

On psychosomatics and the maps in our hands:
Modelling change over twelve months of counselling practice

John William Hills

Submitted in accordance with the requirement of the degree of Doctor of Philosophy

The University of Leeds

School of Healthcare

June, 2020

The candidate confirms that the work submitted is his own and that appropriate credit has been given where reference has been made to the work of others.

This copy has been supplied on the understanding that it is copyright material and that no quotation from the thesis may be published without proper acknowledgement.

Assertion of moral rights:

The right of John William Hills to be identified as Author of this work has been asserted by him in accordance with the Copyright, Designs and Patents Act 1988.

© 2020 The University of Leeds and John William Hills

Acknowledgements

I would like to thank the University of Leeds for being my *alma mater* in my journey into becoming a counsellor. My PhD study would not have been possible were it not for my receipt of the University Research Scholarship and I am proud of and grateful for the investment that the university made in me.

As is evident throughout the thesis, my three research supervisors Dr Jane Cahill, Dr John Lees, and Professor Dawn Freshwater, are leading voices in the dialogue through which the thesis emerges. For Jane, John and Dawn I am eternally grateful for the unique role each has played in supporting me, as I will describe further in the Introduction.

My clinical supervisor Steve Page is also present through the dialogue and his support provided the solid foundations on which I built my counselling practice.

My especial thanks go to Lou, Michael, Jennifer and Myrtle for giving of themselves, their stories, and their voices to my research project. I hope I have honoured their contribution in how I have written about and represented our time together.

Whilst I have not identified the charity through which I delivered the therapy in the production of the multi-case study I would like to thank friends and colleagues who I have worked alongside with either then or in subsequent professional development. I thank them for their community and for the respect and esteem we have held for one another.

Likewise I would like to thank my friends and colleagues at Leeds Beckett University who have welcomed me into their team as I completed the latter stages of my PhD study.

I want to thank my Mum for her support as I had my own family, and for essential Grandma duties that enabled me to get on with my PhD.

I also thank my father who is present throughout this thesis and who held the ideas of the autoethnography in his own hands, in his own time.

And Lorinda, and the family that we have made, for being at the heart of it all.

Abstract

Purpose

The project is a multicase study of the researcher's own clinical work with four clients who each presented with embodied expressions of distress. The researcher practised within a 'narrative-dialogical' framework and set out to build models of therapeutic change. However a parallel thesis emerged during the project: an autoethnographic account in which the researcher's uses of supervision, personal therapy, dreams and life events, including the death of his father, intersect with formal stages of theory development.

Design and Methods

Sessions were audio recorded and coded for qualitative markers indicating the emergence of novel self-narratives. At the end of each client's therapy they received a case report and were invited to provide their own commentaries. Across three 'mini-studies', methods from different approaches within the change process research tradition were applied to the data formalising the analytic approach and driving the evolving theoretical model. However a reflexive narrative running throughout the work highlights the superordinate role of reflexivity in theory development.

Findings

Therapeutic change was typified by an evolving internalised map of self and world, with corresponding change in embodied experience. The theoretical model was observed to develop through four chronological phases: 1) the migration of clients between I-positions, 2) longitudinal stages, 3) cognitive mapping, and 4) dialogism in the therapeutic relationship. In each phase the emergent template was layered on to the previous model, resulting in a new synthesis.

Discussion

As an analysis of one therapist's practice and the experiences of their clients, the study generates hypotheses rather than formally establishing theory. The continuous evolution of change concepts reflects the theory building work of clinicians in their everyday practice. The study highlights the use of self as research instrument and offers a rich example of how practitioner research might be structured and delivered.

Selected publications that have emerged from the production of the thesis

Journal articles and book chapters

Hills, J., Cahill, J., Lees, J., Freshwater, D. and Krivzov, J. 2020. [currently under peer review]. Mechanisms of change in psychotherapy with physical symptom presentations: a qualitative synthesis of case study evidence

Hills, J. 2018. The psychosomatics of distress: Case study insights into lived experience and therapeutic change. *Self and Society*, **46**(2), pp. 58-65

Hills, J., Cahill, J., Lees, J. and Freshwater, D. 2018. Indices of change: Analysing the indexical properties of data from psychotherapy case work to discern patterns of therapeutic change over time. In: Costa, A.P., Reis, L.P., Souza, F.N.D., and Moreira, A. eds. 2018. *Computer Supported Qualitative Research*. Advances in Intelligent Systems and Computing. Berlin: Springer Verlag, pp.418-424

Hills, J., Lees, J. Freshwater, D. and Cahill, J. 2018. Psychosoma in Crisis: An autoethnographic study of medically unexplained symptoms and their diverse contexts. *British Journal of Guidance and Counselling*. **46**(2), pp.135-147

Conference presentations

Hills, J., Cahill, J., Lees, J. and Freshwater, D. 2019. *On psychosomatics and the maps in our hands: Modelling change over twelve months of counselling practice*. Society for Psychotherapy Research UK and European Chapter Conference, 20 September, Jagiellonian University, Kraków

Hills, J., Cahill, J., Lees, J. and Freshwater, D. 2019. *Interweaving Timelines: Longitudinal patterns of change over twelve months of a counselling practice and multi-case research study*. BACP Research Conference, 17 May, Belfast

Hills, J., Cahill, J., Lees, J. and Freshwater, D. 2018. *Reflective Practice in Many Voices: Encountering multiple versions of self in psychotherapy case study research*. Society for Psychotherapy Research International Conference, 28 June, Vrije Universiteit, Amsterdam

Hills, J., Cahill, J., Lees, J. and Freshwater, D. 2018. *Psychotherapy for people who present with somatic symptoms: A multi-case study*. A specially convened meeting of the Department for Psychoanalysis and Clinical Counselling, 6 February, Ghent University

Hills, J., Cahill, J., Lees, J. and Freshwater, D. 2017. *Case study reporting of psychotherapies for people who presented with physical symptoms: A qualitative synthesis*. Society for Psychotherapy Research's UK and European Chapter Conference, 22 September, University of Oxford

Table of Contents

| | |
|--|------|
| Acknowledgements..... | iii |
| Abstract..... | iv |
| List of tables | xiii |
| List of Figures | xiv |
| Use of images..... | xv |
| Key to passages of dialogue | xv |
| Introduction | 1 |
| Cast..... | 4 |
| The counselling practice..... | 8 |
| Positionality..... | 8 |
| The autoethnographic turn..... | 10 |
| A driverless car..... | 11 |
| A map as a metaphor | 13 |
| Signposting..... | 15 |
| Conclusion..... | 19 |
| Blinded like a pit pony..... | 20 |
| Chapter One: The place of this research in the world | 22 |
| 1.1 What do I mean by embodied distress? | 25 |
| 1.2 Effectiveness of psychotherapeutic approaches for clients with somatic-symptom type presentations | 27 |
| 1.3 Psychotherapy with clients who presented with embodied distress | 29 |
| 1.3.1 Mechanisms of change in existing case study and qualitative research | 37 |
| 1.3.2 Innovative Moments and Change | 45 |
| 1.3.3 A narrative-dialogical approach to practice..... | 49 |
| 1.3.4 Pluralism..... | 51 |
| 1.4 Thus, my hypotheses going into the data collection period..... | 52 |
| 1.5 The visibility of the therapist | 54 |
| 1.6 The self as research instrument..... | 55 |
| 1.7 The constructivist and dialogical nature of practitioner research..... | 57 |
| 1.8 Locating the key concepts..... | 60 |
| 1.9 Conclusion..... | 65 |
| 1.10 Amsterdam..... | 66 |

| | |
|--|-----|
| Chapter Two: Methodology, Methods and Mini-studies..... | 69 |
| 2.1 Methodology..... | 69 |
| 2.1.1 Case study as a unit of analysis..... | 72 |
| 2.1.2 Naturalistic generalisation..... | 73 |
| 2.2 Methods..... | 75 |
| 2.2.1 Recruitment of participant clients..... | 76 |
| 2.2.2 Data collection and analysis..... | 77 |
| 2.2.3 Goal setting and review sessions..... | 83 |
| 2.2.4 Outcome measures..... | 84 |
| 2.2.5 Case reports and member checking..... | 86 |
| 2.3 Mini-studies..... | 89 |
| 2.4 Ethical Considerations..... | 90 |
| 2.4.1 Honouring my clients..... | 96 |
| 2.5 Autoethnography as a methodological shadow-layer..... | 98 |
| 2.5.1 The methods of autoethnography..... | 100 |
| 2.6 Structuring the thesis..... | 103 |
| 2.7 Conclusion..... | 104 |
| 2.8 The Salmon swimming upstream..... | 104 |
| Chapter Three: An introduction to the participant clients..... | 107 |
| 3.1 Lou (f, early 30s)..... | 108 |
| 3.1.1 Attainment of therapeutic goals..... | 114 |
| 3.1.2 Lou's feedback..... | 118 |
| 3.2 Michael (m, mid 40s)..... | 121 |
| 3.2.1 Attainment of therapeutic goals..... | 127 |
| 3.2.2 Michael's feedback..... | 128 |
| 3.3 Jennifer (f, mid 60s)..... | 131 |
| 3.3.1 Attainment of therapeutic goals..... | 137 |
| 3.3.2 Jennifer's feedback..... | 138 |
| 3.4 Myrtle (f, mid 60s)..... | 139 |
| 3.4.1 Attainment of therapeutic goals..... | 145 |
| 3.4.2 Myrtle's feedback..... | 146 |
| 3.5 The Fifth..... | 148 |
| 3.6 Conclusion..... | 149 |
| 3.7 A patchwork quilt..... | 151 |

| | |
|--|-----|
| Analysis of the cases through the phased emergence of a map of change..... | 153 |
| Falling not flying | 156 |
| Chapter Four, 1 st template: The migration between dominant and alternative I-positions | 157 |
| 4.1 Lou: The Peacemaker vs “Fire in my belly” | 158 |
| 4.2 Michael: “Keeping my head down” vs “Standing taller” | 162 |
| 4.3 Mini-study: Identification of innovative moments in the case of Michael..... | 165 |
| 4.3.1 Lines of enquiry as informed by the Innovative Moments literature | 166 |
| 4.3.2 Performing the analysis – coding | 168 |
| 4.3.3 Performing the analysis – therapist responses | 172 |
| 4.3.4 Observations | 182 |
| 4.4 Conclusion | 182 |
| 4.5 River of Time | 185 |
| Chapter Five, 2 nd template: Mapping a longitudinal model of change onto the migration between I-positions | 186 |
| 5.1 November 2017 - August 2018: where I was | 186 |
| 5.2 November 2017 - August 2018: where my theory was | 187 |
| 5.3 Lou..... | 192 |
| 5.4 Jennifer..... | 196 |
| 5.5 Extending the 2 nd template: Introduction of novel stages relating to identification | 199 |
| 5.5.1 Lou..... | 201 |
| 5.5.2 Myrtle..... | 202 |
| 5.5.3 Reflections on the use of this template | 204 |
| 5.6 Mini-study: A task analysis of Lou’s conscious repositioning within relational entanglements | 206 |
| 5.6.1 Hypothesising of a rational model to test against the data..... | 207 |
| 5.6.2 Selected therapeutic events from Lou’s therapy | 210 |
| 5.6.3 Towards a rational-empirical model of task resolution | 220 |
| 5.6.4 Observations | 227 |
| 5.7 Conclusion | 228 |
| Chapter Six, 3 rd template: The generation of cognitive maps | 230 |
| 6.1 August - November 2018: where I was..... | 230 |
| 6.2 August - November 2018: where my theory was | 232 |
| 6.3 Michael..... | 234 |

