INFLICT SIG. TRAUMA TO OTHERS. I FIND THERAPY PROVIDES A HELPFUL PLACE TO ENSURE THAT WORK DOES NOT GET TAKEN HOME AND PREVENTS ME FROM LOSING EMPATHY BECAUSE I HAVE NOT PROCESSED MY REACTION TO SUCH ISSUES.
- S28 WORKING WITH DEEPLY DISTRESSED AND DAMAGED CLIENTS LEAVES AN IMPACT ON THE THERAPIST IT IS IMPERATIVE I FIND WAYS TO SUSTAIN MYSELF IN THE FACE OF THIS
- S29 TO ENSURE THAT MY PROFESSIONAL PRACTICE DOES NOT SUFFER DUE TO VERY CHALLENGING PERSONAL EXPERIENCES OVER THE PAST COUPLE OF YEARS.
- S42 THE NATURE OF MY WORK MEANS I OFTEN DEAL WITH COMPLEX EMOTIONS WITH CLIENTS THAT HAVE A PERSONAL BARING ON MYSELF AS A PERSON - PERSONAL THERAPY ASSISTS WITH THIS PROCESS AND IS A GOOD WAY TO GROW PERSONALLY AND DEAL WITH THE DISTRESS OF THE FEELINGS GENERATED THROUGH CLIENT WORK AND EXTERNAL PERSONAL EXPERIENCES

APPENDIX 17

IPA FINAL CONSOLIDATION LIST

IPA FINAL CONSOLIDATION LIST

Frequency

Impact on the "Person"

1 Therapist takes care of self 8

2 Therapist develops as a person 10

3 Enriching experience 13

Impact on the "Professional"

4 Therapist learns from therapy 6

5 Therapist learns from client role 10

6 Maintains working relationships 5

APPENDIX 18

Evidence of Research Ethics Committee Approval

North Warwickshire NHS
Primary Care Trust

Centre for Quality and Education in Health Care
Jepson House
4 Manor Court Avenue
Nuneaton
CV11 5HX

Tel: 024 7637 4045
Fax: 024 7632 1524

Our ref: trust049/daw/approval

14 December 2005

Rebecca Daw
Trainee Clinical Psychologist
[redacted]

Dear Ms Daw

Therapists' Experience of Therapeutic Alliance

I am pleased to confirm that North Warwickshire PCT have reviewed the research entitled "**Therapists' Experience of Therapeutic Alliance**" and have no objections to the study taking place within the Trust on condition that North Warwickshire PCT will not be liable for costs associated with the research. Your research has been entered into the Trusts' database (if applicable this will be entered onto the National Research Register).

Please reply to this letter confirming the expected start date and duration of the study. As part of the Research Governance framework it is important that the PCT are notified as to the outcome of your research and as such we will request feedback once the research has finished along with details of dissemination of your findings. We may also request brief updates of your progress from time to time, dependent on duration of the study. Similarly, if at anytime details relating to the research project or researcher change, the R&D department **must be informed**.

If you have any further questions regarding this or other research you may wish to undertake in the Trust please feel free to contact me again. The PCT wishes you success with your research.

Yours sincerely

Dr Linda Latham
Director of Integrated Governance

cc. Helen Williams, R&D Facilitator, South Warwickshire PCT
Peter Watson, Head of Psychological Services

APPENDIX 19

Evidence of Permission to Use WAI from the Author

SIMON FRASER UNIVERSITY

Burnaby British Columbia, Canada V5A 1S6

Ms. Becky Daw
University of Warwick
Department of Psychology
Coventry
CV4 7AL
U.K.

July 8, 2005

LIMITED COPYRIGHT LICENSE (ELECTRONIC) # 200587.83

Dear Ms. Daw

You have permission to use the Working Alliance Inventory (WAI) for the investi gation: "The impact of training on shaping psychological practitioners."

This limited copyright release extends to all forms of the WAI for which I hold copy right privileges, but limited to use of the inventory for not-for-profit research, and does not include the right to publish or distribute the instrument(s) in any form.

I would appreciate if you shared the results of your research with me when your w ork is completed so I may share this information with other researchers who might wish to use the WAI. If I can be of further help, do not hesitate to contact me.

Sincerelv.

Dr. Adam O. Horvath
Professor
Faculty of Education and
Department of Psychology

Ph# (604) 291-3624
Fax: (604) 291-3203
e-mail: Horvath@sfu.ca
Internet: http://www.educ.sfu.ca/alliance/allianceA

APPENDIX 20

Journal Instructions to Authors

Notes for Contributors

Psychology and Psychotherapy: Theory Research and Practice

Psychology and Psychotherapy: Theory Research and Practice (formerly *The British Journal of Medical Psychology*) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 5,000 words, although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Reviewing

The journal operates a policy of anonymous peer review. Papers will normally be scrutinised and commented on by at least two independent expert referees (in addition to the Editor) although the Editor may process a paper at his or her discretion. The referees will not be aware of the identity of the author. All information about authorship including personal acknowledgements and institutional affiliations should be confined to the title page (and the text should be free of such clues as identifiable self-citations e.g. 'In our earlier work...').

