

Therapists' Experiences after Ending Personal Psychoanalytic Psychotherapy

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Thesis submitted to the Department of Psychology,
University of Sheffield, for the degree of Doctor of Clinical
Psychology

July 2006

DECLARATION

This work has not been submitted to any other institution for any other qualification

ACKNOWLEDGEMENTS

I would like to pass on a huge thanks to:

My supervisor, Gillian Hardy whose calming influence, advice, support and availability have made the process much less difficult than it otherwise would have been

All the participants without whom the research would not have been possible and the many other therapists who suggested names of people I might contact

Others who have been involved at various stages of the process including Rachel, Sharon and the team at Brunswick House

With special mention to my partner Mark and my mum Anna for their patience, understanding and encouragement throughout this and the 3 years of training overall

Anyone else I may have forgotten to mention but who I am sure has been no less important

STRUCTURE

The literature review has been prepared according to the guidance of the journal *Psychology and Psychotherapy: Theory, Research and Practice*

The research report has been written according to the guidance for
Option A

WORD COUNTS

Section 1:

Literature review	-	5400
References	-	6060

Section 2:

Research report	-	11998
References	-	13075

Section 3:

Critical appraisal	-	2508
References	-	2651

Total word count	-	19906
Total with references	-	21786

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ABSTRACT

Literature review:

This review explores the literature on clients' retrospective accounts of their therapy, looking at satisfaction with services, both short and long-term changes reported and factors found helpful and unhelpful in therapy. There are many factors that seem to be common to clients' experiences regardless of the type of therapy they received, although there is limited evidence that some specific factors are important too. Clients' views of therapy also appear to vary according to the time point at which they are measured. However, future work needs to be less theory driven and concentrate more on including clients in the research process in order to decrease constraints on their accounts.

Research report:

An Interpretative Phenomenological Analysis of therapists' experiences after ending psychoanalytic psychotherapy. A sample of eight therapists who finished therapy at least two years ago was interviewed about their experiences. Four master themes were identified including 'Therapy Stays with Me', 'Personal Growth', 'Life and Therapy Becoming Interwoven' and 'Contrasting Information'. Associated sub-themes were also outlined and their relationship to the literature and implications for clinical practice were discussed.

Critical Appraisal:

This section gives a commentary on the processes of planning and undertaking the research, including personal reflections on learning and experience within this.

Therapy viewed in retrospect: a review of the literature on clients' experiences

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Purpose

This paper reviews a variety of research exploring clients' experiences of therapy. In recent years a shift has taken place from the domination of the 'Drug metaphor' in psychotherapy outcome research (where clients are treated as passive recipients of treatment) towards considering, valuing and even prioritising the client's own perspective. Advocates of this change in research culture have cited numerous reasons for welcoming it. Amongst these are the inherent difficulties and apparent irrationality in trying to objectively measure what is essentially a subjective, interpersonal process (Macran, Ross, Hardy & Shapiro, 1999), disagreement between therapist and client accounts (see Weiss, Rabinowitz & Spiro, 1996 for a review) and a call for obtaining a fully-rounded view incorporating multidimensional perspectives on therapy (e.g. Strupp & Hadley, 1977 describe a tripartite model of outcome integrating societal, individual and professional perspectives).

Different aspects of client perspective have been explored in the literature. In their review, Elliott and James, (1989) categorised clients' accounts of specific aspects of therapy including internal psychological processes, experience of the therapist and also experiences of change. In particular they identified three dimensions of the client's experience; evaluation/affiliation, interpersonal control/independence and interpersonal/task factors. From their review, it can also be seen that research has tended to focus on clients' perspectives at specific time points, exploring accounts obtained within or between sessions, at

termination, at follow-up or after discharge. The majority of studies investigate clients' accounts of their experiences during the process. This may be partly due to a 'therapist bias' (since research is often driven by clinicians who are most concerned about what happens before the client is discharged, Baillie & Corrie, 1996) and partly due to a fear that clients will not be able to retrospectively recall their experiences (e.g. Paulson, Truscott & Stuart, 1999). However, it has been found that clients can recall significant detail about their experiences as much as 20 years post-therapy (Hsu, Crisp & Callender, 1992) and whilst it has been suggested that clients may 'rework the historical truth' over time, information about the way they have done this is undoubtedly relevant (Leuzinger-Bohleber, Stuhr, Ruger & Beutel, 2003). Furthermore, it has been argued that clients' post-therapy accounts may be more valid than those obtained throughout the process due to reduced transference effects and increased physical and emotional distance from therapy. These are thought to provide the opportunity to stand back from the experience and enable clients to give a more honest, global overview, focusing on what they find to be the most salient aspects (e.g. Baillie & Corrie, 1996; Feifel & Eels, 1963). It would therefore seem that although clients' retrospective accounts of therapy offer a different and valuable insight into the therapy process, this is a less thoroughly researched area which no reviews to date have focused on.

Method

For the reasons given above, the purpose of this review was therefore to focus on global evaluations of therapy; including only studies that have asked clients

to reflect back on their overall experience of therapy at or following termination. All types of therapeutic approaches were included.

Articles were located primarily through Psycinfo and Ovid online. All fields were searched using a combination of the following three sets of keywords; 1) client or patient, 2) therapy or psychotherapy, 3) experience or view or satisfaction or perspective and only full journal articles referring to post-therapy accounts were selected. Further studies were located through references in identified articles. Twenty-one studies in total were therefore included, and a full list and overview can be seen in Table 1.

In order to evaluate the quality of the studies reviewed, Macran, et al's (1999) suggestions were used as a framework. They identified four potential levels of research into clients' perspectives. Level zero makes inferences about clients' experiences from observations or standardised measures, whilst level one research uses researcher defined criteria to obtain and evaluate clients' views directly. At level two clients' perspectives are held at greater value and they are involved in evaluating information they have given, but the questions themselves are still posited by the researchers themselves. Level three research involves clients directly at all stages of the process. At the time of their review, Macran et al (1999) concluded that most research fell into levels zero and one with few being sufficiently client-oriented to obtain true insight into client perspectives. See Table 1 for ratings of studies reviewed.

Table 1. Overview of Studies Reviewed

Authors	N	Methodology	Type of therapy	Time point	Level
Ankuta & Abeles (1993)	74	Structured Post-Therapy Questionnaire (Strupp, Fox & Lessler, 1969) consisting of Likert ratings. Additional measures of symptomology included	Mostly psychodynamic	Unspecified time after termination.	1
Bende & Crossley, (2000)	25	Semi-structured questionnaire asking about aspects of referral, assessment, therapy and outcome	Cognitive Analytic Therapy, CBT and unspecified others	Average 1 year post-therapy	1
Board (1959)	142	Semi-structured questionnaires.	Psychodynamic therapy	Average 14 months post-therapy	1
Buckley, Karasu & Charles, (1981)	71 (therapist clients)	Semi-structured questionnaire incorporating Likert ratings and items based on the literature	Psychodynamic therapy	1-18 years post-therapy. Time points compared	1
Clarke, Rees & Hardy, (2004)	5	Semi-structured interview asking about changes noticed and causes of these	Cognitive therapy	“recent completion of treatment”	1
Deane (1993)	138	Client Satisfaction Questionnaire (CSQ-8, Attkinson & Zwick, 1982). Eight Likert items and measures of symptomology	Mostly eclectic, some CBT and psychodrama	Pre-therapy, termination and 2 month follow-up	0

Authors	N	Methodology	Type of therapy	Time point	Level
Dimcovic, (2001)	37	End of Therapy Questionnaire. Semi-structured	Mostly CBT, some psychodynamic, personal construct and family	Termination	1
Feifel & Eells (1963)	63 (45 at 4 year follow-up)	Open-ended questionnaires asking about helpful aspects of therapy	Psychodynamic psychotherapy	Unspecified time after termination. Follow-up questionnaire sent 4 years later.	1
Gatson & Sabourin, (1992)	147	Client Satisfaction Questionnaire (CSQ-8, Attkinson & Zwick, 1982). Eight Likert items and measures of symptomology. Tests of association with measures of social desirability.	Eclectic, dynamic and CBT	Unspecified time after termination.	0
Gershetski, Arnkoff & Glass, (1996)	154	Single item open-ended questionnaire; 'were there any aspects of your treatment that were particularly helpful to you? If so please describe' and Likert ratings of satisfaction	CBT, Interpersonal Therapy, medication and placebo with clinical management	Unspecified time after termination.	1
Heine, (1953)	24	120 Pre-prepared statements regarding possible changes and specific events in therapy were categorised by clients	Psychoanalytic, Non-directive and Adlerian	Unspecified time after termination.	1

Authors	N	according to degree of personal relevance	therapists	Time point	Level
	Methodology		Type of therapy		
Hsu, Crisp & Callender (1992)	6	Open ended interview	Inpatient treatment, family and individual psychotherapy	20 years post-therapy	1
Kantrowitz, Katz & Paolitto (1989 a & b)	18	Semi-structured interview asking about experiences of therapy, changes noticed, stability of these and whether clients continued to do self-analytic work	Psychoanalytic psychotherapy	5-10 years post-therapy	1
Kaschak (1978)	75	Semi-structured questionnaire inquiring about, degree of change and attributions regarding these	Mostly eclectic, also psychodynamic, Rational-emotive and Gestalt.	Termination	1
Leuzinger-Bohleber, Stuhr, Ruger & Beutel, (2003)	401	194 participants underwent unstructured followed by semi-structured interviews, 207 completed semi-structured questionnaires. Conscious and unconscious information rated and hypotheses formed by a research group are tested in 2 nd interview. Following this, group independently give ratings of data before coming to a common consensus	Psychodynamic therapy (once weekly) and psychoanalytic psychotherapy (3+ times weekly)	Minimum 4 years post therapy (average 6.5 years)	1
Llewelyn (1988)	40	Helpful Aspects of Therapy Questionnaire used to record specific helpful and unhelpful events in retrospect.	Mostly eclectic, some psychodynamic and behavioural	Termination or 6 months into therapy (whichever came first)	1

Authors	N	Methodology	Type of therapy	Time point	Level
Llewelyn, Elliott, Shapiro, Hardy & Firth-Cozens, (1988)	40	Helpful Aspects of Therapy Questionnaire used to record specific helpful and unhelpful events in retrospect and measures of symptomology	Psychodynamic and CBT	Termination	1
Lipkin, (1948)	37	Open-ended questions. Therapist personally asked clients 3 questions (what was the story before you came here, what went on in therapy, how do things look now) which they are requested to respond to in clinic setting.	Non-directive psychotherapy	Termination	1
Paulson, Truscott & Stuart, (1999)	36	Single item open-ended telephone interview; 'What was helpful about counselling?' Followed by a participant data sorting task	CBT, humanist, behavioural and family systems	Termination	2
Schlessinger & Robbins (1974)	6	Clinical material relating to therapy process reviewed by group of therapists including client's own and designated follow-up analyst. Follow-up questions identified from this and form the basis of 4-6 follow-up interviews. Findings related to pre-ordained categories relating to the nature of the alliance, the Oedipus complex, defense transference and dreams.	Psychoanalytic psychotherapy	2-5 years post-therapy	1
Strupp, Wallach & Wogan, (1964)	44	Semi-structured questionnaire	Psychodynamic therapy	Unspecified time after termination.	1

For the purposes of this review, clients' retrospective perspectives of therapy were categorised and will be explored under three main headings; satisfaction with services, changes noticed following therapy (both in the short term and longer term) and finally what factors have been found helpful or unhelpful in therapy. Arguing the value of the client's perspective and contrasting it to that of the clinician have been adequately covered in the aforementioned reviews. It was therefore not the purpose of this review to revisit these and where studies mentioned explore therapists' views alongside clients', only the outcome of the latter was focused on.

Results

Client satisfaction with services

Overwhelmingly, the majority of clients appear to be satisfied with their experiences of therapy with quantitative ratings ranging from 76-96% (e.g. Deane, 1993; Leuzinger-Bohleber et al, 2003; Strupp, Wallach & Wogan, 1964; Lipkin, 1948; Bende & Crossley, 2000). Whilst some of these studies have utilised specific measures such as the Client Satisfaction Questionnaire (CSQ-8; e.g. Attkisson & Zwick, 1982 in Deane, 1993; Gaston & Sabourin, 1992), the majority of studies used single Likert ratings of satisfaction as an adjunct to other more general measures of client experience. In particular, Ankuta and Abeles, (1993), identified that greater client satisfaction was associated with greater symptomatic change (both were rated by standardised measures and clients themselves). The authors speculated that this highlighted the importance of symptom relief in clients' evaluations of their therapy. However, an important aspect of this study is that clients were offered a financial incentive (percentage reimbursement of fees) to take part. Whilst this may have led to a

greater range of participants (i.e. not just those who had particularly strong views on the process) it is possible that this may have biased the sample by making participants feel more favourable towards their therapy.

This possibility of skewed response rates has been called into question more generally when looking at the validity of client satisfaction as a measure (e.g. Lebow, 1983 in Gatson & Sabourin, 1992). Whilst Gatson and Sabourin (1992) found that social desirability was not correlated with measures of client satisfaction, it has been found that those completing questionnaires at home produced lower and more varied satisfaction ratings (Deane, 1993). This implies that although trait dependent variables may not bias participants' responses, there may be something about the context, or proximity (time or place) of the situation that affects clients' ability to give honest accounts of their experiences. Additionally, it can be debated whether such measures can even be considered to be a reflection of client experience per se since participants' responses were constrained by using a Likert scale and they therefore do not meet the criteria for level one research (Macran et al, 1999). Furthermore, such structured measures do not really provide sufficient information on client experience as they do not differentiate between specific aspects of therapy that may have been more or less important and provide no information as to causality between improvement and satisfaction (it may be the case that clients who are satisfied with their therapy are more able to make changes rather than vice versa).

Changes noticed by clients

In addition to studies assessing clients' overall satisfaction with therapy, there were several which asked clients about specific benefits of therapy. Whilst some were little better than the aforementioned satisfaction ratings and so cited general reports of improvement without giving details (Board, 1959; Ankuta & Abeles, 1993; Heine, 1953), when types of changes were reported there was a striking degree of overlap. It is somewhat difficult to rank these changes as there was a high degree of variability in methodology adopted (some researchers rated the frequency of changes reported, or asked participants to rank the importance of improvements and others simply listed them). However, the most commonly cited changes seemed to be an increase in understanding of self and problems (Dimcovic, 2001; Leuzinger-Bohleber et al; 2003; Feifel & Eels 1963; Strupp, et al, 1964; Lipkin, 1948; Clarke, Rees & Hardy 2004; Ankuta & Abeles, 1993) a greater sense of ability and self-acceptance (Clarke, et al; 2004, Strupp et al; 1964; Leuzinger-Bohleber et al; 2003; Kantrowitz et al; 1990a; Buckley et al; 1981; Ankuta & Abeles, 1993; Hsu et al; 1992; Lipkin, 1948), improvements in relationships (Leuzinger-Bohleber et al; 2003; Strupp et al; 1964; Kantrowitz et al; 1990a; Buckley et al; 1981), symptom relief (Dimcovic, 2001; Strupp et al; 1964; Clarke et al; 2004; Kantrowitz et al; 1990a; Buckley et al; 1981; Ankuta & Abeles, 1993; Lipkin, 1948) and behaviour change (Dimcovic, 2001; Ankuta & Abeles, 1993). However, differences across methodologies are likely to impact on the accounts of change that clients give and may explain some unexpected findings. In particular, it is interesting to note that of those studies where changes were ranked in terms of importance for participants, symptom relief was seen as a "relatively minor gain" (Strupp et al; 1964; Paulson, Truscott & Stuart, 1999) which seems to be at contrast to

what one would imagine (and to the finding of studies into client satisfaction). Whilst some researchers pre-assigned categories of change and asked participants to rate their occurrence (Heine, 1953; Buckley et al, 1981; Dimcovic, 2001) others allowed participants to state whatever changes came to mind, in their own words (Feifel & Eels, 1963; Lipkin, 1948; Strupp et al; 1964; Leuzinger-Bohleber et al; 2003; Kantrowitz et al, 1990a; Hsu et al, 1992; Clark et al, 2004). This therefore has potential implications for the frequency in which changes are reported as the same change might be conceptualized in different ways according to client understanding (Feifel & Eels, 1963) or the interpretation and theoretical orientation of the researcher and perhaps only those made salient by the research process are reported.