| | |
|---|-----|
| 6.4 Jennifer..... | 237 |
| 6.5 Myrtle..... | 240 |
| 6.6 Lou..... | 243 |
| 6.7 Mini-study: A qualitative (hermeneutic) analysis of accounts of change and causality | 247 |
| 6.7.1 Procedure..... | 248 |
| 6.7.2 Measuring change..... | 252 |
| 6.7.3 Expectancy effects | 254 |
| 6.7.4 Correspondence of change to specific events or processes within therapy . | 258 |
| 6.7.5 Outcomes that were specific and idiosyncratic to the client..... | 259 |
| 6.7.6 Plausibility of changes given the degree of difficulty of the problem | 261 |
| 6.7.7 Commentary from Jane..... | 262 |
| 6.7.8 Commentary from John | 264 |
| 6.7.9 Observations | 265 |
| 6.8 Conclusions | 267 |
| Chapter Seven, 4 th template: Dialogism in the therapeutic relationship | 268 |
| 7.1 November 2018 – April 2019: where I was..... | 268 |
| 7.2 November 2018 – April 2019: where my theory was | 270 |
| 7.3 Lou..... | 272 |
| 7.4 Michael..... | 274 |
| 7.5 Observations | 277 |
| 7.6 Conclusion | 278 |
| 7.7 Belfast..... | 279 |
| Chapter Eight: The Emergent Thesis..... | 281 |
| 8.1 Answering the research questions..... | 282 |
| 8.1.1 As a therapist researching my own practice, can I observe mechanisms of change? | 283 |
| 8.1.2 Are these mechanisms common from one client’s experience to another? . | 284 |
| 8.1.3 How might clients identify and describe these mechanisms of change in their own words? | 285 |
| 8.1.4 What particular aspects of my therapeutic approach appear to support observed change processes? | 285 |
| 8.1.5 What qualities of the therapeutic relationship are facilitative of change? ... | 286 |
| 8.2. The best synthesis..... | 287 |
| 8.3 A three state model of change..... | 288 |

| | |
|--|-----|
| 8.3.1 Identification | 290 |
| 8.3.2 Bridging | 292 |
| 8.3.3 Mapping | 293 |
| 8.4 Threshold states | 296 |
| 8.4.1 Appreciation of symptoms as signposts..... | 297 |
| 8.4.2 Transference | 298 |
| 8.5 Discussing these findings in relation to existing evidence and theories of change | 299 |
| 8.6 Antithesis..... | 305 |
| 8.7 Seeing double..... | 309 |
| 8.8 Conclusion | 315 |
| Chapter Nine: So What?..... | 317 |
| 9.1 Congruence with existing theory | 318 |
| 9.2 Practitioner research and the visibility of the therapist | 320 |
| 9.3 Impact | 321 |
| 9.4 A cultural context | 323 |
| 9.5 Quality appraisal | 324 |
| 9.5.1 What would I have done differently? | 329 |
| 9.6 A revisiting of the core ethical dimensions of the project | 330 |
| 9.7 A proposal for further work on the data..... | 332 |
| 9.8 Directions for future enquiry | 334 |
| 9.9 What If?..... | 336 |
| Reference list | 339 |
| Bibliography | 355 |
| Appendix 1: Inclusion of Published Studies | 371 |
| Appendix 1.1: Psychosoma in Crisis | 371 |
| Introduction | 373 |
| MUS and the counselling and psychotherapy profession..... | 374 |
| Ethnography and patient narratives | 375 |
| Data: critical incidents..... | 378 |
| Having a body vis-à-vis being a body | 386 |
| Implications for practice | 387 |
| Conclusion..... | 388 |
| Notes on contributors..... | 389 |

| | |
|---|-----|
| References..... | 390 |
| Appendix 1.2: Indices of Change..... | 393 |
| Introduction | 393 |
| Indexicality | 395 |
| Case vignettes | 397 |
| Conclusion..... | 399 |
| References..... | 401 |
| Appendix 1.3: The Psychosomatics of Distress | 403 |
| History and terminology | 404 |
| Psychotherapeutic approaches..... | 406 |
| Case study literature – learning from the last ten years..... | 407 |
| Introducing my own research | 409 |
| What I hope to achieve | 410 |
| References..... | 411 |
| Appendix 1.4: Mechanisms of change in psychotherapy with physical symptom presentations | 414 |
| Abstract | 415 |
| Introduction | 416 |
| Methods | 420 |
| Identification of studies | 420 |
| Results | 425 |
| Discussion..... | 435 |
| Disclosure of interest | 441 |
| References..... | 441 |
| Table 1: Inclusion and exclusion criteria for relevance of studies | 447 |
| Table 2: General information about the selected case studies | 449 |
| Table 3: Coverage of the mechanisms of change across the ten cases | 450 |
| Figure 1: PRISMA diagram of study identification and selection..... | 451 |
| Figure 2: Visualising the derivation of mechanisms of change through cross-case analysis..... | 452 |
| Figure 3: Two pathways along which the mechanisms of change were observed | 453 |
| Appendix 2: Ethical review..... | 454 |
| Appendix 3: Participant Information Sheet | 502 |
| Appendix 4: Participant Consent Form | 505 |

| | |
|--|-----|
| Appendix 5: Case report example – Michael | 507 |
| Schedule of psychotherapy sessions..... | 507 |
| Presentation..... | 507 |
| Contents of the report that follows | 508 |
| Negotiation of a mutual formulation..... | 509 |
| Hierarchy of exposure as generated collaboratively in 4 th session..... | 511 |
| Breakthroughs applying the exposure technique | 512 |
| Further revision of the therapeutic goals | 513 |
| Potential Mechanisms of Action | 514 |
| A presenting problem not directly addressed | 519 |
| Research effects | 523 |
| Timeline..... | 524 |
| Questions for Michael..... | 526 |
| Appendix 6: Data as generated through case notes and reflective journaling..... | 528 |
| Indications in early case notes of the work we would go on to do | 528 |
| Somatic theorising | 529 |
| Subtext and implicit communications..... | 530 |
| Parallels between personal process and client process | 531 |
| Modelling my theory in therapeutic process..... | 532 |
| Influence of research process – listening to and coding the sessions each week – on therapist understanding..... | 534 |
| Scrutinising my understandings of change process – anticipating hermeneutic analysis | 535 |
| The emergence of the parallel thesis – the autoethnographic strand – as tracked through diary entries | 537 |

List of tables

| | |
|---|-----|
| Table 1: Proportions of Michael's therapy sessions 'covered' by innovative moments and ambivalence markers | 170 |
| Table 2: Transcript from Michael's session two demonstrating therapist's responses to an innovative moment | 173 |
| Table 3: Transcript from Michael's session eight demonstrating therapist's responses to an innovative moment | 175 |
| Table 4: Transcript from Michael's session three demonstrating therapist's responses to an ambivalence marker | 178 |
| Table 5: Transcript from Michael's session six demonstrating therapist's responses to an ambivalence marker | 180 |
| Table 6: Comparing client and therapist steps across three change events | 221 |

List of Figures

| | |
|---|-----|
| Figure 1: Totton's hierarchical model of embodiment (2014)..... | 32 |
| Figure 2: A visual analogy of I-positions as I understand them | 35 |
| Figure 3: A visual analogy of the three levels of innovative moment..... | 49 |
| Figure 4: My adaptation of Totton's hierarchical model | 53 |
| Figure 5: Screenshot of coding stripes as applied to Jennifer's third session..... | 79 |
| Figure 6: A visual representation of the weekly data processing cycle | 80 |
| Figure 7: Ouroboros from German physician Michael Maier's Atlanta Fugiens Emblem (17 th century)..... | 99 |
| Figure 8: Atlantic salmon | 104 |
| Figure 9: Illustration on the Digestive System | 110 |
| Figure 10: Ross Laughlin, W. 1905. Anatomy in a nutshell | 123 |
| Figure 11: My sketch of a patchwork quilt..... | 151 |
| Figure 12: A visual analogy of the purer, simpler patterns that may be extracted from the entirety of the data | 155 |
| Figure 13: Map overlay process | 155 |
| Figure 14: Proportion of Michael's sessions which were 'covered' by innovative moments and ambivalence markers | 171 |
| Figure 15: The preparatory iron armature for an equestrian statue | 191 |
| Figure 16: The rational model that formed the basis of the task analysis..... | 210 |
| Figure 17: The Gestalt Cycle (Clarkson, 1989) | 214 |
| Figure 18: The rational-empirical model, as emerging from the task analysis..... | 226 |
| Figure 19: A three state model of change..... | 289 |
| Figure 20: Three representations of the British Isles..... | 295 |
| Figure 21: The different practitioner 'voices' contributing to the dialogue on psychotherapeutic change..... | 305 |

Use of images

Where an image used in the thesis features no credit I have determined that the image is already in the public domain or has otherwise been released under a license that permits reproduction without credit.

Key to passages of dialogue

Statements in italics – spoken words

Where words in a sentence are underlined – the speaker placed emphasis on the underlined word

((descriptions within two brackets)) – to elucidate qualities such as tone of voice, emotional content, laughter or overlapping speech

... - ellipsis indicates a pause in speaking

[...] – square bracketed ellipsis indicates words removed to improve clarity of passage and/or to convey the essential meaning which is observed within that passage.

Once in a while, I get shocked into upper wakefulness, I turn a corner, see the ocean, and my heart tips over with happiness – it feels so free! Then I have the idea that, as well as beholding, I can also be beheld from yonder and am not a discrete object but incorporated with the rest, with universal sapphire, purplish blue. For what is this sea, this atmosphere, doing within the eight-inch diameter of your skull? (I say nothing of the sun and the galaxy which are also there). At the centre of the beholder there must be a space for the whole, and this nothing-space is not an empty nothing but a nothing reserved for everything.