4. Online submission process

1) All manuscripts must be submitted online at http://paptrap.edmgr.com .
First-time users: click the REGISTER button from the menu and enter in your details as instructed. On successful registration, an email will be sent informing you of your user name and password. Please keep this email for future reference and proceed to LOGIN. (You do not need to re-register if your status changes e.g. author, reviewer or editor).
Registered users: click the LOGIN button from the menu and enter your user name and password for immediate access. Click 'Author Login'.
2) Follow the step-by-step instructions to submit your manuscript.

3) The submission must include the following as separate files:

- Title page consisting of manuscript title, authors' full names and

  affiliations, name and address for corresponding author - Editorial Manager Title Page for Manuscript Submission
- Abstract
- Full manuscript omitting authors' names and affiliations. Figures and tables can be attached separately if necessary.

4) If you require further help in submitting your manuscript, please consult the Tutorial for Authors - Editorial Manager - Tutorial for Authors
Authors can log on at any time to check the status of the manuscript.

5. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate page. The resolution of digital images must be at least 300 dpi.
- For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions: Psychology and Psychotherapy: Theory, Research and Practice - Structured Abstract Information
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.

- SI units must be used for all measurements, rounded off to practical values if appropriate, with the Imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations etc for which they do not own copyright.

For Guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association, Washington DC, USA (http://www.apastyle.org).

6. Brief reports

These should be limited to 1000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

7. Publication ethics

Code of Conduct - Code of Conduct, Ethical Principles and Guidelines
Principles of Publishing - Principle of Publishing

8. Supplementary data

Supplementary data too extensive for publication may be deposited with the British Library Document Supply Centre. Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the Editor together with the article, for simultaneous refereeing.

9. Post acceptance

PDF page proofs are sent to authors via email for correction of print but not for rewriting or the introduction of new material. Authors will be provided with a PDF file of their article prior to publication for easy and cost-effective dissemination to colleagues.

10. Copyright

To protect authors and journals against unauthorised reproduction of articles, The British Psychological Society

11. Checklist of requirements

- Abstract (100-200 words)
- Title page (include title, authors' names, affiliations, full contact details)
- Full article text (double-spaced with numbered pages and anonymised)

- References (APA style). Authors are responsible for bibliographic accuracy and must check every reference in the manuscript and proofread again in the page proofs.
- Tables, figures, captions placed at the end of the article or attached as separate files.

Guide for Authors

SUBMISSION REQUIREMENTS: Authors should submit their articles electronically via the Elsevier Editorial System (EES) page of this journal (http://ees.elsevier.com/cpr). The system automatically converts source files to a single Adobe Acrobat PDF version of the article, which is used in the peer-review process. Please note that even though manuscript source files are converted to PDF at submission for the review process, these source files are needed for further processing after acceptance. All correspondence, including notification of the Editor's decision and requests for revision, takes place by e-mail and via the Author's homepage, removing the need for a hard-copy paper trail. Questions about the appropriateness of a manuscript should be directed (prior to submission) to the Editorial Office, details at URL above. Papers should not exceed 50 pages (including references).

Submission of an article implies that the work described has not been published previously (except in the form of an abstract or as part of a published lecture or academic thesis), that it is not under consideration for publication elsewhere, that its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out, and that, if accepted, it will not be published elsewhere in the same form, in English or in any other language, without the written consent of the Publisher.

FORMAT: We accept most word processing formats, but Word, WordPerfect or LaTeX are preferred. Always keep a backup copy of the electronic file for reference and safety. Save your files using the default extension of the program used.

Please provide the following data on the title page (in the order given).

Title. Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible.

Author names and affiliations. Where the family name may be ambiguous (e.g., a double name), please indicate this clearly. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name, and, if available, the e-mail address of each author.

Corresponding author. Clearly indicate who is willing to handle correspondence at all stages of refereeing and publication, also post-publication. **Ensure that telephone and fax numbers (with country and area code) are provided in addition to the e-mail address and the complete postal address.**

Present/permanent address. If an author has moved since the work described in the article was done, or was visiting at the time, a 'Present address' (or 'Permanent address') may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

Abstract. A concise and factual abstract is required (not exceeding 200 words). This should be typed on a separate page following the title page. The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separate from the article, so it must be able to stand alone.