An attempt to draw all these aspects of client change together into a coherent model has been supported by the German Psychoanalytical Association in the form of a complex, large scale retrospective study of clients' experiences (e.g. Leuzinger-Bohleber et al, 2003). The authors' methodology loosely conforms to the tripartite model (Strupp et al, 1964), in that there is an attempt to triangulate the views of the individual client, the professional and also society in the form of a research group made up of those within and without of the psychoanalytic field in order to attempt to find a 'common clinical view' which was then compared against the client's own account said to act as a 'natural narrative control'. Qualitative data obtained was subjected to a modified theory-guided computerized content analysis to find three dimensions characterizing clients' experiences of change during therapy. These were self reflection, object relations (living in satisfying relationships) and creativity and working ability. There were eight prototypes to define categories of client development during

and post-therapy. There unfortunately does not appear to be any data on numbers of clients found to be represented by each of these categories. However, this study is fairly unique, not only in obtaining such a large sample of clients, and following up several years post-therapy, but also in utilising a variety of measures of client experience and outcome, both clinical and non-clinical and also incorporating the feedback and interpretations of non-psychoanalytic experts within the research group. However, despite these attempts to ensure interpretation of the data is not constrained by theory, psychoanalytic theory has nonetheless clearly influenced the findings. It is also difficult to ascertain to what extent the interpretation of unconscious interview material influenced the results and so to what extent reported accounts really are *clients' own* experiences.

An attempt to combine an array of complex data such as this into a working theory is of undoubtable value. It can be clearly seen how such changes clients report would be interlinked, with improvements in one area affecting another and perhaps it is somewhat artificial to try and separate these out. A model of change has implications clinically for areas of work to focus on in order to facilitate clients' progress along particular dimensions. However, it would seem that there is more work to be done before the complexity of clients' own experiences of change, independent of therapeutic model, can truly be understood.

Clients' experiences of change post-therapy (and stability of change)

It is clear from those studies exploring post-therapy change that therapy often initiates an ongoing process (Buckley et al, 1981; Schlessinger & Robbins,

1974; Kantrowitz et al, 1990b; Leuzinger-Bohleber et al, 2003; Orlinsky, Geller, Tarragona & Farber, 1993; Hsu et al, 1992; Bende & Crossley, 2000; Feifel & Eels, 1963). It would therefore seem important to obtain clients' views on therapy after post-therapy developments and time for reflection has been allowed to occur.

Researchers have interviewed clients between 2-10 years post-therapy to find stability and even improvement of therapeutic change over time (e.g. Kantrowitz et al 1990b; Buckley et al, 1981; Strupp et al, 1964; Leuzinger-Bohleber et al, 2003; Feifel & Eells, 1963). In particular, insight development has been found to continue post-therapy (Bende & Crossley, 2001) and clients have reported being able to deal with any remaining problems adequately by themselves (Strupp et al; 1964). However, it would seem that not only do improvements continue post-therapy, but the understanding that is made of the experience and insight into its impact also change. Feifel and Eells, (1963) found that four years post-therapy, clients were less likely to report that 'everything was helpful' (the primary response at termination) and more likely to criticize therapist characteristics and technique and to make suggestions for how therapy might have been more helpful. The types of changes experienced by clients at each time point also varied; with clients later on more likely to cite behavioural changes as opposed to insight, although this was not significant. Buckley et al, (1981) also found increased reporting of harmful effects of therapy amongst those who had terminated therapy less than four years ago, but that this dropped dramatically amongst those 11-20 years post-therapy. It may or may not be coincidental that a peak was found in having thoughts about the therapist or thinking about returning to therapy in the middle

of this period; 5-10 years post-therapy, which was suggested to be a 'critical time' in post-therapeutic development. Both authors attempt to explain their findings in terms of a dissolution of transference effects and Buckley et al, (1981) suggest that increased sociocentric orientation also occurs over time. However, they ignore the possible interaction with life events over this time period, in which clients might gain the opportunity to make use of what they have learned and truly see just how harmful or helpful their experiences are in the long term. Alternatively, these changes might lend further support to the idea that a certain distance from therapy enables clients to be more honest about their experiences.

Research looking at mechanisms of change in therapy offers some compelling arguments as to how clients build on and make use of their experiences over time. Clarke et al, (2004) use the assimilation model to explain changes reported through therapy by their participants. They suggest that their results demonstrate a continuum of client experience which illustrates the integration of clients' problematic experiences into their existing schema over time. Whilst this model primarily focuses on change that occurs during therapy, it suggests a process of internalisation of therapy which the client carries with them once therapy has ended. One valuable aspect of the methodology in this study was that none of the interview analysts provided therapy to the participants and the analyst panel included one member who was not a clinician and so this may have decreased the chance of demand characteristics and biases in the interpretation. However, particularly as only five clients were interviewed it is difficult to know whether it is possible to generalise the findings to other clients groups

A similar mechanism to the assimilation model has been used in the psychoanalytic literature, to describe the development of a 'self-analytic function' whereby clients internalize their therapist and seem to experience a continuation of the therapeutic process post-therapy (e.g. Schlessinger & Robbins, 1974; Kantrowitz et al, 1990b; Leuzinger-Bohleber et al, 2003; Orlinsky et al, 1993). This effect has been found to be greater in clients who have experienced more intensive psychoanalysis rather than general psychotherapies, (Leuzinger-Bohleber et al, 2003) and has been explained in terms of the development of schemas; internal representations of therapy that form and are rehearsed during therapy, then bridge the gap between therapist and client, session to session. These develop over time into personality structures through processes of internalization and identification and are frequently reactivated post-therapy (Orlinsky et al, 1993). A fascinating series of studies explored these processes by looking at the degree to which clients think about and actively employ therapeutic techniques post-therapy. Clients were asked about their experiences of these therapy representations outside of sessions and post-termination (e.g. experience of the therapist being 'present' and the nature, frequency, duration and vividness of these thoughts). In support of the development of the 'self-analytic function' through internalisation, frequency and occurrence of therapist representations have been found to have supportive-guiding representations in times of distress and to be linked to positive outcome (e.g. Tarragona, 1989, in Orlinsky et al. 1993). Another exciting aspect of these studies is the acknowledgment of sensory aspects of clients' experiences which, (possibly for reasons of practicality) otherwise seem to have been ignored in retrospective studies.

It is unclear from the above studies to what extent life events and ability to remember interact with any of the above factors, but it is likely that they might become so intertwined that it would be impossible for clients to disentangle them and again that the factor most salient to the client at the time of interview is that which is reported. This point is demonstrated in a study by Hsu et al, (1992) in which 25 years after therapy had ended, participants who had recovered from anorexia cited a mixture of life events and therapeutic contact as responsible for their progress. However, the interview data was recounted in the therapist's own words (thereby having been subjected to interpretation in line with the researcher's existing understanding) and since it was not formally analysed it is difficult to draw firm conclusions from it. Furthermore, different forms of therapy were received in combination and at different time points throughout the course of recovery, so when therapy was cited as important, it is difficult to pinpoint exactly which therapy is being referred to. Nonetheless, it is interesting that clients were able to give accounts of their experiences so long after ending therapy and it would have been interesting to compare these to the same clients' accounts at termination. With this exception, however, much of the research in this area has been undertaken in the psychoanalytic field (with the assertion by researchers that such post-therapeutic change and internalisation of the process is specific to this model) and it would be interesting to see the extent to which these findings might be upheld with less intensive models. It would also be interesting to examine the factors that contribute to stability of change and internalisation of the process of therapy by studying clients for whom these have not occurred.

What do clients report is responsible for these changes? (Helpful & unhelpful factors)

When looking at client experiences of therapy and what they find helpful, Gershefski, Arnkoff, Glass and Elkin, (1996) cite the importance of distinguishing between factors that are common to all types of therapy and those specific to the model.

Factors Common across models: Overwhelmingly, findings in early research regarding the importance of non-specific factors are upheld throughout the studies reviewed. The therapeutic relationship was cited as helpful in all and was related to degree of reported change in several studies (e.g. Buckley et al; 1981; Dimcovic, 2001; Strupp et al, 1964; Board, 1959). Learning new things also seems to be an important aspect of the experience (Llewelyn, Paulson, Truscott & Stuart, 1999; Gershefski et al; 1996; Hsu et al, 1992; Clarke, et al 2004; Board, 1959; Lipkin, 1948) although Paulson et al, (1999) emphasise that there is an important distinction between gaining new information and learning new skills. The opportunity for emotional expression and disclosure has also been found to be important (Llewelyn, 1988; Paulson et al, 1999; Board, 1959; Feifel & Eels, 1963; Lipkin, 1948; Kaschak, 1978; Heine, 1953). Other factors less frequently cited as helpful included less use of technical language by therapist (Strupp et al, 1964), gaining honest feedback and having the same sex therapist (Kaschak, 1978). In particular, Buckley et al, (1981) developed a semi-structured questionnaire of therapeutic factors based on the literature to inquire about helpful therapeutic elements of psychotherapy. Out of a concern that clients' perspectives may be inaccurate and fail to identify discrete areas of change, they used a sample of therapists who had undergone personal therapy.

Their hypothesis regarding the relationship between positive outcome and the quality of the therapeutic relationship (with therapeutic technique being less important) was upheld. However this is unsurprising when considering the context of using therapists who themselves have a pre-existing knowledge of the literature with which to make sense of their experiences. Furthermore, it is difficult to know to what extent the imposed structure of the questions may have constrained their answers. An alternative study, which actually attempted to obtain client's perspectives independently of theory, also involved them in the process of analysis, (Paulson et al, 1999). Participants' responses to a telephone interview were sorted into meaningful statements by a team of researchers before clients were invited to return to the clinic where they underwent therapy to rate these for importance and sort them into categories. Researchers then applied cluster analysis and labelled the identified themes. The authors concluded that their findings of the helpfulness of counsellor facilitative interpersonal style, counsellor interventions, generating client resources, new perspectives and client self-disclosure were consistent with previous research. However, they suggest that the additional identified factors of emotional relief, gaining knowledge, accessibility and client resolutions were less commonly found in the research. Client self-disclosure was rated as the most important, followed by the counsellor's interpersonal style and then new perspectives. In general, the authors' conclusion that this approach enables the richness of clients' experiences and the complexity of the therapeutic process to be captured would seem to be a reasonable one. However, the authors could have gone further in their prioritising of clients' perspectives by more fully including them in the process, such as allowing them to label the themes and make interpretations and give feedback regarding the final results. Conducting

the sorting task in the clinic setting may also have resulted in demand characteristics.

It is interesting to note that few studies have described clients citing personal resources such as their own drive and determination as helpful in therapy. Perhaps more work is needed into enhancing clients' awareness of their own role in the therapeutic process. However, just because a client does not talk about a topic does not mean it was not part of their experience, (Baillie & Corrie, 1996) and may again have more to do with the salience of constructs at the time of interview and the way that questions into clients' experiences are phrased. Several studies (e.g. Clarke et al, 2004; Llewelyn et al, 1988; Paulson et al, 1999) also failed to inquire about unhelpful aspects of client's experiences and such an expectation of helpfulness may have made it difficult for some client's to respond with 'nothing helped'. Generally speaking, of those researchers that did inquire (Board, 1959; Feifel & Eels, 1963; Bende & Crossley, 2000; Llewelyn et al, 1988; Heine, 1953), what clients report as most unhelpful about their experiences is simply the reverse of these; most particularly a negative and un-empathic therapeutic relationship. However, it is also striking how unhelpful factors related to number and length of sessions, timing of discharge and assignment to multiple therapists can be (Heine, 1953; Bende & Crossley, 2000; Feifel & Eels, 1963; Board, 1959). These are things that are often entirely out of the client's control (and may be difficult for clients to understand) and whilst they may be due to the therapist misjudging a client's needs, they are also often determined somewhat by service constraints. Disappointment has also been cited as an unhelpful factor in therapy (Llewelyn, 1988) and suggests a mismatch between clients' expectations and reality.

These factors may all relate to lack of clarity of process in therapy, which in itself has been linked to lack of progress or poor rates of change (Strupp et al, 1964; Board, 1959; Llewelyn, 1988). In dealing with these factors then, taking a more collaborative approach between client and therapist to address and explain these factors may be important. However, the importance of such extra-therapeutic factors and their impact on therapy is often neglected both in research and in clinical practice.

Factors Specific to the model: Few studies have compared clients' experiences of different models. Many have assumed that clients' experiences will be uniform across all types of therapy and so analysed multiple types of therapy at once, making it impossible to establish whether there were any aspects of client experience particular to the model (e.g. Deane, 1993; Ankuta & Abeles, 1993; Llewelyn, 1988; Dimcovic, 2001; Paulson et al, 1999; Hsu et al, 1992; Kaschak, 1978). However, several researchers have tried to unpick what it is that clients find helpful about particular models.

Clients seem to report similar changes regardless of type of therapy, (Heine, 1953) and non-specific helpful or unhelpful factors seem to be equally common to all therapies (Gershki et al, 1996). However, when models of therapy are compared, there do seem to be differences in the factors reported as helpful. In their comprehensive study, Gershki et al, (1996) classified participants' responses according to 20 pre-defined categories subdivided according to whether they were judged to be specific to the type of therapy (determined by examination of treatment manual) or common to all therapies (determined by examination of the literature). Clients were found to report significantly more

helpful aspects consistent with the model of therapy they had undergone than those that were not (also, see Heine, 1953; Llewelyn et al, 1988 for similar results). Specifically, clients who have undergone CBT have been found to focus on the helpfulness of looking at thoughts feelings and behaviours, (Clarke et al, 2004; Llewelyn et al, 1988; Gerfeshki et al, 1996), clients who had undergone interpersonal therapy cited changes in awareness of relationships (Gerfeshki et al, 1996), those who undertook cognitive analytic therapy talked about tools used such as diagrams and letters (Bende & Crossley, 2000) and those in psychodynamic therapy tended to mention awareness and interpretation as helpful (Llewelyn et al, 1988; Heine, 1953). There were few reports of unhelpful model-specific factors in the literature, although one study mentioned one participant finding a CAT-specific rating form unhelpful (Bende & Crossley, 2000).

With such a limited number of studies directly comparing clients' experiences of different models, it is difficult to draw any firm conclusions with regards to which aspects clients find most helpful or whether any of the non-specific factors are more or less important in different models. However, it is likely that in reality common and specific therapeutic factors actually interact with each other, the context they occur in and client's expectations of therapy, (Gerfeshki et al, 1996). Furthermore, although few studies have explored exactly what it is about model-specific factors that clients find helpful, it is possible these helped because they are simply alternative vehicles for the delivery of non-specific factors.

Levels of research

It is surprising how little of the research into clients' experiences of therapy truly strives to obtain clients' views by involving them in the process. Questions asked of participants are primarily focused on aspects of therapy that clinicians want to know about and none of the studies reviewed asked participants what they thought clinicians needed to know. Whilst some researchers have attempted to ask open-ended questions, many are quite leading and set up in such a way that it would be difficult for clients to give a fully rounded view of their experiences. Furthermore, the majority of findings (with the exception of Paulson et al, 1999) were then interpreted by researcher/clinicians, in accordance with their knowledge of the literature or their allegiance to a particular model. Whilst there may be some relevance to this, and this does of course aid the dissemination of findings back into therapeutic practice, it may mean that assumptions are made about the data, distinctions between similar constructs are overlooked and important aspects of clients' experiences may be missed.

Conclusions

The findings of this review are in line with earlier reviews, emphasising the importance of non-specific factors in therapy (Elliot & James, 1989). It would seem that clients are fully able to recount their experiences of therapy some considerable time after ending, and that the point at which this is done can lead to differences in accounts given. However, the majority of research to date combines the accounts of clients taken at various time points including the

experiences of those at termination with those having had considerably more time to reflect on and make use of the experience.