Saul Bellow, *Humboldt's Gift*



Introduction

Kierkegaard observed that 'life must be lived forwards, but it can only be understood backwards'. As I write these words at what is in some respects the end of a very long journey, the question as to what this thesis is *about* – a question that I wrestled with throughout the many different legs of that journey – can now be confidently answered. This is a thesis about maps; the maps that we live by. The maps which are of our concern here are internalised maps, which include representations of self, others, and the world. These maps are the frames within which our thoughts, feelings, words, and actions are organised. I have produced this thesis as a practitioner researcher – a counsellor researching into my own clinical work. The clinical population of interest in this research is made up of those clients with whom I have worked who have presented with somatic symptoms, which are described here as embodied expressions of distress. However I have also produced this theory in the spirit of a *Wounded Healer* (Sedgwick, 1994), living myself with chronic pain which I learned over the years had a discernible psychosomatic quality¹. In this thesis I deliver a multi-case study of my clinical work with *Lou, Michael, Jennifer* and *Myrtle* – pseudonyms which each client chose themselves – between the period of November 2017 and November 2018. As I will explain in chapter one I worked with each of these clients within a framework that at the beginning of data collection I described as 'narrative-dialogical' however as will be observed, each of the

¹ I will consider the highly contestable terms we used to describe embodied expressions of distress in chapter one and explain my own choice of language.

four cases took different shapes and evoked different therapeutic strategies reflecting a pluralistic approach to practice (Cooper and Dryden, 2016; McLeod, 2018).

One constancy has driven and shaped this research from its inception and that have been two questions which as a therapist researching my own practice and seeking to generate findings with direct usefulness to practice, were twinned. The first question, which has not changed and is phrased in the same way now as it was in 2015 when I put together the first proposals, is succinctly made. In therapeutic working with clients who presented with somatic symptoms:

What does change look like?

The second question immediately and naturally follows from the first,

And how is change facilitated?

Throughout the years of the project these two questions were a constancy: like *Pollux* and *Castor* within the conceptual firmament onto which I mapped my PhD research. In the act of producing a piece of practitioner research, the questions require a further deconstruction so that they might be understood more formally as research questions. When working with clients with somatic symptoms and asking 'What does change look like', I seek answers to the following questions:

- *As a therapist researching my own practice, can I observe mechanisms of change (as conceptualised by Kazdin, 2007; 2009)?* By which I mean to enquire as to whether there were observable processes in therapeutic working with a client (or extra-therapeutic processes) that could be associated with the client realising desirable outcomes. Mechanisms of change have been theorised since the origins of psychotherapy itself. One might think for example of the centrality Freud placed on making the unconscious conscious, and thus achieving a catharsis, or that Carl Rogers placed on a client internalising their own locus of evaluation, and realising a state of immediacy and openness to experience. This line of enquiry might also come to include observations about the longitudinal patterns or shape of change throughout the duration of a person's therapy.
- *Are these mechanisms common from one client's experience to another?* I could find that across the multi-case study that there are mechanisms of change which

are translatable between one client's unique lived context and another, or I may find that change took on different shapes for work with different clients.

- *How might clients identify and describe those mechanisms of change in their own words?* Recognising the interest in whether mechanisms may be applicable to work with different clients, through this line of enquiry I aim to also preserve and represent the uniqueness of client experience as well as to appreciate whether my clients thought of change as I thought of it,

As to the second part of the enquiry, when I am asking: 'And how is change facilitated', I mean to offer answers to the following questions:

- *What particular aspects of my therapeutic approach appear to support observed change processes?* Where I am able to observe mechanisms of change and patterns that appear to lie beneath good outcomes, what was I doing as the therapist to support these processes; what was my role?
- *What qualities of the therapeutic relationship are facilitative of change?* Because no therapeutic work is possible without a therapeutic relationship, what qualities of that relationship appear to be necessary in order for observed changes to be possible?

The interest in therapeutic change took hold of me in the period immediately following completion of my training in counselling and psychotherapy at the University of Leeds. What was done very well on our course was the attention given to therapeutic process, moment to moment; the significance of micro-phenomena in those therapeutic moments –for example non-verbal communications, moments of meeting, or reveries; and on the importance of the therapeutic relationship and of events within the intersubjective field. Our trainers strived to make sure we students engaged our right-brains in our therapeutic working. However as a newly qualified practitioner, what I was left with was a feeling that I was missing something of the longer view of therapy. Many of my clients complained that they had had previous therapists who hadn't said much, or they had been relatively passive, and they'd ended the process feeling that they hadn't achieved much. Most of them had not sought out therapy because they wanted to experience a 'real relationship', whatever the evidence base around the importance of the therapeutic relationship. Rather they were living through problems or crises or in some other way had got stuck and wanted to discover how they might become unstuck and move on. I felt I was not able to offer strategies that inspired faith in my clients that

therapy was a project that they could get hold of and invest themselves in. Likewise as a client myself, I experienced therapy as a relatively passive process: some exploration into the symbolic qualities of my pain, but nothing that felt like I was finally getting under the skin of it. When I decided to research my own chronic pain for my masters dissertation (Hills et al., 2018b) I presented my findings to various groups of practitioners and found that often psychological therapists simply didn't know what to do when encountering clients who had become 'stuck' on physical symptoms. It wasn't comfortable territory for them: they'd prefer to be working with thoughts and emotions, and these somatic presentations appeared to be stubbornly resistant to psychologising. I found they looked to me for strategies; something that they could take back into their practices. And so the question of change took form in my mind.

During the period of working with each of these clients, and many months following the closure of data collection I returned cyclically to the data to revisit that same core line of questioning: what does change look like and how is change facilitated? Throughout this time and as is documented in the thesis, working models of change were developed in an iterative fashion week by week. I held lightly to these models: they served as a guide to formulate case work and structure interventions but were always provisional in nature and subject to revision as their limitations were revealed. The concept upon which this thesis centres is the best synthesis of all of these earlier iterations, and offers answers to these questions. The thesis describes a process of *cognitive mapping as a platform for therapeutic change*, as will be explained.

Cast

As this thesis tells a story, it is appropriate to introduce a cast of characters. In chapter three I provide a full narrative introduction to each of the four participants who generously consented and actively contributed to the production of this research:

The story of *Lou's* therapy is of a woman arriving for counselling after a lifetime of having to keep the peace within a chaotic and conflict-riven family environment. For the first time in her life Lou was learning to assert herself but this process felt dangerous, perhaps even deadly, and her anxiety was associated with panic attacks, vomiting and with waves of exhaustion.

Michael sought out help because his fear of having his disability seen by others was becoming the source of intense self-consciousness and discomfort. A strategy of concealment that had served him well for the first thirty or forty years of his life had stopped working, and as an engineer he came to counselling looking for a practical solution.

Jennifer had recently been bereaved when she arrived for therapy but what had been most deeply disturbing for her was a tirade launched against her by another grieving relative. She couldn't shake the thought from her mind "does everybody think this about me?" which had dramatically narrowed her social horizons and aggravated her chronic fatigue. During our work she discovered a device that transformed her perception of herself and of other people's thoughts and enabled her go back out into the world.

Finally *Myrtle* sought out counselling upon advice from her GP for anxiety relating to heart palpitations. In our first session she found herself in floods of tears and had an epiphany about guilt that she had carried all of her life. In our remaining sessions she translated this epiphany into a renegotiation of her relationships with significant others.

There are other cast members whose roles were decisive in the production of this thesis, in particular my research supervisors Jane, John, and Dawn.

Jane has been as solid as a rock in her support for me over the previous four years. She has on more than one occasion had to fight my corner when I got caught up in the bureaucratic machinations of the University. Jane on occasion took on a 'good cop' role when I encountered tough criticism of my work. As a quantitative researcher she brought an outsider perspective on methodology, but has also always given me the freedom to run with my ideas. Jane in other ways has helped me to develop in areas that weren't my strong points – her attention to detail brought into my attention the occasional lack of my own. I also learned from Jane the skill of justifying the theoretical positions that we take and which I have demonstrated in the present thesis.

John was my trainer during my MA in Counselling and Psychotherapy, when I began my practice and qualified as a therapist. John offered radical alternatives to the prevailing views at the time. I first connected with him through our mutual interest in Jungian psychology and spirituality. When John supervised my master's dissertation – an autoethnographic study investigating my own chronic pain – he emphasised creativity

and the aesthetic of the work which was a radical methodological position within our School. John has also been the 'bad cop' at times, delivering some of the strongest criticism and deconstructions of my work during my PhD, which called for a lot of soul-searching on my part. But those insights were of such a high quality; I always appreciated his 'tough love'.

For three years before beginning my PhD, *Dawn* was my first clinical supervisor, but she was also my first true mentor. She would often support me in my lowest ebb as a trainee therapist – believing in me even, perhaps especially, in those times when I had lost belief in myself. After reaching stratospheric heights at the University of Leeds, Dawn emigrated to Australia where she has supervised my PhD from afar, aiming to offer her unique perspectives as complementary to those offered by Jane and John. I often experienced Dawn as like a comet – because of the nature of her work we would go many months without hearing from her, but then we would meet and she would illuminate the room. After every meeting with Dawn I felt motivated and inspired, more on a moral than on a technical level. However Dawn's more technical contribution to research was to model reflexivity as a meta-methodology as I will explain further in chapter one.

Another voice is particularly influential across the production of this thesis and that is the voice of my clinical supervisor *Steve*, who supervised all the therapeutic work described here. Data collected formally from our supervision meetings during that period contribute explicitly towards theory development. Coming from a humanistic and person-centred counselling background, what is interesting about Steve's voice in the dialogue is that he would often push back against the sometimes esoteric ways of theorising about the therapeutic work. He found the concept of mentalization vague and unwieldy yet modelled it in his reflections on my client work. Likewise dialogism and multivocality were frames that he would never enthusiastically take up though always understood what I meant when I spoke about my clients in this way. Steve could also offer beautiful metaphors that helped to elucidate my own developing thoughts. Generally I experienced Steve as a steadying force– he would draw from decades of experience which I sought to soak up in my deference to that weight of experience. This provided our sessions with a gravity and sense of continuity beneath the constant evolution of my theories and the language I used to describe them.

And, of course, *I* am at the epicentre of this dialogue and this narrative, so it is also pertinent to provide a glimpse into who I am and what I bring. Throughout the thesis I offer narrative windows into my world – both my relational worlds and my internal worlds. Through these narrative windows I develop a ‘thesis within a thesis’ or alternatively a ‘thesis beneath a thesis’. As I will go on to explain through this approach to reflexivity I demonstrate the personal and subconscious origins of the formal thesis that emerges. I was 33 when I began putting together the first proposals for this PhD project, having just got married and become a father of twins the previous year. There is no doubt that on one level my motivation for doing this – winning the scholarship, going for a doctorate – was to be an adequate provider and a breadwinner for my young family. After a difficult supervision meeting John once remarked “you’re very resilient John”, but my resilience was rooted in the idea that I had to find a way through for the sake of my family. However this thesis also engages with longer-term patterns of my experience: an almost lifelong belief that despite personal qualities I had, that I was lacking something that I would need in order to get through; perhaps even that I was fated to fail. During this period as well as being a very early career researcher I felt to be still a very early career therapist. I was in both worlds in a state of continual development; continually wheeling around the ‘cycle of competence’. In both worlds I experienced waves of confidence and loved the work I was doing, however in both worlds I was also vulnerable to collapses in confidence when my own illusions were exposed. This dynamic drove the development of the ‘thesis beneath a thesis’.

Finally, a fifth participant was involved throughout the duration of the project. Data from our work together were influential in driving and shaping my emergent analyses and theories. They were written into the original version of this thesis, created over the summer of 2019, however made contact in the autumn to request their complete removal. The accounts of the therapeutic work with this participant were those most centred on the use and meanings of the therapeutic relationship and as such the thesis loses the colour or texture that those accounts brought. Their imprint remains within this thesis, almost as a presence-through-absence, which Jane suggested was ghostlike. How might I write about a participant - the impact on this project of both their participation and their withdrawal - without revealing any of their personal qualities? I consider these matters in the penultimate section of chapter three.

The counselling practice

I trained to become an integrative counsellor at the University of Leeds: this means that I incorporate concepts and methods from different schools of psychotherapy in an integrated framework. My training particularly emphasised humanistic and psychodynamic formulations and approaches. With less focus we also covered concepts from cognitive behavioural therapy including schematising patterns of relation, and the relationships between feelings, cognitions, and behaviours. As previously observed, being a product of University of Leeds meant a particular emphasis on skilfully creating and holding a therapeutic environment with my client. At the foundation of my practice are the core conditions of empathy, unconditional positive regard and congruence. In keeping with those person-centred origins, my client is at the centre of the therapeutic story, I strive to use their language, and defer to their own emergent direction of travel. From psychodynamic training I pay particular interest to how the client's current problematic patterns of relation may have their origin in past or childhood experience and will search for these links in what the client tells me, explicitly checking out my theories with them when that feels appropriate. Furthermore, my experience of the transference dynamics between us – particularly an experience of what 'part' I'm playing for the client, or indeed any reactions that my client might trigger in me – provide potentially valuable information, which I'll feed back to my client where I feel it could be helpful to recognise. This transference-based work means with some clients I am particularly mindful of how I might model for my client a different way of relating, in a way that provides a lasting benefit beyond our sessions together.

At the time of beginning data collection I had been qualified for practice for three years and was developing what I have described here as a 'narrative-dialogical' approach to practice. I explain this fully in chapter one, section 1.3.3.

Positionality

As the researcher, producing a piece of qualitative research – especially one in which as a therapist I research my own practice – it is important that I also provide details of my *positionality*. Positionality is defined in Sage Handbook of Action Research as the

‘positioning of the researcher in relation to the social and political context of the study—the community, the organization or the participant group’ (Rowe, 2014, p. 628).

My earliest years were on a family farm – comfortably middle class - and my family on both sides essentially espoused ‘small c’ conservative values. However when I was about three years old my parents separated and my brother and I went to live with our Mum in a working class post-industrial town, with some cultural similarities with the town in which the charity in which the counselling described in this study was delivered. Every fortnight my brother and I would continue to visit our father on the farm and thus we lived a regular oscillation between town and country, working class and middle class. This dualism, an experience of having a foot in both worlds, manifests within the theory-development processes described in this thesis and thus reflects the idea of researcher as research instrument. I did my undergraduate university degree in London and after a shaky start eventually emerged with a good degree. During that degree study I became strongly engaged with radical political ideologies and spiritual ideas. Then during my twenties I worked for various non-government organisations including human rights campaigning, which I understood to be creating in some ways the ‘core conditions’ of human flourishing. Through this work I developed skills in communicating and motivating others.

When I returned from London I spent several years living back on the farm which set up a dialogue for me between the radical ideas I returned home with and the small-c conservatism of my family’s identity; a dialogue which for a large part shaped me into the person I am today. I made the decision to train to become a counsellor at 28. I had come round to the idea that political activism was an attempt to effect change at a meta-level and that I might be able to make a real and tangible difference through the work of counselling. During my undergraduate degree I had become fascinated with the work of Freud and Jung and the idea of counselling also connected with my spiritual leanings. My interest in counselling also re-invoked a longer-standing interest in self-help books I had had since my teenage years, and which might be located in the contemporary period of this thesis in my interest in positive psychology. Likewise as a musician – a singer and a songwriter - I sought harmony rather than discordance. The music I made was all about the melody – direct and pure, music in primary colours. This mindset does manifest in the way I practise as documented here – in some client work,

where appropriate, I might be seen to be a 'let's roll our sleeves up and do this' type therapist.

By the time of beginning my PhD research, at 34 years old, I had left home, got married, become a home-owner and had become a father, living a middle class life in a commuter town with a Leeds postcode. Practising through a charity offering means-tested therapy, my clients came from working class and sometimes impoverished backgrounds, and sometimes my middle class-ness would become a visible factor in work with clients at the charity.

I offer extended thoughts in chapter one on 'the place of this research in the world' which help to contextualise the theoretical contributions being made to the dialogue on psychotherapeutic change, from and through this project.

The autoethnographic turn

Over the period of data collection, in the course of twelve months of a counselling practice, life happens, and not just for the client but for the therapist too. My father died suddenly and unexpectedly in the February of 2018. When I returned to my work following my Dad's funeral I had this feeling that there was a superficiality about the project such as it stood at the time. I identified with the *change process research* tradition and had envisaged producing a piece of research in that genre. However during those first few days of my return to work I found myself asking 'so what': what was the point of this research that I was doing? Whilst I couldn't satisfactorily answer that question two ideas began to take form for me with a weight of certainty about them:

- 1) That I couldn't produce a piece of practitioner research in which the death of my father during data collection was a side event; something for a reflexive paragraph somewhere in the write up. The fact that my life was 'happening' in parallel with those of my clients meant that likewise reflexivity would have to be a thread that ran throughout the thesis. For shorthand I referred to this methodologically as 'the autoethnographic strand'.

- 2) Noting this parallelism, the longitudinal quality of the work came into focus. I took an interest in the interweaving timelines of my therapeutic working with clients, my developing thesis and my internal lives. This 'longitudinal turn' is particularly apparent in the theoretical developments described in chapter five. However its most important impact is that I go on to represent the chronological development of my map of change as a series of theoretical templates which overlay one another, generating a new synthesis during each phase.

Thus in the chapters that follow the autoethnographic material is referred to frequently offering a dialectic with the explicit generation of theory – as though two or more parts of me were engaged in a dialogue. As I will explore further in chapter three, what emerges from this thesis cannot be claimed as an objective piece of theory – if such a thing were possible – but rather as emerging transparently out of *subjectivity* – my internalised dialogues, dialogues with my clients, my supervisors, my therapist, the professional community and the existing literature. I thus situate myself within a constructivist epistemology and consider the implications for the knowledge value of this piece of work, with reference to existing debates about the utility of case study research beyond local contexts.

In recognising the personal processes that underpin the development of theory in this thesis, in the section that follows I provide the first of a series of narrative windows into the reality of my Dad's death.

A driverless car

Tuesday, 27th February 2018

I had the flu. You know, proper flu, not like when people have a bad cold and they say it's the flu. I'd been in bed for several days with it. I was having a dream: Dad and I were travelling in a Mercedes. It was his Mercedes, the one he'd just bought in real life, but in the dream it was a driverless car². I wish I could remember more about it. I woke about half past six - we were moving house on the Thursday and so I had to start helping

² Also known as a 'self-driving car'. At the time of the dream this was still an emergent technology, a prospect for the future rather than an everyday reality.

out. I went downstairs – my wife was already awake and we sat together in the kitchen, with our hot drinks. I was huddled over mine, still feeling completely lousy. About seven o'clock the phone rang. I knew immediately something was wrong – why else would someone be calling at this time? It was my aunt on the other end – I thought there must be something wrong with my Grandma. She was really struggling to know what to say and I think it just came out of her: “John, your Dad’s dead”. She almost sounded apologetic for giving me the news so abruptly. Apparently my Grandma had gone into his bedroom to wish her son a good morning and just couldn’t wake him, and so she called for my aunt, his sister, and she had called 999. I cried a sort of detached or disembodied cry, like it hit me on one level and on another I just couldn’t begin to process the idea. My wife too was stunned. I called my brother and gave him the news - his reaction was much as mine had been. I put on some clothes and drove over to the house.

The ambulance people had been and gone. I remember us all stood about in the kitchen whilst Dad’s body was still sat in the chair in the bedroom just down the hallway. None of us knew what to do or say as we waited for the police to arrive. I was constantly blowing my nose, coughing, my eyes streaming – the flu more than the grief responsible for these symptoms. Then I went through to the bedroom. He just looked like he was sleeping. I said “Dad” softly as though trying to wake him up, and then “Dad” a little louder half expecting that he would open his eyes. I knew he was gone but for some reason this was what I did. Then my brother came through and we stood together, looking on at our Dad. We cried together, still not able to find words to justify the magnitude of what had happened. He didn’t look to be in any pain; he looked completely peaceful. We decided that he’d just gone to sleep as he normally would, and probably never knew anything about it. We told Grandma about this and she said that that was “good” – we were each too stunned to find words beyond these. When the police had been and gone, and then the undertakers to take him away, we remained all together for a few hours; trying to make sense of it together. It was that classic thing, as is always said when someone dies: “it hasn’t sunk in yet”. Grandma told me that she and Dad had just in the last couple of days driven down to our new house and apparently he had said, in his excitable way: “a son of mine is going to live here”, and we both wept at that. She told us how pleased he’d been with his new Mercedes and couldn’t stop raving about all its features.

I thought back to the dream even on that first day. How often did I dream about Dad? How much of a coincidence was it that I should dream about him, indeed us together, on the morning of his death? Was it more than a coincidence? Was this some kind of supernatural communication: a final goodbye? I came to believe – though I can never know – that I had had the dream at the same time as he'd actually died. Being sat in the car together was the one time Dad and I really connected in the last decade or so, perhaps because I was otherwise too busy to sit and talk with him. Was this his way of capturing the essence of our relationship in a final scene? But an important difference – the car was driverless; what was the significance of that? Something about us both being passengers? Something about the future perhaps?