It was interesting that the full range of client experience explored during therapy (detailed in Elliot & James' 1989 review) have not been applied in post-therapy research. However, certain aspects of these, such as sensory experiences of therapy, may be more difficult to recall as time goes by. Furthermore, there has been little progress in the type of research being conducted since Macran et al's (1999) paper. There still needs to be a move towards research where clients are able to answer the questions that are important to them in a way that they feel is relevant and also to play a role in their interpretation. This would also reduce the tendency for research design and analysis to be theory driven and may include a greater number of accounts of what was less helpful in therapy, for which consideration needs to be given into how best to enable clients to disclose this. Whilst it may be important to identify aspects relevant to particular models, therapy is a subjective process and as such our understanding of it is likely to be limited if we attempt to constrain clients' accounts by interpreting them in line with specific models. Future research would therefore do well to distinguish between the experience of common and specific factors outlined by (Gerfeshki et al, 1996)

Future studies should also attempt to establish whether clients' experiences vary according to the problem type and the length of time in therapy. Additionally, more work is needed to understand how clients' experiences and the sense that they make of these change over the course of therapy and at various time points after ending. In particular, it would be interesting to know

more about the way that the impact of therapy interacts with life events over time (an issue largely ignored in research to date). There also needs to be a consideration of potential demand characteristics, with more research being conducted by independent parties outside of clinic settings.

It is hoped that by considering all of these factors, it will be possible to build up a picture of the way that different factors interact in therapy in order to lead to long-term outcome (Paulson et al, 1999). It will be useful to gain accounts of how findings of such research are fed back into clinical practice in order to benefit the clients themselves. In general, there is also a need to continue to build on the present evidence base and provide more up to date research as the majority of the studies reviewed were over five years old.

One final point is consideration of those clients who decline to take part in research. Whilst the response rate for the above studies was generally quite high, it is possible that the few who decline to take part may well be those who have had the most negative experiences of therapy. The failure to include such participants could leave a large gap in our understanding of how therapeutic practice can best be improved.

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Therapists' Experiences after Ending
Personal Psychoanalytic
Psychotherapy: An Interpretative
Phenomenological Analysis

Therapists' Experiences after Ending Personal Psychoanalytic Psychotherapy: An Interpretative Phenomenological Analysis

Abstract

Objectives

This study explored the experiences that therapists have had after ending their personal psychotherapy. The aim was to gain insight into the long-term impact of therapy more generally.

Design and Method

A sample of eight therapists who had completed personal therapy at least two years previously underwent semi-structured interviews, transcripts of which were analysed using Interpretative Phenomenological Analysis.

Results

Four master themes were identified: Therapy Stays with Me, Personal Growth, Life and Therapy Becoming Interwoven and Contrasting Information. These inter-related themes and their sub-themes were used to illustrate the process of post-therapy development experienced by participants.

Conclusions

Although there are methodological limitations with regards to applying the experiences of therapists to a standard clinical population, it is likely that an awareness of these issues can facilitate termination and enable clients to build on their experiences once therapy has ended.

Introduction

Clients' experiences of change and psychotherapies

Previous authors (e.g. Macran, Ross, Hardy & Shapiro, 1999) have highlighted the importance of asking clients for their ideas about the sources and degree of

change in therapy, as these may be different to those of their therapists (see Weiss, Rabinowitz & Spiro, 1996 for a review). Whilst there is overlap in clients' accounts of helpful non-specific factors in therapy, clients reports of specific factors vary according to the model (e.g. Llewelyn, Elliott, Shapiro, Hardy & Firth-Cozens, 1988; Gershefski, Arnkoff, Glass & Elkin, 1996) and also according to the time point at which they are reporting (Feifel & Eels, 1963; Buckley, et al, 1981).

However, researchers in the psychoanalytic field seem to have struggled for longer than other researchers with the question of the validity of clients' perspectives and dealt with it in different ways. This is perhaps due to the unconscious element of the work, as it has been argued that standard research methodology is not appropriate for studying the unconscious processes, conflicts and fantasies that are the focus of psychoanalytic work (Leuzinger-Bohleber, Stuhr, Ruger & Beutel, 2003). However, a number of authors have approached this problem over time with increasingly complex, large scale studies that place an emphasis on psychoanalytic methods as their core (e.g. Schlessinger & Robbins, 1974; Leuzinger-Bohleber et al, 2003; Orlinsky, Geller, Tarragona & Farber, 1993). Although for a number of years there was a tradition against scheduling regular follow-up in psychoanalysis (Wallerstein et al, 1989), more recently this has changed and there is a growing body of research into the long-term impact of such therapies, incorporating client perspectives.

Psychoanalytic Psychotherapy and Outcome

In general, psychoanalytic psychotherapy has been defined as 3-5 times weekly sessions (e.g. Sebek, 2001, although a more inclusive definition of twice weekly psychotherapy will be used from hereon in) with a focus on helping the client free him or herself from the unconscious compulsions expressed in his or her symptomatic behaviour through the use of therapist-facilitated exploration, use of transference and increased understanding (e.g. Ammon, 1974). A distinction is made between this and general psychotherapies, which, whilst focusing on similar issues using similar techniques, are less intensive with clients only being seen once weekly. Whilst both these approaches have been found to be effective, there appears to be a qualitative difference with regards to outcome (e.g. Sebek, 2001; Beutel & Rasting, 2002; Leuzinger-Bohleber, Stuhr, Ruger & Beutel, 2003; von Rad, Senf & Brautigam, 1998), although there have also been a variety of mixed results (e.g. Howard, Kopta, Krause & Orlinsky, 1986; Kantrowitz, Katz & Paolitto, 1990). It has been suggested that such differences are due to changes at the level of personality structure (and therefore often undetected by conventional symptomatic outcome measures) particular to intensive psychoanalysis only (Grande, Rudolf, Oberbracht, Jakobsen & Keller, 2004).

Follow-up of psychoanalysis

This belief in core personality change rather than symptomatic relief alone has led researchers to begin to investigate the stability of change over time in psychoanalytic psychotherapy. Several studies have followed-up clients over several years since finishing psychoanalysis in order to evaluate outcome.

Kantrowitz et al, (1990) interviewed 17 clients 5-10 years post termination to find stability of change or improvement in seven of these. However, defining the factors responsible for these outcomes proved impossible, as they seemed to be related to neither analyst nor self-assessments nor psychometric tests completed at termination.

The long-term outcome of psychoanalytic and psychotherapies 'STOPPP' study (e.g. Sandell, Blomberg & Lazar, 1999; Blomberg, Lazar & Sandell, 2001) used a quasi-experimental quantitative methodology to assess outcome in 74 psychoanalytic clients and 331 in psychotherapy, three years after therapy had ended. They found that clients showed increasing improvements post-psychoanalytic therapy only, suggesting a qualitative difference between the two models. However, their methodology was unable to bring to light the process responsible for such post-therapy change.

Sandell, Blomberg and Lazar (2002) studied temporal interactions in long-term follow-up of three years for 156 clients ending psychotherapies. They found that those with a modest outcome at discharge showed the greatest improvement at follow-up, whilst those with a good outcome were more likely to deteriorate. Again, however, they used a quantitative methodology that could not identify factors responsible for these findings and they did not appear to distinguish between psychoanalysis and other psychotherapies.

Outcome as a process:

This maintenance and even improvement of change over time post-therapy has led theorists to speculate about a developmental process that begins in

psychoanalysis but continues once it has ended (Schlessinger & Robbins, 1983). In their study; 'STOPPP' Sandell, et al (1998) and Blomberg, et al (2001) evaluated therapy at various time points and concluded that outcome itself is a process. Grande et al (2004) present a model of therapeutic change to explain this, suggesting that psychoanalysis produces a deep, structural change through internalisation of the therapy process over time. This has been further described as the development of a 'self-analytic function' thought to be specific to this form of therapy, (e.g. Schlessinger & Robbins, 1983; Kantrowitz et al, 1990b; Leuzinger-Bohleber et al, 2003; Orlinsky, Geller, Tarragona & Farber, 1993; Wzontek, Geller, Farber, 1995) although there is one report of it occurring in purely supportive psychodynamic therapy (Wallerstein, 1989).

Theories of post-therapy change derived from client accounts

In an attempt to understand the process of post-therapy change (what it is that happens or continues to happen in order to produce continued improvements) there has been a move towards the adoption of more qualitative methods in psychoanalytic research.

Grande et al (2004; the Heidelberg-Berlin study) are currently addressing this question, amongst others, in Germany by investigating structural change in clients in psychoanalytic treatment as compared to psychotherapy. These clients have been followed-up at one and three years post-therapy. However, the outcome of their large-scale naturalistic outcome study has yet to be published in English.

Another German study (also not yet translated into English) interviewed 43 clients 10 years after therapy about post-therapy developments in their lives (Leikert & Ruff, 1997). The authors describe that, after a period of latency, clients used new modes of conflict solution acquired in therapy to re-organise their lives. The same authors later identified the importance of a supportive framework of peripheral relationships and deferred action in order for clients to translate therapeutic experience to daily life (2003).

Finally, the importance of the development or refinement of a self-analytic capacity once therapy has ended has been identified in further qualitative studies (e.g. Kantrowitz, et al, 1990; Leuzinger-Bohleber, et al, 2003). The latter of these was a large-scale German study of 401 clients (an average of 6.5 years post-therapy) to whom questionnaires were administered.

Personal therapy and using therapists as a resource

A large proportion of studies into the long-term impact of psychoanalytic psychotherapy have been undertaken outside of the UK, where use of this model is more widespread. This inevitably has implications for the availability of such participant samples in the UK. Due to limited resources within the NHS, psychoanalytic psychotherapy is less widely available in the UK and therapists trained in this approach have often turned to other ways of working or had to adapt current practice (Holmes, 2000). However, there are still considerable numbers of therapists who have themselves undergone psychoanalytic psychotherapy (e.g. Macaskill & Macaskill, 1992). Whilst this is often a mandatory adjunct to training in psychoanalytic psychotherapy, the reasons that therapists undertake personal therapy tend to be perhaps as diverse as the

general population (Macran & Shapiro, 1998; Williams, Wiseman & Shefler, 2001) and it is often viewed as one of the most important factors in both their personal and professional development (Wiseman & Shefler, 2001). This population is therefore a valuable source of information with regards to the process of psychoanalytic psychotherapy and several researchers have utilised this as such (e.g. Buckley et al, 1981).

Rationale for proposed study

Several studies have therefore demonstrated the continued impact of psychoanalysis (over and above less intensive psychotherapies) once therapy has been terminated, but few have investigated the processes related to this or asked clients about their experiences. Whilst some large-scale studies have been conducted in Germany, little work has been undertaken in the UK and there may well be cultural differences. Therapists who have undergone personal therapy may provide a valuable and easily accessed sample within the UK.

Aim of the study

- To gain an understanding of the ways that psychoanalysis may or may not continue to affect client's lives in the longer-term

Methodology

A qualitative methodology was chosen in order to assess clients' subjective experiences and to fill a gap in the literature by identifying potential variables for quantitative research.

Interpretative Phenomenological Analysis (IPA; Smith, 1996) met the needs of the study as it is a well established means of exploring peoples' experiences and can be used to form recommendations for clinical practice. It is realistic to use within the time frame and fits with the author's personal philosophy by acknowledging the impact of the researcher on outcome through interpretation of the data and knowledge of existing theories.

This methodology was chosen over those such as grounded theory (GT) and template analysis (TA). Although a more explanatory approach such as GT would have been interesting, it would practically be too difficult to utilise the full version and it is less well suited to exploring peoples' experiences. Additionally, it ignores the impact the researcher has on interpretation of the data and unrealistically suggests bracketing of prior knowledge. The use of template analysis was also ruled out as this imposes some themes a priori and may therefore miss important aspects of clients' experiences, creating a blinkered perspective.

Inclusion/exclusion criteria: Participants were included if they had reasonable command of the English language and worked as therapists who had undergone personal psychoanalytic psychotherapy (minimum of twice weekly at least part of the time), a minimum of two years ago, with some memory of the experience terminating by mutual agreement. Participants were excluded if they had a diagnosis of schizophrenia (due to the high likelihood of relapse) or had been admitted to hospital or received other forms of non-psychoanalytic therapy prior or subsequent to therapy (as it would be difficult to separate out the effects).

Participants: Eight participants (six men, two women) between the ages of 41-60 (mean age of 53) participated in the study. It was hoped that this number would allow for sufficient richness of data whilst also being manageable within time constraints. All participants were practising psychotherapists (all but one working psychoanalytically) although three held dual roles as clinical psychologists (including two consultants) and one was also a consultant psychiatrist and lecturer. All were white (though two were born in Europe), six were in committed relationships, one divorced and one single. One participant described their reason for undertaking therapy as purely training related, one as personal reasons/interest and the other as a combination of these. Length of therapy ranged from 4.5 to 9 years (mean=7), with number of sessions ranging from approximately 200 to approximately 2000. Six participants undertook a combination of once and twice weekly therapy, one combined once and five times weekly, and another once and three times weekly. Although all termination of therapy was by mutual consent, three participants also mentioned ending training as being influential, one cited the therapist moving and two felt that therapy continued for longer than they would have liked. The time since ending therapy ranged between two and 18 years (mean=7 years). During this time, one participant had returned to psychotherapy for one further year and also had group therapy experience, another solely entered group therapy and a third entered brief psychodynamic couples counselling. All participants were asked to focus on their longest individual therapy experience for the purposes of the interview.

Procedure

Recruitment: An established team of psychoanalytic psychotherapists were initially consulted as to the aims of the study, and their support was obtained in identifying potential participants. A snowballing recruiting procedure was applied, whereby initial participants identified potential acquaintances who might be contacted for recruitment, and these in turn identified further potential participants. Potential participants were contacted by e-mail, letter or telephone (depending on available details) to inform them of the study and those who were interested in taking part and felt they met the criteria were then forwarded an information sheet (see appendix D for letter template, E for information form and F for informed consent sheet). Consent to collect data was obtained prior to the interview and consent to use data was obtained at the end.

Development of interview schedule: A semi-structured interview schedule developed for the purposes of this study can be found in appendix G. These questions were designed to be non-leading and to encourage participants to think about their post-therapy experiences, their attributions of these, the development of their personality, self-view and view of others and their expectations, past and present. They were under specific headings that group participants' post-therapy experiences into three time periods; reflections on finishing therapy, the present and the future.

Data Collection: Firstly, pilot interviews were undertaken with two psychoanalysts who did not meet the criteria for full inclusion in the study and had themselves previously undergone therapy. Their feedback was used to

gauge the usefulness and validity of the questions in the schedule and it was felt that these were appropriate and therefore did not need to be altered.

Data was collected from each participant on two occasions. Firstly, data was collected with the initial interview schedule as a guide and the descriptive information sheet (see appendix H). Interviews were semi-structured, one hour long and audiotaped. Participants were interviewed in a home or work location as was convenient to them and encouraged in a non-leading fashion to elaborate on their answers. Time was allowed to debrief at the end.

Following data analysis, further data and feedback was collected from the original participants via an additional half hour interview or through paper format according to convenience (see appendix I for schedule). This was aimed at validating the findings (see validity checks below) and to give participants the opportunity to supplement any additional information that may have been triggered by the initial interview.

Confidentiality

The transcriber was asked to complete a confidentiality sheet (see appendix J) and client data was kept in an anonymised form. However, clients were informed that quotes from the data would be used in the write up (appendix E).

Ethics

The proposal was approved by the North Sheffield Ethics Board and Sheffield Care Trust Clinical Governance.

A possible issue was the risk or need for further therapy being identified. It was felt unlikely that this should occur, due to the nature of the participant group (practising therapists who had successfully completed therapy). However, participants were informed that in this situation they would be advised to contact their former therapist or GP.

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Analysis

The standard IPA procedure (e.g. Smith, 1996) was employed. The first interview was transcribed by the author in order to get a feel for the data. Following audiotapes were transcribed verbatim by a paid transcriber. These latter were read through by the author whilst checking them against the tapes in order to achieve concordance. Each text was read through, and initial thoughts and points of possible importance noted. Further read-throughs lead to the labelling of potential themes within sections of the data. These themes from individual transcripts were then compared across transcripts to identify overarching themes, clusters of themes and hierarchies.

Validity checks

A diary was kept, incorporating quotes from the data, to record how themes arose. Identified themes were checked back against the original research question to assess for relevance. Results were audited by the author's supervisor and a peer group member. They followed the process by which themes were obtained and checked them against the transcripts in order to reach agreement. Additionally, the summary of themes was presented to participants (either face to face at the second interview or by post at this time point) and feedback about these requested with changes made accordingly.