When something as big as that happens in your life it tears a hole in your day to day fabric – all your familiar reference points go to pot. You look for something you can do, and for me that something was taking care of all the administrative stuff, funeral arrangements etc. You have moments that are bizarrely normal, as if nothing's happened, just running the same programs as ever, because "it hasn't sunk in yet". Nobody has a script or a set of instructions for what to do in those circumstances – my aunt couldn't find the words to give me the news appropriately over the phone, neither did my brother or I know what to do or say stood looking on at our father's lifeless body. We had nothing to compare it to, and were still feeling round for a map to find a way through it all.

A map as a metaphor

In chapter one I will situate the concept of the cognitive map within the existing literature. However the metaphor of the map is one that features throughout the thesis and so some expansion of its meaning as a metaphorical device is necessary here. A map is a representation of a location, a situation, a scenario or a world. Whilst maps have many different purposes, the activities a map facilitates are classically orientation and navigation i.e. where we are now, and how we get to our destination. The maps that I will invoke in this thesis each facilitate orientation and navigation. Like maps in the real world the maps written about here operate on different scales; scales of both space and time. A map could organise our thoughts and behaviours in how we might

present ourselves in a 90 minute job interview, or how we might map a career over 30 years. A map might organise our elicitations of care or extensions of support within a family unit including parents, siblings, or children; and this may be a zoomed-in segment of a larger map that defines our roles in our families as well as those of our loved ones. As a therapist I might hold onto a map of how I believe therapeutic change is realised for each of my clients which determines my strategy across the therapeutic work, but I may have other maps that organise my momentary responses to a client who appears tense or anxious, as though something needs to be said; or to a client who appears emotionally detached from the highly evocative content they are sharing with me. In each case we locate ourselves within the map and thus acquire a sense for how to navigate through the landscape in which we stand.

Traditionally a map is a two-dimensional representation of a three-dimensional space. The way I think of this is that a map does not serve to represent the whole of reality, but one plane or horizontal slice of it. If we were to look in at any one situation – for example the charity in which I delivered the sessions described in this thesis – we could consider many different fields of interest. These different fields might include the financial structuring and human resources of the charity, or the anthropological nature of an internal culture; we could look at practice and the different modalities the therapists brought to their work, or we could look at the wider social context, including around the social determinants of mental health, in which the charity sat. Each of these different fields of interest would map the same place in a distinct way; each map offering two-dimensional representations of three-dimensional space.

A map also features its own symbolic language: of different colours for different layers, the use of icons for different features, and a key to explain these. Likewise the maps that are of concern here each feature their own symbolic language as a form of shorthand so that complex dynamics can be referred to quickly. In this thesis I highlight symbolism in my own personal processing – of roads, and rivers, and flight. Each of my clients also brought their own symbolic language: from the meanings embedded in *Michael's* strategy of “keeping my head down”, or in *Myrtle's* declarations that she was no longer “playing the game”.

All maps contain direction or directionality (Cooper, 2019a). Thus in the maps of interest here: our thoughts, feelings, words, and our actions are geared towards

something; their meaning points towards a greater movement, like individual steps in a greater journey.

Signposting

Chapter one situates *the place of this thesis in the world*. I set out my thoughts on the dialogical nature of practitioner research: that each practitioner puts out their research and their theories as one 'voice' within an ongoing dialogue in which theories are continuously evolving. These theories are incorporated and applied in the real-world contexts of our clinical working, and sometimes big ideological fault lines emerge and separate us into tribes. I identify with one such tribe – the *constructivists*, but also recognise the creative influence emerging from the dialectic with another tribe, the *positivists*. In this chapter I review my engagement with the literature on psychotherapy for psychosomatics including briefly exploring the problematic social contexts in which psychosomatics - and those who present with them - are alienated and stigmatised. I land upon a 'narrative-dialogical' concept of therapeutic working which informed my own clinical approach and provided the basis of a hypothesis which I took into the period of data collection.

In chapter two I explicitly set out my *methodology* and thus my research *methods*, and explain my concept of *mini-studies*, which in this thesis sharpen and develop my analyses. I explain why I settled upon the production of a multi-case study as the appropriate vehicle to answer my research questions. I go on to explore the concept of 'naturalistic generalisation' which is a core concept for case study researchers in making the case for the knowledge and evidential value of their work. In this chapter I consider some of the ethical dimensions of the research and emphasise the importance of honouring my clients.

In chapter three I provide *an introduction to the four participant clients*. I provide some basic information on the timing and frequency of sessions, the quantitative outcome measures routinely collected at the charity and the qualitative outcomes identified in the case reporting. I seek to provide a narrative glimpse into what it was like to work with each of the four participants, including how I responded to them, with reference to

some dialogue and other imagery invoked in me during the work. The physiological mechanisms underpinning different clients' somatic presentations are briefly explored. For each client I provide an appraisal of where and how I think therapy was successful: i.e. where and how change happened, but also a realistic account on where and how our work fell short: i.e. the parts of the client's life and experience we weren't able to 'touch'. As previously observed I will also provide some reflections on the impact upon this thesis of my fifth participant who decided to withdraw from the study.

Then follow four chapters of analysis based on the theoretical templates of change that emerged going into, during and beyond the period of data collection. In chapter four I consider the data in the light of the first of these templates: *the migration between dominant and alternative I-positions*. This phase of analysis centres on the narrative-dialogical concept of our clients occupying I-positions – explained in chapter two – which are essentially versions of our selves that we perform depending on context and audience. I find evidence of my clients' somatic experience shifting in tandem with their ability to perform alternative I-positions in key relational scenarios associated with their distress. I go on to perform the first mini-study in which I seek to identify *innovative moments* across the 10 sessions with *Michael*, including how I responded therapeutically to innovative moments or Michael's expressions of ambivalence, and how these innovative moments appeared to grow in complexity in the later sessions.

The analysis of chapter five emerges from the *mapping of a longitudinal model of change* onto the narrative-dialogical account of change expounded in chapter four. I briefly review the existing literature on existing longitudinal models before landing upon an application of Prochaska and Norcross' (2001) *Transtheoretical Model* of change to this frame – a synthesis which at the time I called the 'migration model'. However in the analysis that follows, in response to the limitations apparent in the stage-based concepts of change I go on to theorise a novel stage which I named 'identification' which may also be located within existing literature. This chapter concludes with the second-mini study: a *task analysis*, sequencing client and therapist performances during three key therapeutic events during the work with *Lou* in which she was able to successfully create space for and reposition herself within key relational situations.

In chapter six a third analytic template is introduced: the clients' *generation of cognitive maps*. Here I turn to existing literature from neuropsychology where cognitive factors such as attention, expectation and interpretation modulate and perhaps even construct

a person's somatic experiencing. Importantly, somatic experiencing is embedded within wider cognitive mapping of self and world. Without a cognitive map clients might be considered to experience *subjective incompetence* which is associated with the aggravation of somatic symptoms, and likewise where clients have discovered and are learning to apply a cognitive map this appears to be associated with a shift in embodied experience. If chapter four might be conceived of as focused on *self*, chapter six focuses on *self in world*, and I provide brief overviews into the different cognitions and behaviours associated with different maps. This chapter ends with the third and final mini-study which is a *qualitative (hermeneutic) analysis of accounts of change and causality* in the cases of *Jennifer* and *Myrtle*.

In chapter seven the final analytic template – of *dialogism in the therapeutic relationship* – is applied. Here I consider the dynamics underpinning the therapeutic relationship as a generalised mechanism of change in its own right. I consider what therapy meant for the participants as an 'event' in their lives, and what I meant to them as their therapist. This chapter helps to build upon the limitations of the different pieces of therapeutic work as described in chapter three e.g. in illuminating the barriers to more effective and deeper therapeutic working as the platform for change.

In chapter eight I deliver *the emergent thesis*. I thus advance the thesis that my participants' capacity for metacognition depended on their discovery of cognitive maps – as platforms of meaning – in which cognitions and behaviours were organised according to fit and congruence. I observe that the relief the participants experienced from their embodied distress was embedded within an integrated movement into alternative I-positions, and that these I-positions in turn were situated within cognitive maps which included representations of self, others and the world. I propose a 'three-state model' to account for the mechanisms of change that I believe is evidenced across the four cases. These are supplemented by two additional threshold states within the therapeutic process that are necessary in order to do the work or determine the depth of the work possible. Then I relocate the emergent theory within my 'thesis beneath a thesis' which is rooted in my personal and often subconscious processing – the cognitive mapping I have been doing during my PhD study.

Finally in chapter nine I ask the question *So What?* So I have ventured a huge amount of content, analysis, and theory but for what end? I consider the congruence of my own emergent thesis with the existing literature on psychotherapeutic change and thus how

it makes an incremental contribution within an ongoing dialogue. I consider the different ways in which my research may have an impact both in academia and beyond, by virtue of my publication strategy, my continued clinical working, and my roles as university lecturer and counselling trainer. The methodological significance of this piece of practitioner research is explored, including some reflections on the values embedded within research work. I then identify some directions for future enquiry. Finally I pose an additional question: *What if*, considering the different paths down which I might have taken my research, and the wider philosophical questions that the thesis may in turn give rise to.

The most sustained work of situating this project within the existing theory and literature are made in chapters one and two. However my utilisation of the literature is represented in this thesis as it was in reality: as an ongoing, longitudinal process. As such each successive chapter situates developing theory in the existing literature. I have followed the lead of Balkin and Kliet (2017) who, when writing on counselling research, advocated what they described as an 'active approach' to literature reviewing rather than a passive and exhaustive approach. In an active approach, as the researcher's conceptual framework evolves this directs the literature that they seek out in developing the theoretical 'answer' to their research question. Crucially for Balkin and Kliet the creation of the conceptual framework depends upon the subjectivity of the researcher, who pulls together those threads of literature based on her own experience. I undertook an active approach to literature reviewing driven by my own engagement with the research question and my evolving framework. What this meant for me in practice was that rather than setting aside a period of my PhD study to provide a comprehensive and relatively passive review of everything that was ever written of significance about my research topic, instead I reviewed my literature through a modular approach. Each time my map of change was in the process of metamorphosis - developing a new feature or template - I would perform a smart search based on the key words that I associated with that development. This process is reflected in the way I have written this thesis – rather than presenting the literature as a monolithic slab contained within a single chapter I have invoked the literature where and when it is relevant.

In addition, throughout this thesis I have written in the first person. This reflects my epistemological understanding of practitioner knowledge emerging through dialogue, as

will be explained in chapters one and two. Because mine is one voice within a community of voices I have sought to represent my voice as authentically and as accurately as I can in accounting for my engagement with the existing theory, and the data and theories emerging through this project.

Conclusion

This Introduction thus maps out the direction of the thesis as a whole including introducing the key cast members whose voices each contribute towards a dialogue in which this thesis emerges. In chapter one I will expand further on what I understand by this dialogue and how I and my research are situated. In chapters one and two I also develop the theory underpinning the ‘thesis beneath the thesis’, emphasising the visibility of the therapist and the researcher as subjectively participating in the production of theory. Thus in the chapter that follows, attention is drawn to locating myself and this research in the world, including within professional and researcher communities and within the vast library of theory that already exists in relation to psychotherapeutic change and therapeutic working with clients who present with embodied distress.

Blinded like a pit pony

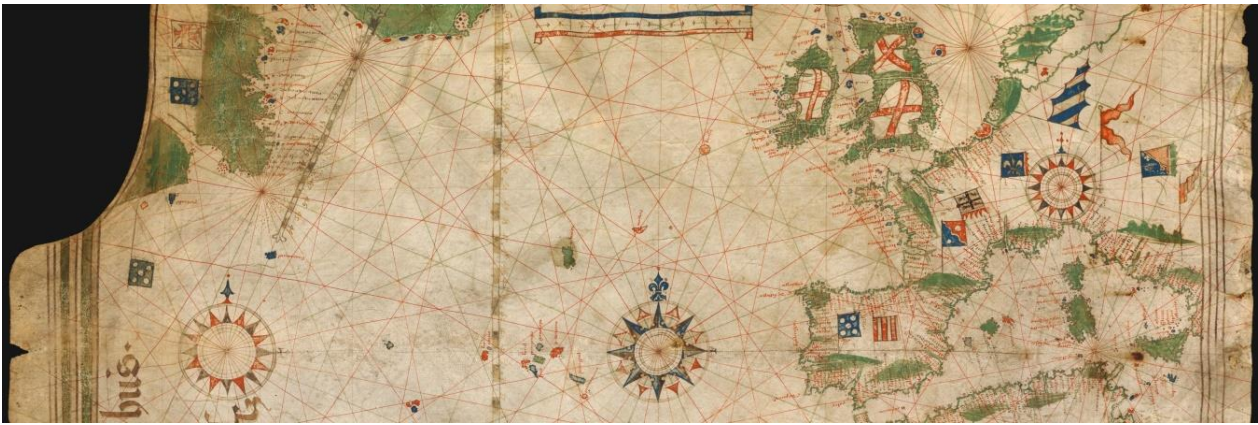
Tuesday, 6th September 2016

A dream. I was wearing an eye patch that was made from one of the baby car seats. I was trying to cross the street and the road was busy, and with no depth perception I could have easily got hit. I thought how sad it would be for me to die without seeing my children grow up. At the other side of the road was a van and there were two people in there that I knew from earlier in my life (I can't remember who). I climbed in the back with them and assured them that I interchanged the patch between eyes so as not to damage my sight. However when I removed the patch from my left eye I became anxious as I'd forgotten to change it – my vision was blurred, useless, and I was frightened it would never return.

I note the timing of the dream – just before I began my PhD study. We had news of the Scholarship in the May and so had been preparing for the start of this new phase over the summer. When I woke from the dream I first thought of pit ponies whom the miners used to take down with them into the caverns to haul back carriages of coal. I believed because I'd once heard somewhere that because they spent their whole lives in the darkness that they would eventually go blind (I've since learned that this is a popular misconception). Thus by keeping one eye in darkness it would be blinded. Using the material from the baby car seats is a clear reference to my family mission – our twins were still babies, I had to become a provider because my family depended on me. I did everything I could to secure the scholarship – it ate into all my free time. I had become myopic in my mission to become a provider. Additionally in this dream, because I lose sight in one eye I lose my depth perception – which depends on binocular vision - i.e. my single-minded quest was narrowing my horizons; I was losing contact with the transcendent experiences that might otherwise be available to me and I might reach a point where I permanently lose my sensitivity to transcendent experiences. Not only that but I'm in danger of getting flattened trying to cross the road to the van. It may also be significant that my left eye is the one being blinded: I associate the left side of the body with the right-brain which is typically associated with creativity, imagination and seeing the bigger picture. The van represents my past – perhaps getting to a music festival in my twenties and access to a different kind of subjectivity. Thus the dream is

about psychological inflexibility (Kashdan, 2010). I am losing my capacity to navigate between different I-positions, using different maps.

I note a further relevant interpretation which is about the importance of binocular vision. My master's dissertation project had had its origins in a traumatic double bereavement when I was eighteen, then during my MA our twins were born. Later during my PhD study I have struggled to maintain a foot in two worlds – the scientific change process researcher world occupied by positivists – and the experiential-subjectivist world occupied by constructivists like my own supervisor John Lees (an epistemological fault-line I consider in the following chapter). John warned me that if I tried to keep a foot in both worlds I would be in danger of falling down the middle. Jane on the other hand suggested there may be some valuable insight to be had spending time falling down the middle. Notwithstanding some anxieties on my part about falling into such a hole, I held that if I could maintain this binocular vision my project would be the richer for it.



Chapter One: The place of this research in the world

Shortly after the publication of *Ulysses*, James Joyce is quoted by Irish journalist and author Arthur Power as saying: 'I always write about Dublin, because if I can get to the heart of Dublin I can get to the heart of all the cities in the world. In the particular is contained the universal.' (O'Toole, 2014). Joyce was speaking about the city of his birth and that maxim 'in the particular is contained the universal', goes to the heart of the knowledge value of autoethnographic research as indeed it does case study research. These are pieces of research which, at their best, are written from the perspective of the *inside looking out*, rather than the *outside looking in*. As such in situating the place of this thesis in the world I will not be providing generalised overviews on the 'topics of interest' in this project. Rather I will take ownership of my particular entry point into each of these topics, thus making it clearer how my situatedness within these topics influenced the course and shape of my subsequent research.

My former trainer Meekums (2008) writing about her own doctoral research identified a question which she posed at the beginning of her own autoethnographic study: 'how did I get here?'. I offer some answers to that question in this chapter. I completed my MA in Counselling and Psychotherapy at the University of Leeds in 2014. In my final year I produced an autoethnographic study of my own experience living with chronic pain in my jaw as well as other somatic symptoms including palpitations and depersonalisation attacks, which I linked to a traumatic double bereavement when I was 18 and

subsequent drug use. I had years of experience as a patient being passed from one consultant to the next, cycling through hope and disappointment in my quest for a breakthrough, undergoing treatments in both the NHS and private sector; from exercises, anti-depressants and myofascial pain therapy, to splints, Botox injections and magnesium gels; to no gain. I also experienced two long-term periods of counselling in which my pain had been addressed vaguely, as something that perhaps had symbolic meaning, but here too I was never able to get hold of anything useful. Through three cycles of analysis for my MA dissertation research I made greater sense of my own pain flare ups. In understanding why and when they would 'kick in', I learned that my pain had become a receptacle for excesses of affect – imagine the way a cup overflows once its capacity has been reached. I learned that my pain seemed to flare up in situations where I felt out of my depth, or impotent even. For example it would flare up during a dinner party where I felt tongue-tied and unable to keep up with the pace of conversation. Pain might also flare-up when counselling clients who were themselves heavily defended and thus we didn't seem to be getting anywhere. In later analyses I linked the pain to a loss of proprioception – literally our ability to perceive our own position and movement in space. This was meant figuratively: it was associated for me with situations where I felt I had lost my bearings and felt to be stood on shaky ground. Thus my lived experience of chronic pain was that it was situational and context-dependent and thus intimately related with my psychosocial experience. As I will demonstrate in this study, appreciation of my own chronic pain has shaped my understandings of psychosomatics, and my approach to working with psychosomatics as a therapist.

Once I completed the MA dissertation, I continued to volunteer for some months at a cancer support charity as a therapist. Then during 2015 I volunteered at HMP Leeds (Armley Prison). Finally, at the beginning of 2016 I began my first paid position as a therapist at the Charity and it was in this setting that I counselled each of the four participant clients³. The charity offered means-tested low cost therapy and was situated in a town in Northern England with challenging levels of poverty that was once economically centred on its textile industry. Throughout all my clinical working during this period I retained my interest in what I called psychosomatic presentations. Psychosomatic presentations were distinguished to me from ordinary 'organic' physical

³ For the purposes of protecting the anonymity of my participant clients I haven't named the charity in this thesis.

symptoms where they appeared to be patterned and related to the client's psychosocial experience either presently or historically. I read widely on the subject of psychotherapy for psychosomatic presentations and delivered lectures at the University on the topic each year following my own graduation. I also presented at research conferences, to patient groups⁴, to other practitioner groups in the NHS and third sector, and worked with Jane, John, and Dawn first on getting my autoethnographic study published in the form of a journal article (Hills et al., 2018b – was available online from 2016). I had the bit between my teeth and in May 2016 I got the news that I'd been successful in applying for a University Research Scholarship, starting the coming October. I remember driving into Leeds on my first day and, navigating the traffic through Hollin Park, I first spied the University of Leeds clock tower on the horizon, still a distance of 2.4 miles out according to Google Maps. I felt so proud to be part of the University – that clock tower became a central reference point for me over the next couple of years.

In answering Bonnie's question 'how did I get here' I visualise this in terms of space and time. I imagine myself within an evolving landscape that includes, for the purposes of this research: me; my participant clients; significant actors such as Jane, John and Dawn, my research supervisors; Steve my clinical supervisor; and beyond these to the professional communities of therapists and psychotherapy researchers at large. Within this evolving landscape is a continual conversation, described by Bakhtin (1981) as a *dialogue*. This dialogue is fundamentally dialectical – with syntheses emerging through the dialectic between one unique voice and the ones – at times the dialogue becomes oppositional, with different groups branching off into their own ideological tribes.

In the sections that follow I aim to provide a glimpse into my engagement – as a therapist and a researcher - with the different topics of interest of which I made sense within my own local context.

⁴ Note that throughout this thesis, where I am writing about people receiving counselling and psychotherapy they are referred to as 'clients' but otherwise when a person is being referred to in a medical context they are described as 'patients'.