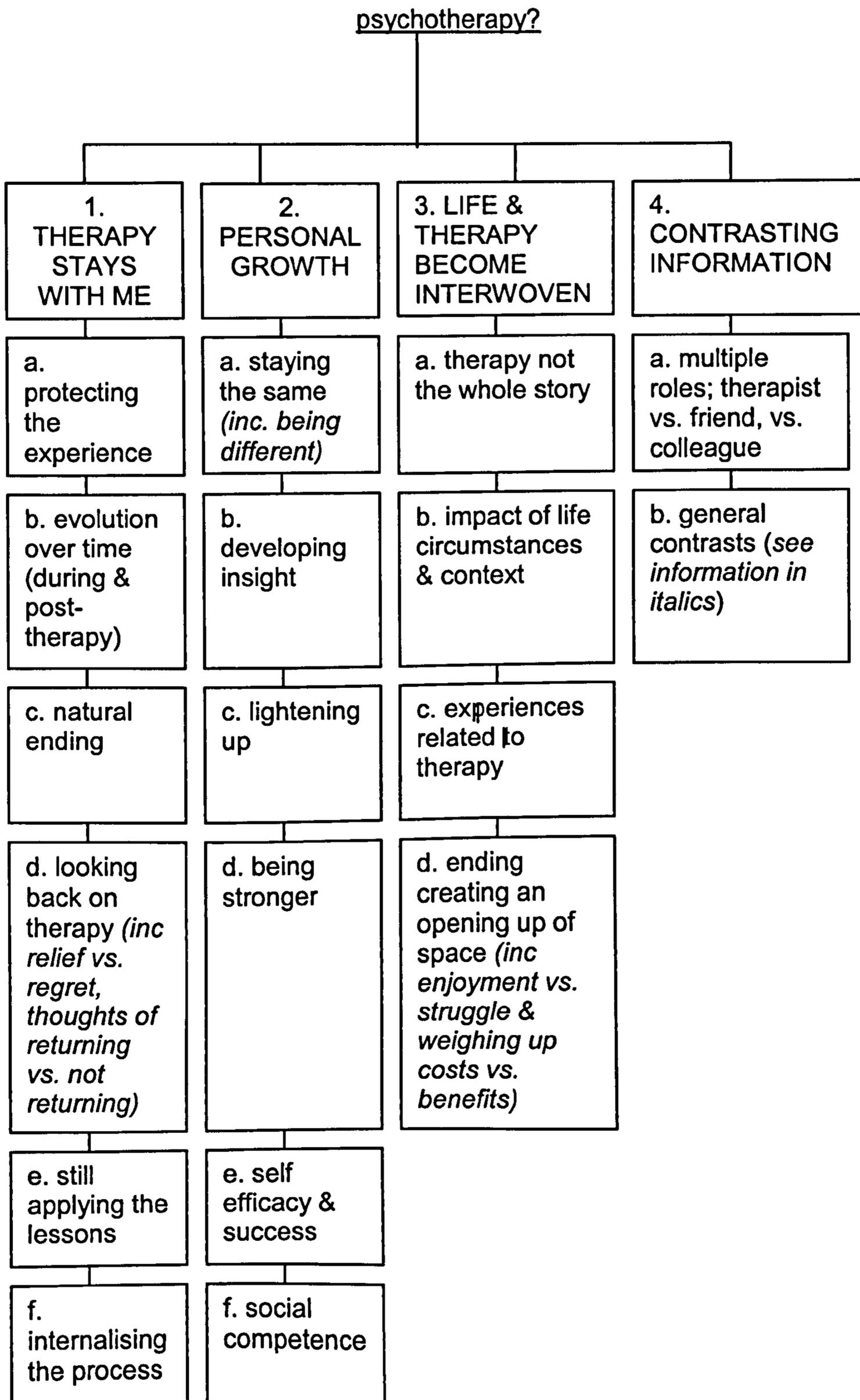
Results

Analysis of the transcripts identified four master themes and 18 sub-themes encapsulating therapists' experiences after ending their personal therapy (see Figure 1 for flow diagram and appendix K for worked example of transcript). Five further sub-themes were disregarded as they related to participants' experiences during therapy only (see appendix L). However, where aspects of clients' experiences during therapy help to set post-therapy experiences in context, they will be referred to, albeit briefly.

The first master theme '*therapy is still with me*' describes how participants talked about their therapy as if it was still a part of their life, an ongoing process, with no clear demarcation between therapy ending and life continuing. In the second theme, participants also talked about '*personal growth*', this included ways in which they felt they had stayed the same but also changes and achievements they had noticed in themselves and their relationships, often beginning during therapy but continuing to develop once it had ended. Related to these two master themes, was the third master theme '*life and therapy becoming interwoven*' in which participants' accounts of post-therapy experiences were intertwined with life events and the context they were set in, making it difficult for them to separate out causal factors. The final master theme related to '*contrasts*' in accounts given which can be seen throughout each of the other themes and also in terms of the conflict between the roles of the participant and their therapist. In relation to these themes, the narrative of participants' post-therapy experiences derived from the transcripts can be seen below illustrated by extracts from individual participant's accounts.

Figure 1. Overview of Master Themes and Related Subthemes

What are therapist's experiences after ending personal psychoanalytic



Therapy is still with me

There were several ways in which participants talked about therapy as if it was still a part of their lives.

Natural ending: Six participants described an ending that occurred naturally, as if finishing therapy was not so much a concrete event, but rather merged into the post-therapy period. For instance, when describing the ending, one participant described:

Phil¹: “ *well, it took a while.. because, there was no obvious point.. to finish, it’s not like going shopping, saying well, we got what we came for.*”

And later said about therapy:

Phil: “ *...it’s, an earlier period of my life... quite a long period... not a clear demarcation*”

George described that “*the material dried up*” and Michael, Rick & Harry all said that they felt “*ready*” to end. Conversely, Peter and Ruth were less satisfied with the way that their therapy had ended and described a less natural ending. Ruth described that whilst she felt it might not have been productive to go on any longer, her therapy ended prematurely due to the therapist moving away:

¹ To preserve anonymity, pseudonyms will be used throughout

Ruth: *"...it didn't feel quite right because I didn't feel I'd fully done what I'd wanted to do...so perhaps a bit like it was unfinished"*

However, rather than finishing too soon, Peter described that therapy continued past the natural point of ending:

Peter: *"... long since run out of steam, and out of interest and also... the obligation to do so as part of training..."*

Protecting the experience: Despite the fact that therapy had ended, seven participants spoke about their experience as if it was still something to be either protected or exposed and valued now just as much as ever. One way this manifested itself was through participants trying to maintain a balance between presenting an accurate picture and not wanting to disclose too much:

George: *"...it's just a dilemma, how personal you want to be and how detailed you want to be. I don't like speaking in many ways, I like speaking in more detail and giving more examples but... I didn't do much of that today..."*

Whilst Peter wanted to make sure not to 'lose the negative' when describing his experience Harry, Rick and Phil were all hesitant to ascribe the term 'unhelpful' to any aspects of their experiences:

Harry: *"...I suppose there's a distinction between what's unhelpful and what, wasn't as helpful as it could have been"*

Furthermore, Michael talked about writing to complain when some years later he heard that his training course was due to be axed, and Eileen said that :

Eileen: *“I don’t think you ever forget it... it’s something very special I think, I find.”*

Looking back on therapy: Seven participants described being in two minds about ending; feeling relief and looking forward to the rest of their lives, but also looking back and feeling emotions such as regret, resentment or uncertainty over whether it had been the right time to end. The eighth participant (George) had felt at the time that therapy had ended appropriately, but came to realise that it had not been finished and returned for further work after the death of a family member brought up issues that *“I didn’t know existed in me”*. However, whilst five other participants also had thoughts of returning to therapy none of them did this. Rick used the idea of being able to return to therapy as a way of coping with the ending, however when he was offered the chance to do so after becoming ill, he turned it down:

Rick: *“I mean I did, at one point think about going back into therapy, in fact my therapist knew that I was [had a serious illness] and asked if I was going to... but in the end I said no, I did make him the offer but then I thought, at this point in time, in a way, I’ve wanted to cope with it with my family rather than kind of go off and explore things away from them”*

The idea that it would be possible to re-enter therapy seemed instead to be used as a source of comfort or a kind of fantasy to get through difficult times:

Eileen: *"...sometimes I just, I don't know, I wish I could have more (laughing).. more therapy... but I suppose that those are the kind of opportunistic moments when I think, I could do with, particularly something im going through a difficult few years with some very difficult patients and... so in that way... I probably will go back at some point"*

Ruth: *"... although she [the therapist] moved to a different area of the country I sometimes used to think, oh, if I needed to I could go back and find her, wherever, and have another session..."*

Both Ruth and Eileen felt that if they were to return to therapy then next time it would be different, that they might use it differently as it would be *"internally rather than externally motivated"* (Ruth) i.e. not as a requirement of training.

Evolution over time: All participants described that changes that had begun in therapy continued to evolve after it finished. Eileen felt that

Eileen: *"... in one way it's finished, but in another way it's a continuation of it and I guess... changes happen all the time"*

George and Rick talked about an ongoing *"internal journey"* and Peter felt that it was not just the positive effects of therapy that continued to impact on his life but that *"...it's continued to have a downside..."*.

Still applying the lessons: Seven participants talked about continuing to use what they had learned in therapy. Descriptions of this centred on both general application of lessons; *"I have a book where I write out my thinking..."* (George) and Michael said that he planned to *"go out to the theatre more often... which is one of the things my therapist was trying to encourage..."* and there were also specific problem solving efforts:

Harry: *"I suppose if there are difficulties, say maybe interpersonal ones...I might... whether at the time or subsequently I would... invoke you know my thinking... so therapy may be invoked"*

Harry, Ruth and George also all referred to thinking about how their therapist might have handled specific situations

Harry: *"sometimes when I'm with a patient, and I'm wondering how to put something to the patient... Then I'll think... how might my analyst have put this..."*

Internalising the process: Several participants described that this kind of actively thinking about therapy had become less frequent over time: *"...it...can come into my mind... I don't sit down and have kind of thinking about it sessions now..."* (Phil) and that memories of therapy itself had become somewhat

distant; *"I don't know how I ever did it"* (Rick). Instead participants described more frequently using therapy in a *"semi-conscious"* way (Harry), *being "half aware of something being in operation"* (Peter). This suggested a kind of internalisation of the process of therapy which was talked about further by George;

George: *"...I sort of have the analysis inside, integrated inside, so it's all constant, a friend and companion and reference point... aiding understanding..."*

Personal growth

Staying the same: Seven participants described, being *"not radically different"* (Ruth, Peter) at present to how they were before therapy. Participants themselves seemed unsure about whether they had changed or not:

George: *"Well I wasn't terribly different, outwardly just, you know, same yet different, same and different at the same time..."*

The idea of staying the same seemed to be at contrast with the huge changes in themselves and their lives that all participants described. Participants partly explained this in relation to identifying aspects of themselves that had and hadn't changed:

Harry: *"I don't think analysis changed the basic character structure"*

Rick: *"I don't think it changed who I am, but it helped me understand a bit more about who I am"*

Phil: *"In some ways it's the same, or similar and some ways it's a bit worse... in some respects it's better..."*

Three participants also talked about a lack of change in relation to not necessarily having *"learned the lessons"* (Michael) from therapy and that there were areas that they were *"continuing to struggle with"* (Harry).

Developing insight: In general, participants described a number of personal changes that they often reported occurring in stages although they were not always able to distinguish between those occurring during or following therapy. All participants described an increase in insight and for most this began with a difficult process of owning previously denied feelings (this generally occurred primarily during therapy):

Michael: *"...having therapy was actually discovering quite a lot of home truths about myself, which in theory I knew, in my kind of theological perspective, ideas... ideas about sin (laughs) and things like that, er...but actually then beginning to see that in myself, and coming to terms with that with myself wasn't called sin, was just called...kind of my envy and jealousy, anger and negative emotions..."*

Rick: *“...that left very difficult issues that we dwelt on, on and off for probably several years so that was a kind of, you know, discovery, I suppose capacity to hate really, which on the whole...I’d like to pretend I didn’t, you know, it became very real.”*

Insight and learning continued following therapy; *“...as time goes on I’ve learnt more about myself...”* (Harry) and for Ruth the interview process itself contributed to this as she used phrases such as; *“Just thinking about it now, I realise...”* *“in retrospect it must have been”*. In general, the language used was more matter of fact and less emotional than that surrounding time in therapy, suggesting that participants had come to terms with the more difficult aspects of their personality.

Lightening up: For some participants, having more insight and coming to terms with themselves led to *“lightening up”* (George) as it enabled participants to better contain unhelpful behaviours and so react to situations differently:

Harry: *“I was much more contained, erm, much more able to think about my reactions...I would realise that I was competitive so I wouldn’t have to act it, you know... or if I could see that somebody... understood something better than me, I wouldn’t just get depressed, I’d think, oh, there you go again, you always find that difficult... but my personality’s a lot more manageable”*

Michael commented that for him this was an ongoing struggle:

Michael: *"It's a constant position to aim at if you like... be honest about one's self, one's feelings...recognising things like rage and, erm...and once recognising that then being able to, to want to, trying to kind of, erm, modify those in some way...rather than blaming other people all the time, attacking myself"*

Having a more realistic view of things also seemed to allow participants to accept things as they are. All participants described that they were now able to be much more accepting (and therefore less critical) of themselves, others and situations, whether reflecting on the past, present or future. Peter and Phil described coming to terms with the fact that the past could not be changed. Peter said that he had learned that *"you can't go through every door"* and Phil talked about dealing with disappointment:

Phil: *"...because the difference between a rainy day and a sunny day... enjoy the sunny day and, learn to put up with the rain, you know, that's all... there is, there's no magic... my expectations, had modified...which can mean of myself and of others obviously, or the weather... what sort of person was I, erm, probably increased capacity to... enjoy, all that's going down, rather than, perhaps pine or regret what had gone down, or what, or it wasn't about going down..."*

Michael talked about learning to deal with day to day uncertainty: *"... one of the lessons I learnt was, negative capability... it's about being able to be in a place of uncertainty, unknowing, without getting into a panic"*

And Rick described how seeing others as more real and realising his own role in interactions enabled him to stop trying to change people close to him:

Rick: *"I suppose they [relationships] became more real and then became less based on kind of, you know, illusion and fantasy... slowly becoming to accept really how they are... to see that, you know, lot about this is to do with me rather than, them (laughs)... it's about kind of, wanting your partner to be different in some kind of a way and, realising... the ridiculousness of, that really, because, they're who they are, that's why you love them..."*

However George focused on not worrying about the future:

George: *"... I'm much more in the moment, in the process of where I am now and accepting that, you know, things might happen, it might start snowing... no, I think about them but I don't get caught in it, because as soon as one starts projecting into the future, you know, and the future doesn't exist, you aren't living well, you, you're off balance, you're not centred...so therefore I live much more in the moment and I notice things much more deeply, and much more powers of observation... Have increased enormously...now I'm... more reflective and let things happen..."*

Participants reported that over time, they also 'lightened up' in terms of becoming "calmer" or "more relaxed", less depressed/better mood and more

humorous and predicted that these factors would continue to increase in the future. Whilst for most participants, this was a positive, Peter suggested that:

Peter: *"...there's a downside to that too... less... perpetual or impulsive or passionate or whatever... I think to some extent there's a danger in just becoming, so laid back that you're falling over..."*

However, most participants described that these changes were quite situation specific, that they could in fact be less accepting when the situation called for it and that despite lightening up, they also felt that they had "grown up" or become more "mature" (Phil, Peter, Rick, Harry, Eileen) over time.

Being stronger: Related to this, three participants also described having become stronger and more confident:

Eileen: *"I think I've become a lot more understanding, and accepting things and also not as accepting as you know, things that I'm... less, sure about that I would agree with than before beginning therapy... so I guess I'm a lot stronger in terms of my own mind, my own way of thinking... more assertive about it, and... confident... Whereas before I would feel that I was right, but not have a confidence about it.."*

For George, this meant being able to take risks with his future:

George: *"If I retire.....so that's a risk I'm taking... friend, a good friend of mine is very challenging, er, he's been meaning to retire a few times but he can't do it... totally different from him, he's challenged by me saying look, I've had enough now, I want to, risk it although I fear loneliness",*

And for Rick that he felt *"I do think it's helped me... feel strong to deal with getting [serious illness]"*

Self-efficacy and success: All participants referred to areas of achievement in their lives after therapy ended, particularly in relation to their professional lives. For Peter this was about having a *"fixed contract"* and being *"more established professionally"* and for Michael this meant increased *"job satisfaction"*. Harry described being more *"affluent"* and Phil also talked about *"tangible gain"*. Harry felt that he was also *"moving towards being seen as an authority"* whilst Peter and George also described finding the role of leader, supervisor or mentor to *"the next generation"* to be *"rewarding"*.

These changes seemed to be related to an increased sense of self-efficacy as participants described having *"control of my own destiny"* (Peter) or just a general sense of being more in control (Eileen). However for Peter, being in control was specifically about no longer being in therapy as he described that this was a period of his life when he had felt hugely dependent;

Peter: "...you start sort of living and experiencing living, in order to take them back there [to therapy].. so it's putting the cart in front of the horse....when its as intense and protracted as that"

and that the effects of this had continued to some extent once therapy ended:

Peter: "...nine percent, something like that, maybe has contributed to things not being as fulfilling, or as great as they might have been at this point"

Whilst this was not described to the same extent or as explicitly by other participants, there was a noticeable contrast in the use of language comparing during therapy when participants talked as if they were passive recipients of changes, and following therapy when they described themselves as instigators:

Rick said of therapy that he "*quickly came to rely on it*" but by the end felt "*I can leave therapy*"

George felt that prior to therapy "*forces were unleashed within me*" but later that "*I can do these things*", "*I can change*"

Eileen described that during therapy "*I convinced myself I couldn't do it*" but that since then she has been able to "*be independent, stay it and survive*".

Harry talked about "*depending upon somebody... and not being so... self-dependent*" alongside "*sometimes biting off more than I could chew*" during therapy and that now "*...it's a lot more manageable by me*".

As time went by, participants had experience of managing difficulties independently, however, some participants expressed doubt over whether they would be able to maintain this in the future:

Harry: *"I think... unless something really terrible happens, I'll probably be able to manage but however, contained one is there are some... things that can really hit, you know, that can stop anybody from... like, , becoming paralysed or having a stroke I... don't think I'd cope with that very well..."*

Michael: *"I'm kind of starting a new career quite late in my life... I don't have as much energy as I used to have, to throw myself into... reading... keeping up with stuff...so I feel quite uncertain I suppose...what the future is, whether I can carry on doing this..."*

And other participants stated a wish to return to a state of dependence: *"it would be nice to have your therapist do that for you"* (Rick) or recognition that they could not do it all themselves and some help might be needed. For instance, Ruth felt that *"certainly the support of others was a very good influence... I'm not very good at doing things on my own"* and Michael described that *"I'm finding it quite, quite stressful and draining at the moment, I do, I recognise I need the help, on some wave length, getting a bit more balance"*

Social competence: The final area of personal growth participants described related to social competence. This related firstly to participants noticing changes in the way they interacted with others. Perhaps in relation to the

increase in acceptance discussed previously, six participants described being either more 'thoughtful', 'sensitive', 'benign', 'supportive' or 'compassionate' towards others following therapy. Michael and George also both noticed that their communication skills improved and Ruth noticed increased empathy and interest in others. As a result, Michael, Ruth and Rick all noticed general improvements in their relationships, George commented that "*my social sphere widened*" and both Harry and Rick felt that they became "*easier to live with*". For Eileen and George who were both of European origin this also had a specific impact on their feeling of belonging to their community and on their cultural competence:

Eileen: "*I guess I learned my place in this world... I come from a different culture and it's often been very difficult for me to fit, or feel that I could fit....so I, that's changed quite a lot. I feel more confident in what I do*"

When talking about what his life might have been like without therapy, George described

George: "*I would have been more, living within a learning, I wouldn't have integrated in that my community living wouldn't have been as, as good as it is, ...and in terms of cultural integration it wouldn't have been as good...*"

For George, this allowed him to pick and choose those he did and did not want to relate to, so that the relationships he did have could be more satisfying and worthwhile in comparison to those early on in therapy. For him, this also

mirrored a move away from what he felt to be the confines of his early training in clinical psychology and towards integration into the psychoanalytic world:

George: *“colleagues... I found them by and large rather boring...and I regret to say that, I... couldn't relate to them personally because of my psychotherapy interests... then I gradually evolved, and developed friends within the psychotherapeutic community, and now I have quite a lot of friends, all over the place (laughs)”*

As participants themselves grew and changed, others noticed and reacted to their changes and this seemed to instigate a process of social comparison on behalf of the participants themselves and those around them. Eileen reported that she now felt that she could *'stand in the same place as others'* and that her sister reported admiration for the changes she had made. However, at times the perceived changes had a negative effect on relationships:

Eileen: *“He [her husband] would say I've become too assertive...because... that particular relationship has been very fraught retaining some of the things which are, there because it's a way of kind of coping, others are patterns that two people get in themselves together and then obviously those things start changing...it's complicated and I guess that's one of those things that, in terms of my husband, that's a lot more about what I was...and that doesn't always go well...and they feel a bit more uncomfortable that you feel a bit more comfortable about yourself because they can't do the same themselves...”*

George talked about having been concerned that he was moving ahead of his wife in terms of personal growth:

George: *"...so it was like a balance between family and myself... and I guess the unhelpful thing was, my wife catching up with me, (laughs).... I was evolving and developing and she had to evolve and develop with me in a way because we were set in our living system, together and she had to catch up with me... you know, and she couldn't stop it"*

(George later described how his wife later underwent therapy herself at his suggestion in order to deal with this process)

Life and therapy becoming interwoven

Ending creating an opening up of space: In addition to the impact of their own personal growth on relationships, participants also talked about the impact of the time given to therapy and how this affected their relationships. Harry reported that his wife felt "excluded" and Peter reported a widespread impact on his life:

Peter: *"...it can become... the principle and dominant intimate relationship you have, for a very, very long period and that can have a very, curious I'd call it, and alienating effect, on other relationships..."*

The time commitment of therapy also seemed to contribute to therapy occurring in a rather "chaotic" (Ruth) time, in which participants were "struggling" (e.g.

Eileen), *“running around rails”* (Peter) between being therapists, students, patients and also part of a family. Most participants also travelled considerable distances in order to attend therapy and all contributed large parts of their income to finance it. As a consequence Harry, Ruth and Phil struggled with the fact that they were obligated to undergo therapy as part of their training and a certain degree of resentment contributed to the difficulty of the experience.

Therefore, when therapy ended there was something of a feeling of anticipation described by all participants:

Phil: *“there was also a sense of, I think of freedom and release, you know, I mean coming down to... oh well that’s a (claps hands together) few bob I’m not going to spend (laughs)..., I’ll buy an electric kettle now, sort of”*

However, this was also coloured by a feeling that in a very practical sense something was missing,

Eileen: *“...Firstly I was missing it... from a practical point of view, you get into a routine and you have set times, certain days, and, you rely on the others. Because I mean, it costs so much for nine years, part of it was my life really... and it’s not longer there, so from that point of view there was a gap, but also from not having to go and see her”*

Therefore participants described finding ways to fill this *“opening up of space”* (Rick) that occurred, not only by planning what to spend the extra money on, but they also described having *“more free time”* and *“being able to do things I’d*

given up" (Peter). However, Michael found this gap somewhat difficult to deal with at first, particularly as for him ending therapy meant having to make a difficult decision about his career:

Michael: *"but then I eventually decided I didn't, want to go on being a [career] for the rest of my life and actually decided to stop, and then had nothing, and... I'd finished therapy as well then so that, that was a very difficult time... so for about a year, I had very little to do, apart from one or two private patients, I actually got quite depressed then..."*

Perhaps in response to this negotiation of the new use of resources, several participants described entering into a process of weighing up the costs and benefits of therapy. Peter and George did this in a very literal manner:

Peter: *"over a thousand [hours of therapy]... yeah, I remember adding them up bitterly and ruefully at one point and trying to calculate the cost..."*

George: *"...the world as it were, is my... personal la- largesse, you know... like an investment, or you use, the... the psychological rent that it gives... you're constantly using it, it's constantly producing stuff... because it was literally, cost a lot of money"*

But also more generally, Peter described weighing the positive factors of his experiences up against the negatives of *"...Ds; debility, debt and dependency"*, commenting:

Peter: *“... perhaps, if I’m saying ten percent good thing then ...maybe almost as much, I mean... nine percent, something like that, erm, maybe has contributed to things not being as fulfilling or, as great as they might have been at this point, so erm...plusses and minuses, unsure in my mind, I think on the whole, probably just edging it, positive rather than negative experience”*

George also described that certain aspects of his experience were *“difficult whilst it lasted but in the end it was good for us all”*

As time after ending progressed and when predicting what the future might look like, participants talked less about struggles in their life and more about enjoyment:

Eileen: *“... the future is more of the same really... I enjoy what I do, basically expanding all the time on what I’ve learned and (sighs) enjoying the rest of my life.”*

Ruth, Harry, Michael, George and Peter also all talked about the decreasing importance of material success and that what they hoped or intended for the future was less about obligation and more about choice:

Ruth: *“... the future’s less in the direction of achieving certain things and more in the direction of just feeling more like I’ve done... do what I want to do really, and be happy with that”*

Therapy not the whole story: Whilst participants were generally able to pinpoint at least some specific changes in their lives that happened “*directly through the content of some of the therapy*” (Phil), they found it difficult to picture how their lives might have been without it and “*quite hard to disentangle*” (Peter) the effects. In particular, Michael and Harry found it hard to separate the impact of training and therapy and Rick felt that “*life played an enormous part*”. It therefore seemed that therapy was “*only part of the story*”(Rick). Participants therefore felt that therapy had provided “*a basis*” (Harry), “*planted seeds*” (Ruth), or helped put them “*on a trajectory*” (Peter) but that in actual fact they had “*assembled bits from everywhere*” (Phil) and that later events “*consolidated*” (Harry) what had been gained from therapy. George also commented that life had put him “*in a position to make use of the changes*” as they occurred.

Ruth: “*I can’t say it definitely wouldn’t be... different... without the therapy or... yeah, I imagine the therapy’s played part of it but, that could be anything from a... range between the sort of twenty percent and sixty percent...*”

Impact of life circumstances and context: In general, participants’ accounts of therapy were intertwined with the context they were set in. Not only did therapy impact on participants’ lives whilst they were still having sessions (and vice versa), they also seemed to interact with each other in various ways after therapy ended. Participants all felt that age was an important factor in influencing their post-therapy experiences, particularly as some were approaching retirement. Added to this, participants described that having a family and watching their children grow up has also played a role:

Peter: *“so relative to then, decade ago, well I’m... older, wearier, god knows, maybe a bit wiser, erm...much more settled, I have a, family, erm, so all those kinds of responsibilities, and rewards...”*

In addition to general life development, some participants also described specific life events that had affected their life course. An important factor for Eileen was getting divorced, and for Rick, getting a serious illness meant that his entire life had changed:

Rick: *“Well, erm, life is, completely different because I’ve been diagnosed with [serious illness]... I can’t say, you know, it’s just the most devastating thing that’s ever happened to me and my family and, wasn’t at all expected”*

Experiences related to therapy: All participants worked as therapists, regularly interacting with like-minded colleagues and most had experiences of supervising others, training and teaching. Since ending therapy, participants were able to use these and other experiences to continue to make sense of and sort their memories of therapy:

Ruth: *“it’s quite powerful for me having somebody just focus on me... for that length of time, erm, the analogies... that sometimes come to mind for me... are going to the hairdressers...where I sometimes get a little bit of the same feeling where I sit and think, oh, there’s somebody who’s just like, looking after me and my hair for a whole hour or... or I’ve had, just*

recently I had, erm, a few odd sessions with a personal trainer and I've decided that that's like therapy but it's focussed on the body instead of the mind"

Gaining knowledge of the theory also helped and Michael described an incident during therapy where he had been upset at seeing another patient at the bottom of the stairs in his therapist's house:

Michael: *"I suppose that's an example of what, the difference working somewhere like this [professional building] where there's, you know... rather than in somebody's home which has a different kind of dynamics if you like, because you find, in Freudian language a quite Oedipal dynamic there in a sense"*

For Peter, subsequent experiences highlighted the limitations of therapy:

Peter: *"...I have had long supervision experiences with a couple of analysts as well, or p-patients, in some ways one of those was, arguably more powerful than therapy..."*

and in general, these factors seemed to aid participants in becoming clearer and building allegiances to particular ways of working:

Peter: *"I think had it [the ending] happened a whole lot earlier, it might have brought up other things that the brief therapies I mostly work with, do now..."*

Contrasting information

As already indicated, striking contrasts can be seen in the information given within individual accounts. A number of different factors seemed to account for this. Within the sub-theme of *'looking back on therapy'*; participants expressed relief vs. regret, thoughts of returning vs. not returning and these seemed to reflect a degree of ambivalence, and a process of coming to terms with having ended. This process seemed to be related to the process of weighing up the costs and the benefits of therapy which occurred once participants were left with an *opening of space* in their lives after ending. However, the contrast between struggle and enjoyment which also occurred at this time reflected more of a change or progression as time went by. Finally, when participants talked about staying the same yet being different this seemed to relate to the complexity of the factors involved.

Multiple roles: One common contrast not yet mentioned refers to the contradiction in roles that participants adopted in relation to their therapist:

Peter: *"I liked the woman I saw, we had... for seven years, an intense, intimate relationship, although fraught... and complicated by the fact that it was a professional one, but, also not, and that's one of the things about psychotherapy, it is and it isn't, I mean it also, can be quite commodified I think because it's also a, genuine human relationship"*

On the one hand, the therapist fulfilled a primarily therapeutic role for participants. George described that his therapist *"did not always get it right"* and Harry remembered the *"therapeutic presence"* of his therapist. However, the

fact that participants were also therapists themselves meant that this was complicated, for instance George referred to being aware that his therapist was a “*Doyenne*” in the field. Some participants referred to wishing for more from their therapist. Phil joked regretting that “*I never got invited round for tea*” and Harry talked about “*at one time the idea that my analyst did not like me would have been utterly devastating*”. The relationship that participants had with their therapist also changed over time. Phil commented “*it loosens up a bit at the end*”, becoming more “*collegial*” and “*...almost as if you can say, if it’s also therapy, we can go for a drink... or talk about football*”.

These factors seemed to contribute to the difficulty of the ending:

Phil: “*...some element of regret, because I knew, because of who we both were... because after all I am one too, therapist I mean... we probably wouldn’t, unless I chose to as a client, see each other again... so that’s difficult isn’t it, you know, I mean it’s one thing if the relationship breaks down or someone deserts you... but you’re deserting someone who you actually, don’t particularly want to desert*”

Although for some this was eased by the knowledge that they would continue to have some form of contact with their therapist in a professional sense, this necessitated a renegotiation of roles. George talked about referring to his therapist’s published work in presentations he gave and Rick described “*ending this relationship and embarking on some other kind*” but he found exactly what the relationship was “*difficult to define*”. However, Phil described that he still missed his therapist:

Phil: *"...which I've done nothing about, er other than, in the first year afterwards, then I sent him a Christmas card."*

For most participants, this seemed to become easier over time:

Harry: *"I heard him speaking at a meeting... he made it clear that he wasn't at all interested in football... he had many hours of football conversation from me... and I thought bloody hell, we're very different people... he must have thought I was coarse and common, and you know, it didn't really bother me... that's what we kind of call the transference, is sort of, diminished..."*

Validation

Member validation was obtained with six therapists, who were all in high agreement with the themes identified, suggesting no major changes. The only addition was that two participants commented on how the interview itself had been helpful in stimulating reflection on the therapy process and facilitating further post-therapy insights. Peer and supervisor audit further validated results.