1.1 What do I mean by embodied distress?

It is appropriate to start with etymology. The symptoms of interest would typically include chronic pain, fatigue, nausea, vomiting, irritable bowels, eczema or alopecia; but how would I refer to these? As I would relay to students when delivering seminars on this topic, there are a plethora of names to refer to phenomenon of physical symptoms which are associated with psychological experience. The classic term is *psychosomatic* – literally the union of psyche and soma. The psychosomatic term is typically associated with the work of Freud, his contemporaries and followers, but the origins of the word are in the eighteenth century Romanticism movement as a reaction to the prevailing enlightenment movement of the time which seemed to be reducing all life down to mechanical biology. Psychosomatic maladies were those that originated in the mind or the heart. Indeed centuries before the naming of them, psychosomatic expressions of the emotional life were part of popular imagination. It is possible to discern ten different somatic symptoms of grief throughout Shakespeare's canon with grieving characters experiencing vomiting, panting, toothache and their hair turning white (Heaton, 2012). As the last Catholic King of England, James II, went out to battle against William of Orange in 1688, he is said to have experienced a heavy nosebleed which was understood at the time as a psychosomatic reaction to seeing his own support haemorrhaging around him, before he eventually fled to France (Monarchy, 2006).

In the 20th century the term psychosomatic as understood by Freud and his contemporaries denoted the conversion of psychic distress into a physical symptom. For Freud psychosomatic symptoms were the product of repression with impulses being redirected towards physical tension in order that the person not experience the original distressful idea directly and consciously (Freud, 1954). Freud preferred the term *conversion*, and psychoanalysts to this day use the term conversion disorder to refer to physical presentations that appear to have originated in this way (Gubb, 2013). The 20th century saw a host of terms with much or complete conceptual overlap within both medicine and psychotherapy, including *somatisation*, *somatoform disorders*, and *psychogenic symptoms*. Nowadays it is rare for these terms to appear on a person's medical notes as they carry with them a subtext that a condition is unreal, imagined, all in the mind, and perhaps even that they are of the person's own fault (O'Sullivan, 2015). From about 1990 the use of the term *medically unexplained symptoms* (MUS) soared and whilst the literal meaning of the term is to denote somatic presentations for which

an organic aetiology cannot be discerned, in the subtext of the use of this term is that the symptoms have a psychological context. Whilst MUS is still the most frequently used term in the present day and may appear on a person's medical records, it is considered problematic conceptually because it not so much a diagnosis as the absence of one, and indicates uncertainty in treatment and prognosis rather than adding any clarity (IAPT, 2014). It has furthermore been criticised as a 'catch all' diagnosis for doctors who simply do not know what is wrong with their patients (IAPT, 2014). In the light of these criticisms, several alternative terms have been advanced including *functional disorders*, *bodily distress*, and *persistent physical symptoms*.

However the subtext of each of these terms remains the same and my personal experience approaching patient groups for people living with chronic fatigue syndrome, or fibromyalgia, and then later presenting my early research at conferences, is that the use of any of these terms attracted hostility, mostly for the same reasons that the word psychosomatic is no longer commonly used: that any such label was invalidating of the person's experience. For the avoidance of doubt the presentations I was interested in involved *real* physical symptoms that appeared to be aggravated by psychosocial distress. The emphasis on real physical symptoms is important in this statement – in this study I have not been interested in hypochondria or health anxieties per se. When it came time for me to settle on a term to refer to this phenomenon of interest for the purposes of production of the ethical review and the related participant information sheets, my supervisors and I decided we would refer to 'somatic symptoms' and this was the term that went on to the participant information sheet. A somatic symptom, we reasoned, denotes a physical symptom without any allusion to its aetiology. However conceptually referring to symptom presentations in this way allowed me the latitude to consider their psychological correlates and context. It is possible that given my recruitment process as described in chapter two that I might have recruited clients to my study for whom their presentations could have been characterised as hypochondria or pertaining to health anxiety. However as we will see from chapter three onwards as I provide clear clinical descriptions of my work with each of the four participants, these terms would not have applied to them.

During the course of my study I came to find the term 'somatic symptom' to be problematic too. Referring to somatic symptoms had the effect of compartmentalising my client's physical experience as being a focus in and of itself, detached from its holistic

context, as indeed referring to any symptoms would. I thus sought a term that didn't separate off symptoms at all, which was one of the appeals of the more recent term bodily distress (Fink and Schröder, 2010). Because emphasising bodily distress (e.g. as opposed to mental distress) might have the implicit consequence of perpetuating clunky Cartesian dualism I eventually settled on the term *embodied distress*.

Within the dialogue into which my voice is contributing, a cultural shift already seems to be underway. Creed (2016) argued that the lines between organic and medically unexplained symptoms were becoming increasingly blurred, such that the distinction was not a helpful one, with primary physicians encountering multiple presentations that might be considered to fall into both organic and medically unexplained categories in each consultation. However Winnicott's (1966) observation from more than half a century ago still holds conceptually true in my own understanding as applied in this project. For Winnicott what makes a symptom 'psychosomatic' is its dissociation from psychic events. These symptoms are still real symptoms but they are psychosomatic precisely because they've been cleaved away from the wholeness of experience in which they originated. As I will demonstrate throughout this thesis, my attitude as a therapist has been consistent on this matter – somatic symptoms, or embodied expressions of distress, are regarded as signposts to underlying psychic experience and this is where the true focus of the psychotherapeutic work should be. This places me in a different theoretical context to body psychotherapists who may engage with physical expressions as intrinsically meaningful. In the work with my participant clients I haven't encouraged sustained work on the communicative or symbolic qualities of symptoms in and of themselves as I found that richer, more productive work could be done elsewhere.

1.2 Effectiveness of psychotherapeutic approaches for clients with somatic-symptom type presentations

A short review of the present literature on the effectiveness of psychotherapeutic approaches for these presenting problems is also fitting at this point. In the general sweep of effectiveness studies in this area, the emerging picture is that psychotherapies can facilitate moderate but significant and sustainable improvements for clients with somatic symptom type presentations. Kroenke (2007) reviewed 34 randomised controlled trials on a variety of treatments for somatoform disorders and concluded that

cognitive behavioural therapies (CBT) were consistently effective in the alleviation of a variety of somatoform disorders. CBT approaches were the best evidenced of psychotherapies, although Kroenke recognised that only 2 of the 15 studies which featured psychotherapeutic treatments featured non-CBT approaches. Kleinstäuber et al.'s (2011) meta-analysis aggregated 27 studies on a variety of short-term psychotherapies – defined as less than 30 sessions or 30 weeks of therapy – for treatment of medically unexplained physical symptom presentations. These psychotherapeutic approaches were most commonly cognitive behavioural or psychodynamic approaches and the meta-analysis observed a small but clinically significant effect size on symptom improvement which was sustainable at follow-up. Koelen et al. (2014) produced a meta-analysis of ten randomised and six non-randomised trials of various psychotherapies for clients with a formal diagnosis of somatic symptoms disorder. They found that psychotherapies were more effective than treatment as usual (TAU) for alleviation of somatic symptoms and functional impairments and that these improvements were sustained at follow-up. Interestingly, Koelen et al. found no comparable improvement in psychological symptoms compared with TAU amongst this client group. More recently Liu et al. (2019) produced a meta-analysis of fifteen randomised controlled trials of cognitive behavioural therapies for somatoform and medically unexplained physical symptom presentations. They found that the CBT therapies could be associated with symptom improvement, and increased physical functioning, and also the alleviation of co-morbid anxiety and depression, and that these effects were sustainable at follow-up.

Taken as a round then, the evidence does appear to support the proposal that psychotherapeutic working with clients who presented with somatic or medically unexplained symptoms is effective, in terms of relief of physical symptoms per se. This does not of course tell us much about the mechanisms underpinning symptom relief. Are we for example seeing evidence of measurable symptom reduction, for example in the amount of skin covered with lesions or irritable bowel episodes, or subjective improvements in the experience of pain or fatigue, or all of the above? Neither do the meta-analyses provide insights into the nature of the clinical working that made these therapies effective, for example the underlying mechanisms of change. We will need richly described qualitative evidence in the form of case studies, and other smaller empirical studies to provide insights into those more complex clinical questions. In the coming sections I review the theoretical literature on psychotherapeutic approaches for

embodied distress presentations and offer my hypotheses about the mechanisms that appear to be indicated in existing literature.

There is however an ethical point to make here which is that the meta-analytic evidence supports my endeavour as an individual counselling practitioner to help my clients living with somatic symptom type presentations using psychotherapeutic approaches. The evidence indicates that a variety of psychotherapies may support improvements in the client's experience, physical functioning and symptom alleviation, but it does not of course necessarily follow that my approach as an individual practitioner will support similar improvements. I have invoked some quantitative data in chapter three in evidencing good outcomes for the four cases discussed in this thesis. Though primarily I have sought to evidence these good outcomes through qualitative data. In the mini-study in chapter six I produce a qualitative (hermeneutic) analysis of accounts of change and causality statements made in relation to the cases of *Jennifer* and *Myrtle*. As will be seen, the emergent picture is that good outcomes were well evidenced with some important caveats around questions such as placebo and expectancy effects, which will be explored.

1.3 Psychotherapy with clients who presented with embodied distress

When I first began my PhD I remember I went for a coffee with Jane and Dawn, and Dawn asked me an innocent and friendly question, along the lines of: what is the therapeutic approach you're developing for working with psychosomatic clients? I gave her a long and tongue-tied reply that didn't land. I surprised myself with how I'd struggled to provide the answer and explicitly observed this with Dawn and Jane at the time. Thinking back my difficulties stemmed from never actually considering the question formally. In the presentations I was delivering at the time I advised student-practitioners to:

- 'Treat symptoms as symptoms'; not to collude with the client's fixation with symptoms
- To encourage embodied awareness, especially noticing triggers and patterns underpinning symptom flare-ups
- To help with the management of impacts of quality of life and relationships; and

- The creation of ‘illness narratives’; the latter of which I’ll return to in this chapter.

Thus I started with a somewhat vague framework of assimilated ideas as and when they felt useful. In this section then I chart my subsequent engagement with the leading theories in psychotherapeutic work with this area and what I took (or rejected) from them.

Early on in my literature reviewing it appeared that in contemporary practice there were two leading psychotherapeutic ‘protocols’ for therapeutic working with psychosomatic presentations in an explicit, structured way. These came from the cognitive behavioural and psychodynamic/psychoanalytic traditions respectively. The first of these was Allen and Woolfolk’s (2006) *Affective Cognitive Behavioural Therapy* which was intended for somatising clients. Allen and Woolfolk’s protocol was planned over ten therapy sessions and in the early stages focused on teaching clients relaxation and behavioural skills before progressing onto clients learning to identify and describe their somatic experience better and develop their interpersonal skills. Allen and Woolfolk observed that somatic symptoms can be experienced more intensely at times of stress or indeed can be catastrophised as signs of serious illness and as such ‘dysfunctional cognitions’ may elicit negative emotions and dysfunctional behaviours. In the final stages of their protocol their clients are encouraged to renegotiate their ‘sick role’ which might have a perpetuating influence over the meaning clients are deriving from their illnesses and thus shaping their behaviours.