Discussion

In exploring the question of the nature of clients' post-therapy experiences there was a large degree of overlap between participants' accounts, with each participant contributing data to all of the master themes and most of the sub-themes. Earlier research viewing outcome as a process that continues to

develop post-termination was supported as participants invariably described that changes had continued over time (Blomberg, et al, 2001; Feifel & Eels, 1963; Buckley, et al, 1981).

Therapy stays with me

The memory of therapy seemed to stay 'alive' in various ways for the participants interviewed. Six participants described thinking about returning to therapy which is similar to the proportion reported elsewhere (Pope & Tabachnick, 1994) and has been found to be a common experience (Buckley et al, 1981; Hartlaub, Martin & Rhine, 1986; Calef & Weinshel, 1983) although it may vary according to time since ending (Buckley et al, 1981; Hartlaub et al, 1986). Nonetheless, only one participant had actually contacted their therapist for further work, which is rather less than that found by other authors (Hartlaub et al, 1986). However, six of the eight participants were still within the 5-10 year post-therapy period thought to be 'critical' in post-therapeutic development (Buckley et al, 1981) and so may not yet have reached resolution of this issue. Alternatively, thoughts of returning may have nothing to do with the need or desire for further work (having been found to be unrelated to the 'completeness' of the initial therapy) and have instead been said in the literature to reflect unresolved transference issues (Hartlaub et al, 1986; Calef & Weinshel, 1983; Buckley et al, 1981). However, the descriptions of participants in this sample seemed to suggest instead that the idea that they could return to therapy if they wanted was actually a way of coping with having ended therapy, by keeping in mind that the option was there if they needed it. It is possible though that unresolved transference did play a role in the ways that participants strove to either protect or expose their experience within the interview.

Participants described that over time they consciously evoked memories of therapy less frequently and instead there was an overall awareness of it just being there in the back of the mind. This shift in ways of thinking about therapy (from consciously to '*semi-consciously*') was similar to that found by Wiseman and Shefler (2001) and may reflect the process of internalisation of the therapist and therapy itself described in the literature, (Grande et al, 2004; Craige, 2002; Wzontek et al, 1995; Orlinsky et al, 1993). This has been explained in psychoanalytical theory in terms of the development of therapy-related schemas, (Orlinsky et al, 1993). Alternatively, a more cognitive explanation of these findings would suggest that these shifts are the result of building on existing schema within therapy. In particular, the assimilation model has been used to describe the way in which therapy helps clients integrate problematic experiences into their existing schema over time in order to achieve problem solution and mastery of their difficulties (Honos-Webb, Stiles & Greenberg, 2003).

Participants also described that they continued to use what they had learnt in therapy and were able to carry on the work themselves. This may reflect the development of the 'self-analytic function' found by previous researchers (e.g. Schlessinger & Robbins, 1983; Kantrowitz et al, 1990b; Leuzinger-Bohleber et al, 2003, Orlinsky et al, 1993; Grande et al, 2004; Conway, 1999), although again, this could be explained in cognitive terms as problematic experiences having been fully assimilated and mastered, so that the client can cope independently (Honos-Webb et al, 2003). Whichever of these mechanisms is more accurate (and they may simply reflect different terminology for the same

process) support is lent to the idea that perhaps 'analysis never terminates, only visits to the analyst terminate' (Witenberg, 1976) and that in this sample aspects of the experience were still very much present as much as 18 years post-therapy.

Personal growth

Participants in this sample made little reference to the reduction of specific 'symptoms' or behaviour change from therapy. It cannot be ruled out that this might be an artefact of using a therapist sample whose reasons for entering therapy may not be related to these factors, yet other authors have also noted this omission in previous research (Strupp, Wallach & Wogan, 1964; Paulson, Truscott & Stuart, 1999). Several participants reported being '*not radically different*' following therapy and that their '*basic character structure*' had not changed. This seems to contradict the type of core personality change described in the literature (Grande et al, 2004; Sandell et al, 1999; Blomberg et al, 2001) and again, could relate to the use of a therapist sample. However, on inspection of the general clinical literature, there is a high degree of overlap between this sample and types of changes reported elsewhere (Dimcovic, 2001, Leuzinger-Bohleber et al, 2003; Feifel & Eels, 1963; Strupp, et al, 1964; Lipkin, 1948; Clarke, Rees & Hardy, 2004; Ankuta & Abeles, 1993; Buckley et al, 1981; Hsu, Crisp & Callender, 1992; Kantrowitz et al, 1990a). Furthermore, the changes reported did appear to be maintained, if not improved over time in the manner expected of the structural change found in earlier studies (Grande et al, 2004; Sandell et al, 1999; Blomberg et al, 2001; Kantrowitz et al, 1990). In the present study, the manner in which changes were reported seemed to

provide an insight into the processes of change and how they might be interrelated. In particular, participants described an increase in insight which generally seemed to lead to increased acceptance of self and those around them, and therefore containment of difficult feelings which allowed them to feel stronger and in turn impacted on their relationships. Perhaps then to talk about personality change as such might be misleading and that instead insight gained through therapy leads to an attitude change which permeates other areas of a client's life. Peebles, (1980, in Macran & Shapiro, 1998) suggested that personal therapy primarily affects therapists' cognitive style, and this might also be a more accurate way of perceiving changes reported in a clinical population.

One interesting finding from the interviews was reports of negative changes noticed by participants (such as becoming too '*laid back*' or finding that others around '*felt uncomfortable*' about changes). Whilst the potential of therapy leading to disrupted marital relationships and emotional withdrawal has been noted in the personal therapy literature (Williams, Coyle & Lyons, 1999; Macran & Shapiro, 1998) there does not appear to be any consideration of this in the clinical literature (although there are reports of harmful factors in therapy, the way in which these affect clients in the long term or the possibility that supposedly positive changes can also have a negative impact appears to have been largely ignored).

Life and therapy become interwoven

Participants described that there was '*a gap*' in their lives once therapy had ended and some found this to be a sad time that was difficult to deal with. This has been described as a period of mourning (Craigie, 2002; Conway, 1999;

Palombo, 1982; Weigert, 1955) or of latency in which clients use the self-analytical capacity learned in therapy to understand and come to terms with the loss of therapy and begin to re-organise their lives (Craigie, 2002; Leikert & Ruff, 1997). However, participants also talked about the feeling of relief that came from ending therapy and how this opened up a space to do other things. The burden on resources (financial, emotional and time) created by undertaking a training therapy has been frequently noted as complicated and potentially anti-therapeutic (Pope & Tabachnick, 1994; Macran & Shapiro, 1998; Williams, Coyle & Lyons, 1999) leading to a weighing up of what was lost and what was gained from therapy (costs and benefits, Williams, Coyle & Lyons, 1999) over time that could also be seen in the accounts of the present sample.

Participants in the sample found it difficult to separate out the impact of therapy from that of later life events, which is perhaps unsurprising given the length of time that had gone by. There seems to have been little research looking at the interaction between the impact of therapy and life and even less using long-term control groups in order to ascertain whether similar changes occurred over time in a population who have not had therapy. However, it has been found that significant life events are coped with better following therapy (Grande et al, 2004) and conversely, two studies exploring the experience of recovery from eating disorders have highlighted that life experiences can also play a huge role in outcome (Rorty, Yager & Rossotto, 1993; Hsu et al, 1992), ideas which seem to be mirrored by the present sample. However, this says little about the precise mechanisms through which these occur. It has been found that a person's relationships can provide a supportive framework enabling them to translate the experience of therapy into everyday life (Leikert & Ruff, 1997).

This is supported by the reports of participants that context was important and that they needed to be in a position to make use of the changes from therapy. It also suggests that life experiences after ending could be a catalyst for long-term therapy impact, giving participants the opportunity to test out new coping strategies and gain the experience of coping independently. It may also be that later experiences can help clients reflect on and make sense of therapy, therefore building on the experience over time (Fleischer & Wissler, 1985). This would seem to be particularly pertinent for a therapist sample who have many experiences related to the process of undergoing therapy and in particular several researchers have described that boundaries between personal therapy and supervision can become blurred (Macran & Shapiro, 2001) and that there are likely to be complex interactions between working as a therapist, training and being a client (Wiseman & Shefler, 2001). Indeed, participants in the present study all described ways in which these experiences and others all added to the experience.

Contrasting information

There were several ways in which participants seemed to contradict themselves within their accounts. As these could be related to a number of complex factors, it is difficult without additional information to see how these might relate to the literature. However, a 'developmental view' of termination (Shane & Shane, 1984) implies that these may relate to different stages in the process and since accounts of these are complicated by the fact that participants were requested to reflect on different periods of time all in one interview, this may have blurred or confused the distinctions.

One area of contrast that has been frequently referred to in the literature is the concept of multiple relationships between analysing therapist and client-therapist (e.g. Fleisher & Wissler, 1985; Goldin, 2002, in Lazarus, & Zur, 2002; Lazarus, & Zur, 2002; Everett, 1999; Pedder, 1988). Pedder (1988) described how analysts often continue to have professional contact with their therapist after termination and this has been seen to lead to potential difficulties with regards to role conflict (Goldin, 2002, in Lazarus, & Zur, 2002) and maintaining boundaries (Fleisher & Wissler, 1985). However, whilst participants in the current sample seemed to struggle with these issues somewhat during therapy (this has been described as the therapist's struggle with 'patienthood', Fleisher & Wissler, 1985), this seemed to be an issue that they dealt with fairly well and even benefited from in the long term. The idea of therapeutic gains from maintaining client-therapist contact following therapy has been discussed in the literature (Lazarus & Zur 2002; Everett, 1999) but it is an issue that has not only been ignored but is also frequently discouraged amongst a general clinical population (Pedder, 1988).

Methodological limitations

The main methodological flaws in this study relate generally to the use of a qualitative design and more specifically to the use of therapist-clients and the homogeneity of the sample. An assumption was made in this study that gaining an understanding of the experiences of therapist-clients would provide an insight into the experiences of clients in general. However, whilst there is clearly a degree of overlap between the findings of this research and that of non-therapist samples, factors pertinent to this particular sample cannot be

ignored. Although therapists may enter therapy or even training itself in order to meet their own unmet needs (Doyden, 1991, in Williams, Coyle & Lyons, 1999) it is likely, by the vary nature of their profession, that they would often be more highly functioning than the majority of clients that enter into mental health services and so this is likely to impact on the process and outcome of therapy. Furthermore, whilst therapist-clients have been described as a more 'sophisticated' sample, (Buckley et al, 1981) this also means that they have a variety of experiences and knowledge through their own training and work that helps them make sense of the process, which is something that clients do not normally have. It is unsurprising then, that participants' accounts relate so closely to the literature. It is difficult to predict how it might be different for clients without this knowledge base, although it might reasonably be assumed that the process would be harder and more confusing. Whether this would mean that clients would ultimately be aware of more or less changes it is difficult to know. However, another factor raised by some participants was that despite an interest in undergoing therapy, due to the mandatory element, they felt pressured to attend and were actually less motivated once there. Add to this the fact that participants' lives were frequently '*chaotic*' with the conflicting demands of training and therapy it could be argued that therapists are actually in a position where they are less able to make use of the time than ordinary clients. This might mean that changes for them would not be as great as for a clinical sample.

Another shortcoming of the sampling method was that therapists who agreed to take part were generally those who had an investment in the process. Several participants expressed a desire to take part to help compensate for the lack of

research validating psychoanalytical therapy. Furthermore, as all except one worked as psychonalytical psychotherapists themselves, it can be assumed that they were strongly in favour of this approach, and perhaps also personal therapy itself and this is likely to have coloured their responses. It is interesting to note that the only person who was generally critical of the process no longer worked in this way. The problems inherent in only interviewing those who are positive about their experiences has been raised elsewhere, and it has been suggested that there is a need to control for levels of satisfaction with therapy and personal health at the start (Macran & Shapiro, 1998), yet this was beyond the bounds of this study.

There were several issues with regards to the homogeneity of the sample. Most of the participants were men, all worked as therapists and all were aged over 40, which means that participant characteristics were relatively homogenous and it is therefore easier to generalise to other similar groups. However, the small sample size does make this more difficult. Furthermore, all participants mentioned growing older as a factor in changes they had noticed and as five of the participants were within ten years of retirement age, it is possible that this could create a bias in the sample and their accounts (Williams, Coyle & Lyons, 1999). In particular, experiencing greater success professionally and plans to '*do more of what I want*' may have been present in most samples of this age group rather than being a factor related to time since ending therapy.

With regards to levels of experience of therapy, the sample was too heterogeneous; there was huge variation in the number of years of therapy

received, the total number of hours, the frequency of sessions, time since ending and whether participants has undergone other forms of psychodynamic therapy since, so any distinctions between these were lost. In particular, since research has shown that clients' experiences can vary depending on the time point at which they are measured (Feifel & Eels, 1963; Buckley et al, 1981) this seems like an important flaw. Whilst all participants experienced at least some degree of twice weekly therapy, this degree of variability in the form in which this took also means that it is impossible to gauge the extent to which it conformed to that which is said to result in 'structural personality change' described in the literature (e.g. Grande et al, 2004). However, despite these factors, it was striking how much concordance there was between participants' accounts and between those and the literature and it therefore seems that valuable information was still obtained.

In contrast to other qualitative methods, IPA does not expect the researcher to 'bracket' prior knowledge, however it is important to consider in what ways preconceptions and expectations influenced data analysis (Stiles, 2003). In general, the present author had a knowledge base and practical skills related to therapy, but minimal knowledge of and no experiences of using psychoanalytical methods. This could be seen as a distinct advantage of this study as there was no personal investment in attempting to bolster psychoanalytical concepts and perhaps more openness to considering alternative explanations of findings. Furthermore, participants were aware of the researcher's naïve status and this seemed to facilitate engagement in the interviews and result in accounts that were not overly psychoanalytically-constrained as they took the time to explain their experiences in lay language.

In the context of this study, some basic awareness of the literature meant that findings regarding internalisation of therapy and development of the self-analytic function were expected. However, despite the fact that the interview style was non-leading, participants still spoke of these concepts themselves, using similar terminology which confirms that this was not a bias on the researcher's part. The fact that results were further validated by a second marker, a peer group member and the participants also reduced the chance of researcher bias. In particular, participants demonstrated 'catalytic validity' of the data (Stiles, 2003) through their responses that the interview process and findings further stimulated growth and insight.

Whilst the kinds of personal growth described do also fit with the literature, the ways in which participants described keeping the same personality structure was at contrast to the literature and therefore more surprising. However, despite attempts to remain open-minded about findings and not be too theory-driven by the literature, it was difficult to find non-psychoanalytical explanations since there is a dearth of research into post-therapy processes outside of this field.

Clinical implications

It is difficult to translate the findings of this research into implications for clinical practice, since clearly further work is needed to establish the validity of these findings for other client groups. Furthermore, psychoanalytic psychotherapy is not commonly practised within the NHS as there has been a move towards the use of Cognitive Behavioural Therapy (CBT) as advocated by the National Institute of Clinical Excellence (NICE, 2004) and a focus generally on less

intensive forms of therapy through stepped care service models (e.g. Bower & Gilbody, 2005). The present study did identify that there can be some potential negative consequences to undertaking more intensive therapy, and this does of course lend support to these newer ways of working. However, it is important not to 'throw the baby out with the bathwater'. Guidelines such as those produced by NICE can only be as good as the evidence that is available and to date little research into psychoanalytic psychotherapy has been available in order to contribute to this. It is therefore hoped that this research might provide a starting point for considering the potential benefits of longer term therapies and whether they might still have a place within the NHS context, and if so, what this might be. Furthermore, whilst the scope of the current study makes it difficult to generalise, common sense would imply that issues identified as important for this sample could also have practical value to those undergoing other forms of therapy. Implications for clinical practice can therefore be read as such.

These findings suggest that internalising therapy is an important process, it is therefore necessary to consider ways in which therapy can be kept alive for clients. Perhaps helping clients to think about ways they may continue to practice techniques and instilling an expectation of post-therapy change during therapy might facilitate this. Follow-up sessions or other forms of post-therapy contact may be beneficial in enabling clients to reflect on processes and changes that have occurred, so stimulating further post-therapy developments. These factors may also be important when clients undertake briefer forms of therapy, in which there is an expectation that the majority of change and skill development occurs once sessions have ended. Since increased understanding

about the experience helps to build on changes, it would seem that clarity of process is particularly important for clients undergoing all forms of therapy and therefore they might need more information on the process and the opportunity to normalise their experiences. Perhaps directing clients towards some post-therapy reading might facilitate this. When assessing outcome of therapy, it would also clearly seem important that this take place not just at termination but even several years after as a full picture of change may not emerge until some time later. Furthermore, since symptom relief may be less important to clients than other changes once therapy is over it may be important not to be too blinkered by the original problem when assessing a client's development. Enabling participants to talk more broadly about changes in their lives might be beneficial in identifying unexpected areas of change. In fact, with this in mind it then seems somewhat strange to attempt to measure outcome using only standard measures of symptomology and it may be that more appropriate measures need to be developed.

The emotional impact of ending therapy is usually dealt with around termination time, yet less consideration may be given to the practical implications. More thought is then needed about how therapy fits in with clients' daily lives and this suggests that a model of offering clients the least intensive option first (i.e. 'stepped care', e.g. Bower & Gilbody, 2005) may be important. The possible negative consequences of time devoted to therapy need to be enquired about and opportunity for discussion of how to manage these may need to occur within therapy. It is also important to consider how clients in longer term therapy can manage the practical aspects of the transition and fill the gap that

has been left once therapy is ended. This may be less the case for clients in less intensive forms of therapies.

In relation specifically to personal therapy, the findings of this research imply that perhaps it might best be undertaken either prior or subsequently to training and explicit discussion of the impact of undertaking multiple roles should be addressed.

Future work

This study needs to be replicated with a larger sample and other groups, particularly that of a standard clinical population, in order to establish whether the findings generalise. With the help of variables identified as important here and in the literature, it might now be possible to also obtain quantitative data to add to this, perhaps in the form of standard outcome measures. There has been little work comparing psychoanalytic psychotherapy outcome long term with other therapies and it is therefore important to undertake this in order to establish whether these findings really are specific to this model or if elements can also be seen elsewhere. This is of particular importance considering the current NHS context in which CBT is the primary model advocated. It would also be helpful to compare the accounts of participants at different times following termination in order that changes over time can be more clearly defined and particular stages of post-therapeutic development identified. Within this the specific impact of life events and their interaction with therapy needs to be determined. A control group might help establish whether the developments reported are truly a result of therapy or might just occur over time anyway. It would seem that a large scale prospective longitudinal study might

be most suited to cover each of these factors. As this study was not designed to enter into the debate on the value of personal therapy, issues regarding the impact of therapy on work as a therapist in the long-term were not directly addressed, although this might also be a useful avenue for further work in this area.

Conclusion

It is very difficult to generalise from this study and determine the precise influence that being a therapist had on participants' experiences of their therapy. However, it has been argued that due to the nature of qualitative analysis, results can only ever be 'tentative' (Stiles, 2003). Despite methodological limitations, the findings appear to support previous literature in this area with regard to changes experienced and internalisation of the process so that it continues over time. It may be that the concept of 'structural personality change' resulting from therapy needs some revision and it is hoped that future work will continue to provide insight into this area, relating findings to an NHS context.

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Critical Appraisal

Critical Appraisal

Planning the proposal

I began the research process being fairly open-minded about different methods of research, but with a curiosity about qualitative methods as I had not had the opportunity to use them before. However, it soon became clear that most of the avenues of research that caught my interest involved focusing on client's experiences of therapy and therefore on qualitative methods.

The idea for this research came from a more general interest in therapy process and in particular, the way that people make use of what they have learned in therapy and apply it in their daily lives. My first idea came from clinical experience and focused on how people generalise skills learned and apply them to areas of their lives and problems that were not the focus of therapy. However, despite several meetings with both my NHS and academic supervisor, we found it difficult to clarify exactly what the research question would be and to therefore establish how I might measure this. From this idea then developed a discussion on how clients maintain gains made in therapy after ending. This moved on to wondering more widely about clients' experiences after therapy has ended and in what ways therapy continues to impact on this. My supervisor therefore referred me to the psychoanalytical literature on post-therapy gains of which I had been unaware. From this arose the idea to focus on clients' experiences after ending psychoanalytical psychotherapy. At first I was a little unsure about focusing on this type of therapy as it was an area I had no experience in and very little knowledge of. However, I soon decided that this would be a good way to explore a different

model of therapy without having to take an elective placement using it as there were other therapeutic models I was also interested in.

Ethical Approval, Governance and Indemnity

The above proposal was submitted for ethical and governance approval which was a time consuming process. The ethics board raised the issue of confidentiality in contacting clients who had not had contact with services for some time. They suggested that sending them information in an initial letter might be inappropriate as this could potentially be opened by people now living with them who might be unaware of their former mental health difficulties. Whilst the ethics board suggested that a telephone call might be preferable in order to clarify that clients were agreeable to being sent information, it was decided after discussion with the service recruiting from that this might actually be more intrusive. The only alternative option then was to send out an initial letter with no disclosing information and a request that participants get in contact if they want to know more. This was discouraging as it seemed likely that this would be a potential obstacle to recruitment.

Recruitment

I was very aware from the start that I might not get sufficient participants due to the need to obtain people who had been discharged from services some time ago. Having to rely on people to be interested enough to actually request further information before even knowing what the study was about was also likely to create further difficulties. However, there were a lot of service issues to do with staff sickness and vacancies within the service I was recruiting from and so it took a while to even begin the process, particularly as I was not based in

the department and so had to tread a fine line between gently reminding staff and not pestering them. However, once I did, it emerged that it would not be easily possible to even obtain the kind of information needed in order to identify potential participants. This was very disappointing and quite frustrating given the amount of time that had already gone into the project and the fact that I had already piloted the interviews. Upon meeting with my NHS and academic supervisors, I was given the choice of either continuing with the current project but using therapists who had finished personal therapy as a sample (which I was told should be easily obtainable) or to do something entirely different. This was a difficult decision to make as I was concerned that a therapist sample would be too different from a clinical one to draw comparisons and I was not really interested in the issue of personal therapy. The other idea sounded really interesting but would mean starting from scratch and probably not handing in on time. The support of colleagues and friends was invaluable here and helped me realise that not only would interviewing therapists be interesting (I had already found this of the pilot interviews) but I could take an angle away from the debate on the value of personal therapy. It also would have been too ambitious and stressful to begin again and it had been suggested that changing my sample to a non-NHS one would mean that I would not have to resubmit to the ethics board. However, when I went for this option I found it was not that simple and after consultation with several different people it emerged that as my project had initially been registered through the ethics board, they would continue to need to oversee it. Obtaining confirmation of this and re-submitting took a while and delayed the start of the project considerably.

Following this, I began the process of recruiting therapists by word of mouth. It was interesting to note just how many therapists did not themselves meet the criteria of at least twice weekly therapy, despite usually working psychoanalytically themselves. Furthermore, some people I contacted were quite discouraging about the project, saying that they would be surprised if anyone wanted to talk to me about something so personal and also seeming particularly wary of the fact that I was coming in from the outside of their profession and was not psychoanalytically trained myself. It seemed important to these people that due to the nature of the material, findings be interpreted in line with psychoanalytical theory, which has also been argued by previous researchers (Leuzinger-Bohleber, Stuhr, Ruger and Beutel, 2003). I began to think that it was no wonder so little research was done in this field! I thus tried to bear the issue of potentially being seen as an 'outsider' in mind throughout the rest of the recruitment and interview process, making my status clear to participants, but also making it clear that I was not there to judge them and would be willing to learn from them. However, this further reinforced to me that there could also be potential benefits in asking questions as someone from outside of the psychoanalytical world.

Interviewing

It felt as if it was a privilege to be allowed an insight into something so personal to the participants as therapy (Grafanaki, 1996) and so I felt it was especially important to develop a rapport to enable them to feel comfortable enough to talk about this. I was aware that people may be more open in interviews if they know that their vulnerability is a concern to the researcher (Grafanaki, 1996) and that obtaining consent throughout can ensure participant protection

(Munhall, 1988) as it cannot be known what the interview may uncover (Smith, 1992). I think that being transparent about these factors with participants did facilitate the process so that they felt more comfortable to disclose information to me.

It was quite anxiety-provoking and sometimes intimidating interviewing such experienced, knowledgeable people. Since both I and the participants had an interest in the area, I sometimes also had to work quite hard to resist the urge to deviate from the interview and enter into a discussion on interesting issues. I was further aware that when participants gave minimal information on a topic, it might simply be they were adept at safeguarding themselves against disclosing too much. These factors seemed to inhibit me against inquiring into their responses as much as I might otherwise have done. Added to this I was new to qualitative approaches and so felt unconfident about deviating too much from the interview schedule in case I ended up asking leading questions. For these reasons, I therefore did not get as much information as might have been useful in some areas and later found myself frustrated at not having asked more when reading back through the transcripts. However, the fact that participants were therapists too made it easier to treat them as 'co-researchers' (Grafanki, 1996). I also think that the power differential meant that whilst I was able to use basic techniques such as reflecting and summarising to facilitate the process, I did not get drawn into using my clinical skills inappropriately in the interview.

Data Analysis

Once the interviews were transcribed, I read through each one listening to the interview tape. This was really helpful in filling in parts that the transcriber had

been unable to understand, but in also refreshing my memory of the interview and the way in which certain phrases were said. Whilst I had been warned that qualitative research is time consuming and demands considerable intellectual effort (Polkinghorne, 1991), I do not think I quite realised how long it would take or how hard it would be. I initially set myself three weeks in which to do the bulk of the data analysis, however it took nearly two months! Whilst this was again slow and frustrating, I found it quite satisfying identifying themes and being able to pull all the information together. However, I was quite uncertain of my findings at first as it seemed so subjective as to which statements would go in which category, or how to interpret different phrases. I was worried about reading too much into what people were saying, but became more confident of my findings when I found they were represented across several participants. I developed quite a useful strategy of switching between different transcripts and moving phrases around across two computer monitors so that I could see as much of the information as I could at once and could physically move it around between screens. Over time this got much easier and I realised I quite enjoyed qualitative research!

Member Validation

I was not able to obtain feedback from all participants due to time constraints and this was disappointing but understandable given that both myself and participants had busy schedules. However, the feedback I did receive was encouraging and it was interesting how animated the participants I met with were when talking through the findings and the way that it seemed to further provoke their thought processes enabling them to elaborate on earlier points. I had been concerned that they would feel that the themes had either been

interpreted too much so that they would be unable to identify with them and therefore critical of them, or that they might be uncomfortable with the fact that they did not focus on psychoanalytical terminology to a great extent. However, this was not the case at all and participants were very open to my ideas about the findings, yet also able to suggest areas where they might relate to current theory.

Writing Up

I was surprised to find that despite not being exactly adept at writing up research reports in the past, the write up was not as difficult as expected. I attribute this to the fact of having been immersed in the data (e.g. Smith, 1996) which meant that I was very familiar with the findings and had already devoted a lot of thought to them. I think it also helped that this use of qualitative data fit much more closely with my personal style as translating experiences into numbers has always seemed quite artificial to me and I have therefore found such information difficult to make sense of, whilst the current findings seemed much more 'real'.

Literature Review

The literature review was a helpful process in terms of condensing what at first seemed like overwhelming amounts of information into some kind of manageable order. Although it was a separate piece of work to the research report, the degree of overlap was also really helpful in obtaining an overview of the literature and enabling me to not be too constrained by psychoanalytical theory when considering the research project.

Multiple Roles

One of the hardest things about undertaking this project has been the fact of having to undertake the role of researcher alongside that of trainee, clinician and just ordinary human being. There are of course parallels between this experience and that of the participants too. Each role seemed to require a different mindset and switching between them was often hard, meaning that I often felt that I was unable to give my best to any of them. Whilst it may be the case that practitioner's in the field are often required to undertake several roles at once and it therefore may be considered good experience, it is likely that once qualified, these multiple roles may have greater continuity between them or possibly create marginally less drain on emotional resources all at once.

What was Learned from the Process

Practical issues:

- The ethics process is really vital and can help with thinking about issues not previously considered. However, it is important to also consult with clinicians within the service recruited from as they may see the issue from a different angle and have alternative ideas about how to overcome it
- The usefulness of being based in or having good links with the department in which you are undertaking research and particularly ensuring clarity on policies or methods of data storing that may affect recruitment
- It is helpful to view setbacks and problems as part of the process rather than something additional that is hindering it

- It is important to be realistic about what can be achieved within a time frame and resist the urge to be overly-ambitious, especially when working to tight deadlines
- Building rapport in a research interview is just as important as in clinical practice and some basic clinical skills are therefore useful in undertaking research
- Ensuring participants that their consent will be checked throughout is helpful in enabling them to talk more freely

Insight into new areas/ways of working:

- Qualitative research can be valuable and provide a much greater depth of information than quantitative data
- IPA is a useful research tool that becomes less difficult to use with practice
- An increased understanding of the processes of psychoanalytic psychotherapy and outcome and what it may be like to undergo a long-term therapy
- An increased understanding of the role of personal therapy and the pros and cons of undertaking this

Factors that will affect my clinical practice:

- The importance of enquiring about any negative consequences of therapy on clients' lives and how these might best be addressed
- The importance of enquiring about areas of change unrelated to the initial problem that clients arrive with

- The importance of helping clients to find ways to keep therapy alive once it has ended

References

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Polkinghorne, D. (1991). Qualitative procedures for counselling research, in C. E. Watkins & L. Sneider (Eds). *Research in Counselling*, (pp 163-204) Hillsdale: Lawrence Erlbaum

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Smith, L. (1992). Ethical issues in interviewing. *Journal of Advanced Nursing*, 17, 98-103.



The
University
Of
Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training
& consultancy.

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Course Director: Prof Gillian Hardy

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Clinical Practice Director: Ms Joyce Scaife
Course Administrator: Carole Gillespie
Prof Nigel Beal

22 February 2006

Laura Freeman
Third year trainee
Clinical Psychology Unit
University of Sheffield

Dear Laura

I am writing to indicate our approval of the journal(s) you have nominated for publishing work contained in your research thesis.

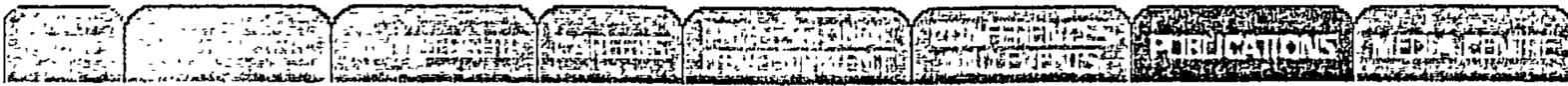
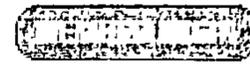
Literature Review: Psychology and Psychotherapy

Research Report: Option A.

Please ensure that you bind this letter and copies of the relevant Instructions to Authors into an appendix in your thesis.

Yours sincerely

Andrew Thompson
Chair, Research Sub-Committee



Search the website:

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You Are Here: BPS > Publications > Journals > Psychology and Psychotherapy: Theory, Research and Practice > [Notes for Contributors](#)

Notes for Contributors

Psychology and Psychotherapy: Theory Research and Practice is an international journal with a focus on the psychological aspects of mental health, psychological problems and psychotherapeutic treatments. Its aim has been to bring together the psychiatric and psychological disciplines and this is reflected in the composition of the Editorial Board. Nevertheless we welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The traditional orientation of the Journal is towards psychodynamic and interpersonal approaches, which have defined its identity, but we now additionally welcome submissions of original theoretical and research papers of any theoretical provenance provided they have a bearing upon vulnerability, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. The Journal thus aims to promote theoretical and research developments in the fields of subjective psychological states and dispositions, interpersonal attitudes and relationships and psychological therapies (including both process and outcome) where mental health is concerned. Submission of systematic reviews and other reports which support evidence-based practice is also welcomed. Clinical or case reports can be considered only if they illustrate particularly unusual forms of psychopathology or innovative forms of therapy which carry important theoretical implications.

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 has discretion to publish papers beyond this length in cases where the clear 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 comments about authorship including personal acknowledgements and institutional affiliations should be confined to the title page (and the text should be free of such 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 follow the details as instructed. On successful registration, an email will be sent to you of your user name and password. Please keep this email for reference and proceed to LOGIN. (You do not need to re-register if you change details 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:

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

The Psychologist
Division / Section Publications
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 - .. Journal Scope
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- .. British Journal of Developmental Psychology
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4) If you require further help in submitting your manuscript, please consult 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 should be numbered.
- Tables should be typed in double spacing, each on a separate page with an explanatory title. Tables should be comprehensible without reference to the text and should be placed at the end of the manuscript with their approximate location indicated in the text.
- Figures can be included at the end of the document or attached as separate files. They should be carefully labelled in initial capital/lower case lettering with symbols in a font suitable for text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate page. The resolution of images must be at least 300 dpi.
- For articles containing original scientific research, a structured abstract (usually 200-300 words) should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions.
- 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 where 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 length of text, 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, (<http://www.apastyle.org>).

6. Brief reports

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

7. Publication ethics

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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. This should be submitted to the Editor together with the article, for simultaneous consideration and 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

their article prior to publication for easy and cost-effective dissemination

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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. Check every reference in the manuscript and proofread again in the page proof.
- Tables, figures, captions placed at the end of the article or attached as separate files.

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Laura Freeman
Trainee Clinical Psychologist
Clinical Psychology Unit
Department of Psychology
University of Sheffield

Dear Ms Freeman

Study title: What are clients experiences after ending psychoanalytic psychotherapy?

REC reference: 05/Q2308/87

Amendment number: 1

Amendment date: 25th January 2006

The above amendment was reviewed at the meeting of the Sub Committee of the Research Ethics Committee held on 6th February 2006.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

- Letter dated 25th January 2006.
- Notice of Substantial Amendment dated 25th January 2006.
- Participant Information Sheet version 5.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Research governance approval

All investigators and research collaborators in the NHS should notify the R&D Department for the relevant NHS care organisation of this amendment and check whether it affects research governance approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

05/Q2308/87

Please quote this number on all correspondence

Yours sincerely



Dr G P M Clark
CHAIRMAN
North Sheffield Research Ethics Committee

Copy to: *Professor Hardy (supervisor), R & D Consortium*

Enclosures *List of names and professions of members who were present at the meeting and those who submitted written comments*



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08 August 2005

Ms Laura Freeman
Trainee Clinical Psychologist
Clinical Psychology Unit, Sheffield PCT
University of Sheffield
Western Bank
Sheffield
S12 2FR

Dear Ms Freeman

Full title of study: What are clients' experiences after ending psychoanalytic psychotherapy?
REC reference number: 05/Q2308/87

Thank you for your letter of 01 August 2005, responding to the Committee's request for further information on the above research [and submitting revised documentation].

The further information has been considered on behalf of the Committee by the Chairman.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation [as revised].

The favourable opinion applies to the research sites listed on the attached form.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application		16 May 2005
Investigator CV	Student	(None Specified)
Investigator CV	Supervisor	(None Specified)
Protocol	2	16 May 2005
Summary/Synopsis	2	16 May 2005
Peer Review		01 April 2005
Interview Schedules/Topic Guides	2	16 May 2005

Letter: Initial therapist request letter to be sent to former clients.	1	01 August 2005
Participant Information Sheet	3	01 August 2005
Participant Consent Form	2	16 May 2005
Response to Request for Further Information		01 August 2005
Request for information (reply slip)	1	01 August 2005

Management approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final management approval from the R&D Department for the relevant NHS care organisation.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the sheet enclosed with our letter dated 5th July 2005.

Notification of other bodies

The Committee Administrator will notify the research sponsor that the study has a favourable ethical opinion.

Statement of compliance

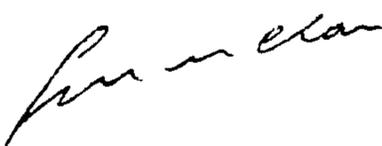
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

05/Q2308/87

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project,

Yours sincerely

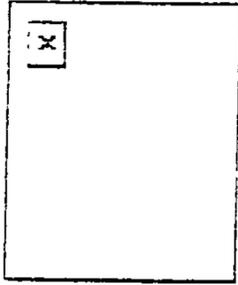


Dr G P M Clark
CHAIRMAN – North Sheffield Research Ethics Committee

Email: april.dagnall@sth.nhs.uk

Copy to : Professor Hardy (supervisor)

Enclosures: Standard approval conditions, Site approval form (SF1)



THE UNIVERSITY OF SHEFFIELD
Clinical Psychology Unit
Department of Psychology

Doctor of Clinical Psychology (DClin Psy) Programmes (Pre-registration and post-qualification),
Clinical supervision training and NHS research training and consultancy

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Course Director: Prof Gillian Hardy

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Email: dclinpsy@sheffield.ac.uk

Clinical Practice Director: Ms Joyce Scaife
Course Administrator: Carole Gillespie
Prof Nigel Beail

«name»
«address»

Dear «name»

Re: Research into experiences after ending personal psychoanalytic psychotherapy and post-therapy change

I hope that you do not mind me contacting you. I was given your name by «referrer» who suggested that you may be able to help with my research. I am undertaking a project as part of my Doctorate in Clinical Psychology exploring people's experiences once their therapy has ended. I have encountered some difficulties in obtaining a clinical sample through the NHS and so am instead hoping to obtain a sample of therapists such as yourself who have been through personal therapy and are willing to talk about their experiences, particularly focusing on the time since ending therapy. I wondered whether this might be something you would be interested in? It should not take up too much of your time!

I enclose an information sheet outlining the research, including inclusion criteria. Should you feel that you match these criteria and would like to take part, I would be grateful if you could contact me using the details below so that we can arrange a convenient time.

Yours sincerely

Laura Freeman
Trainee Clinical Psychologist
Supervised by Ms Sharon Warden and Professor Gillian Hardy

Tel: 0784 1111 363
E-mail: laurafreemanashill@hotmail.com

Appendix E
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Clinical Practice Director: Ms Joyce Scaife
Course Administrator: Carole Gillespie
Prof Nigel Beail

PARTICIPANT INFORMATION SHEET

Study title: *What are therapist's' experiences after ending personal psychoanalytic psychotherapy?*

You are being invited to take part in a research study for educational purposes. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take 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.

Consumers for Ethics in Research (CERES) publish a leaflet entitled 'Medical Research and You'. This leaflet gives more information about medical research and looks at some questions you may want to ask. A copy may be obtained from CERES, PO Box 1365, London N16 0BW.

Thank you for reading this.

1. What is the purpose of the study?

I am interested in speaking to therapists who have undertaken their own personal psychoanalytic psychotherapy. Previous research has found that psychoanalytic psychotherapy begins a process that does not always stop when therapy ends. I am therefore interested in hearing about therapist's experiences once their personal therapy has ended, whether this be that their life has remained the same or if things have gotten better or worse. I hope that this information will later be helpful in helping clients to prepare for getting on with their lives once they have left therapy. I will be asking to interview people between October 2005 and June 2006.

2. Why have I been chosen?

You are suitable if you received psychoanalytic psychotherapy (at least twice weekly) and finished at least 2 years ago (with some memory of the therapeutic experience) and the decision to end therapy was reached by agreement with yourself and your therapist. You are not suitable if you have a diagnosis of schizophrenia or psychosis, if you have received other forms of therapy either previously or since, or if you have been admitted to a psychiatric ward at any point since ending therapy. I am hoping to interview between 8-12 people such as yourself.

3. Do I have to take part?

It is up to you to decide whether or not to take part. If you do 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. You may choose not to answer certain questions. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of any care you receive either now or in the future.

4. What will happen to me if I take part?

If you decide to take part, I will arrange to see you either in the service where you work or at a time and place convenient to you. I will be interested in hearing your view on how life has been for you since finishing therapy. Interviews will last approximately 1 hour and will be audio taped. Once I have analysed the data from all of the interviews collected, I would like to interview you for a second time, taking approximately ½ an hour. During this second interview I will ask you about anything else you may have remembered since our initial interview, give you a summary of my findings and ask for your feedback. Should this not be possible I will send you a summary of my findings and ask you for you to post any feedback you may care to give.

5. What do I have to do?

If you agree to take part, I will arrange a date to undertake the interview with you.

6. What are the possible disadvantages of taking part?

The interviews will take around an hour and a half of your time in total, over 2 separate occasions. During this time I will ask you to be as open and as honest with me as possible. However, I am obliged to tell you that this is not a therapy session and of course I will not personally be able to offer you any further treatment.

7. What are the possible benefits of taking part?

Appendix E

Hopefully, you will find this an enjoyable experience. It may help you to reflect on the experience of therapy now that it is over. The information we get from this study may help us to better prepare clients for ending therapy in future.

8. What if something goes wrong?

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, please contact the project co-ordinator: Gillian Hardy on the University Number below

Otherwise you can use the normal University complaints procedure and contact the following: Research & Consultancy Unit, University of Sheffield, 2/4 Palmerston Road, Sheffield, S10 2TE.

9. Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you will have your name and address removed so that you cannot be recognised from it and will be kept in a locked filing cabinet for the duration of the study. Only the researcher, their supervisor and an approved transcriber will have access to the data and no direct information about you will be fed back to your therapist.

However, as good practice requires, if I consider that you may be at risk to yourself or others as a result of any information you have given me, I will recommend that you contact your GP or former therapist, who may want to offer you an appointment.

Interview tapes will be destroyed once they have been transcribed and all other information will be destroyed after 5 years.

10. What will happen to the results of the research study?

The results of the research study will be written up as part of my doctoral thesis. It is possible that a shortened version may be sent for publication at a future date. You will not be identified in any such written work. Whilst direct quotes may be used from your interview, any identifying information will be removed.

Who is organising and funding the research?

This research is being funded by the Clinical Psychology Unit, University of Sheffield. As part of this research, I receive supervision from 2 qualified Clinical psychologists, one within the University and one who works within the NHS.

Nobody who is involved in this study is receiving any payment other than their normal salary.

Appendix E

11. Who has reviewed the study?

This study has been reviewed by both University and NHS ethics boards.

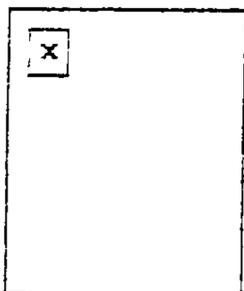
12. Contact for Further Information

Should you have any further questions, please don't hesitate to contact me on

E-mail: laurafreemanashill@hotmail.com

Tel No. 01142 226 570

Thank you for taking the time to read this!



THE UNIVERSITY OF SHEFFIELD

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Clinical Practice Director: Ms Joyce Scaife
Course Administrator: Carole Gillespie
Prof Nigel Beail

CONSENT FORM

Client Identification Number for this study:

Title of Project: *What are therapists' experiences after ending personal psychoanalytic psychotherapy?*

Name of Researcher: Laura Freeman

Please initial box

1. I confirm that I have read and understand the information sheet dated
(version 5) 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 any reason, without my medical care or legal rights being affected.
3. I agree to take part in the above study and understand that my interview will be
audio taped

Name of participant

Date

Signature

Address

Contact telephone number

Researcher

Date

Signature

Interview questions

I'd like to ask you about your experience of how things have been for you since ending therapy...

Finishing therapy:

- What do you remember about therapy?
- What was helpful/unhelpful about that experience?
- What was your day-to-day life like during therapy?
- What kind of a person were you during therapy?
 - how did you think about yourself/others?
- What was it like for you finishing therapy? Thoughts/feelings
 - how do you feel about it now?
- What was your day-to-day life like once you finished?
- What kind of a person were you when you finished?
 - how did you think about yourself/others?

Present time:

- What is life like for you now compared to when you finished therapy?
- (if a difference) to what do you attribute this difference?
- What kind of a person are you now compared to when you finished therapy?
 - how do you see yourself/others now compared to then?
- (if a difference) to what do you attribute this difference?

Appendix G

- How much do you think your life would have been like this without therapy?
- Thinking back, is this how you imagined life would be once you finished?
- What might someone close to you say about you/your life now compared to when you finished?
- Do you still think about your time in therapy?
 - Tell me more

The future:

- How do you picture the future?
- What kind of a person do you think you'll be in 5 years time?
 - (if a difference), what do you think would cause this?

Descriptive information sheet

Age:

Gender: male / female

Occupational status/professional title:

Marital status:

Single
Co-habiting
Married
Separated
Divorced

Ethnicity:

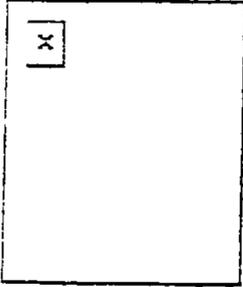
Reason why therapy was undertaken/type of problem

Length of time receiving therapy

Approximate number of sessions

Reason therapy ended

Approximately how long ago did your therapy end?



THE UNIVERSITY OF SHEFFIELD
Clinical Psychology Unit
Department of Psychology

Doctor of Clinical Psychology (DClin Psy) Programmes (Pre-registration and post-qualification)
Clinical supervision training and NHS research training and consultancy

Clinical Psychology Unit
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Assistant Unit Director : Prof Pauline Slade
Course Director: Prof Gillian Hardy

Telephone: 0114 2226570
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Email: dclinpsv@sheffield.ac.uk

Clinical Practice Director: Ms Joyce Scaife
Course Administrator: Carole Gillespie
Prof Nigel Beail

Feedback form

What are therapist's experiences after ending personal psychoanalytic
psychotherapy?

Thank you for taking part in this study. I have now finished the interviews and have analysed the data. On the attached sheets I have summarised the main themes that arose from your individual interview and also across all of the interviews that took place. I would be grateful for your thoughts on these themes.

Overall, how much do these themes fit with your experiences?

0-----1-----2-----3-----4-----5

Not at
all

Somewhat

Completely

Comments:

Are there any parts that you disagree with? Please say which and why

Are there any parts that you agree with? Please say which and why

Appendix I

Please comment on anything else relevant to your experiences and the research question that may have come to mind following our interview:

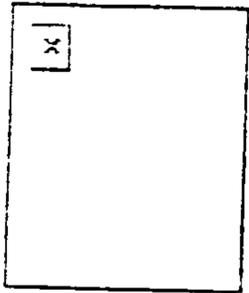
Thank you for taking the time to complete this. I would be grateful if you could return this form to me in the envelope provided as soon as possible

Should you have any further questions, please feel free to contact me on

E-mail: laurafreemanashill@hotmail.com, Tel No. 07841111363

THE UNIVERSITY OF SHEFFIELD
Clinical Psychology Unit
Department of Psychology

Doctor of Clinical Psychology (DClin Psy) Programmes (Pre-registration and post-qualificatio
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Clinical Practice Director: Ms Joyce Scaife
Course Administrator: Carole Gillespie
Prof Nigel Beail

Transcriber Confidentiality Form

Title of Project: *What are therapists' experiences after ending personal psychoanalytic psychotherapy?*

Name of Researcher: Laura Freeman

Please initial box

I understand that all information obtained from the audiotapes must be kept confidential

I understand that should I realise that I recognise an individual being interviewed, I should cease transcribing immediately

Name of Transcriber

Date

Signature

Should you have any questions please contact me on:

E-mail: laurafreemanashill@hotmail.com

Tel No. 01142 226 570

Appendix L

THEMES UNRELATED TO RESEARCH QUESTION

The following themes and sub-themes were dropped from the analysis as they referred primarily to participants' experiences during rather than following therapy:

- *Coming to terms with the therapy process*
 - a. *initial expectations vs. accepting limits of therapy*
 - b. *reality vs. fantasy in life and therapy*
 - c. *accepting change vs. being defensive*

- *Multiple roles:*
 - a. *Therapist vs. client vs. trainee*

- *Obligation vs. choice to undertake therapy*

- *Degree of control over the therapy process:*
 - a. *happened slowly vs. quickly*
 - b. *confusion vs. clarity*

- *Noticing and valuing the therapy process:*
 - a. *just talking to therapist vs. seeing technique (specific vs. non-specific factors in therapy)*

The following theme was also not included as it related to the experience of one participant only and it was unclear how it related to other themes or how this might be interpreted:

- *Interesting vs. challenging issues (talking about issues that sounded very difficult as being 'interesting' rather than acknowledging the challenge)*