The second leading protocol was Luyten et al.’s (2012) *Mentalization Based Approach for the Treatment of Functional Somatic Disorders*. Luyten et al. observed that during times of heightened stress we seek out attachment figures – either real or internalised – and through our interaction seek to downregulate stress. Deficiencies in mentalization - i.e. ‘the capacity to interpret oneself and others in terms of mental states’ (Luyten et al., 2012, p.126) - mean we are not able to down-regulate stress through ‘the attachment system’ and this is associated with the emergence of functional somatic disorders. The Mentalization-Based approach spans sixteen sessions, the first four of which are dedicated towards identifying attachment patterns exhibited by the client that appear to be associated with the onset or perpetuation of symptoms, rather than to ‘force’ a biopsychosocial concept on the client. In the middle stages, spanning eight sessions, there are some commonalities with the cognitive behavioural protocol, with a focus on

the interpersonal contexts of physical symptoms, developing clients' 'capacity to reflect on self, others, and self in relation to others' (Luyten et al., 2012, p.133) including linking somatic affect to interpersonal experience and vice-versa. The final four sessions of Luyten et al.'s (2012) protocol involved the co-creation with the client of a 'goodbye letter' that they take with them which sets out realistically what has been learned and achieved, but also what had not been achieved .

The appeal of these approaches to health service commissioners is that they offer a structured, time-limited approach that can be deployed as treatments alongside other medical interventions. However in practice my interventions were highly sensitive to what my client was 'bringing' in that moment and if I attempted to schedule what kind of work we should do when, this strategy was often abandoned mid-session as inappropriate for the present quality of the work. Rather what I took from engagement with these protocols was their practical and targeted emphasis. I found Woolfolk and Allen's conceptualisation of the 'sick role' particularly compelling and this fed into my thoughts about how my own clients would develop an 'illness identity' which would need to be re-authored if they were to make progress. Mentalization – which I return to later in this chapter - was at the heart of Luyten et al.'s (2012) protocol but was an idea that I only began to understand and appreciate clearly towards the latter stages of my data collection window. Before understanding the term mentalization I nonetheless was encouraging my clients to reflect upon and challenge their self-constructs. I also appreciated the emphasis both protocols placed on the relational quality of their somatic experience: that clients' self-constructs emerged through their relationships with others and these were the terms under which they would make sense of their somatic experience.

It is also important to observe that what I practised was talking therapy as opposed to body therapy. Talking therapy was how I was trained during MA at the University of Leeds, and body therapy would have been a significant departure for me as a practitioner. Orbach (in Corrigan et al. 2006, p.71) argued that since the 1950s the body has been treated by psychotherapists like a 'dustbin' for everything the psyche can't cope with. Her critique was targeted at the traditional psychoanalytic framing of somatisation but indeed as a patient I'd learned during my MA dissertation research that my somatic symptoms did flare up in the times my psyche couldn't cope – I likened it to an overflow system in a sink. In critiquing the psychologising of the body Orbach

goes on to argue that bodily distress needs to be addressed through the body. Totton (2014) argued like Orbach that we should engage with the body on its own terms and proposed a style of working that progresses through a hierarchy which begins with physiology, and progresses through feelings, fantasies and then latterly to thoughts and beliefs. McDougall (1989) similarly encouraged her clients to describe their symptoms in terms of imagery and fantasy in order to develop their capacity to symbolise their somatic experience.



Figure 1: Totton's hierarchical model of embodiment (2014)

Gubb (2013), on the other hand, in reviewing the leading psychoanalytic approaches to somatisation argued that the most important psychotherapeutic interventions to treat bodily symptoms are made through speech, as mentalization is conceived of as the universal mechanism across different psychoanalytic approaches. What appeared to me to be the essence of the distinction between what Orbach and Totton were saying on the one hand and psychoanalysts like Gubb on the other is either that embodied presentations were psychologised – and thus that the underlying psychic constructs are the site of the work – or rather whether they should be engaged with on their own

terms, permitted to blossom through symbolisation and fantasy. With reference to Totton's hierarchy, one approach might be described as top-down and the other bottom-up. I don't claim in this thesis any capacity to be able to resolve these different viewpoints except to suggest that in the end both approaches encourage the client to reflect on their psychosomatic experience as an active rather than passive process, in that it is made up of layers of meaning, with these meanings fluid rather than rigid. This indeed was the attitude that I took into my clinical working.

As will be demonstrated, throughout 2017 (e.g. in the run up to the commencement of data collection in November 2017) my framework for practice become increasingly oriented around what I describe as a narrative-dialogical approach. At the heart of dialogical psychotherapy is the notion that selfhood itself emerges through dialogue with others. During 2017 I paid a lot of attention to the construction of one's self, one's sense of identity and how they stood in relation to others; including the internalisation of ideas about what aspects of our selves are acceptable and which are unacceptable. Freud (1926, p.98) observed that the purpose of the ego was to 'bind together and unify', to 'synthesise'. In Freud's account of the emergence of the psychosomatic symptom, if the ego cannot admit the repressed impulse, then it instead identifies with the symptomatic representation. I imagine generic examples: if a situation is so frightening that it gives us palpitations, in this repressive state we think not about the original source of the fear but about the palpitations themselves, perhaps fantasising that we are having a heart attack. If a situation is so disgusting that it makes us vomit, in the repressive state we think not about the original source of the disgust but become fixated with the vomiting. The ego – in Freudian thought – is the integrated version of self that we present to the world, that is acceptable in the world, and 'works' relationally. I see a link here back to Woolfolk and Allen's conception of the 'sick role'. Winnicott (1966, p514), writing later, presented this process of dissociation more directly on dialogical terms. For Winnicott the process of increasing integration of soma and psyche is the basis of ego development – such that he named the process 'personalisation'. Psychosomatic illness for Winnicott originated when this process broke down. He described this stage of integration as the 'I am stage'. What I as a therapist took from this was that a person's embodied experience was bound up within an integrated sense of self. To whatever degree each of us, including my clients and I, arrive with a version of self which is functional enough that it 'works' for us in our relational worlds. However these versions of self may be associated with certain

physical patterns, literally the way we 'hold' ourselves, that might be responsible for the somatic symptoms that we complain about in the therapeutic interview. A parallel strand in my reading, from theory that came directly from the narrative-dialogical tradition of psychotherapy seemed to point in the same direction. Hermans first conceived of the *I-position* in the early 1990s (Hermans et al., 1992). I understand an I-position to describe the way that we as people can present as different versions of our selves, speak with different voices etc. depending on audience and situation. Thus each self can occupy and perform multiple I-positions throughout the course of a single day, and indeed acquire new I-positions and let go of old ones as we progress through life. Ribeiro and Gonçalves (2010), developers of the *innovative moments coding system*, applied the concept of I-positions to therapeutic change. Ribeiro and Gonçalves observed that the concept of the I-position could be superimposed onto an existing concept of therapeutic change in narrative therapy – the process by which a client begins to re-author their 'story' from what is originally a problematic or dominant self-narrative, towards a transformation in their self-narrative. Crucially for Ribeiro and Gonçalves, a transformative self-narrative is not only to be told but to be voiced and performed.

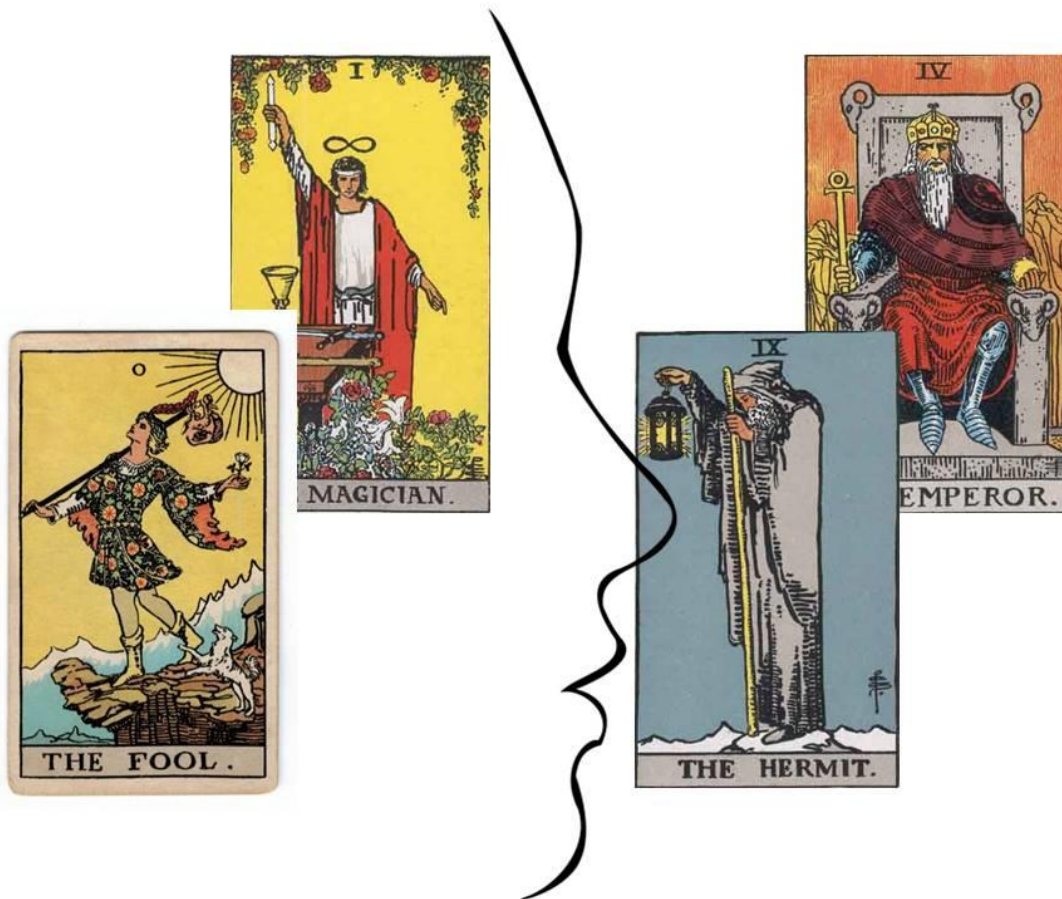


Figure 2: A visual analogy of I-positions as I understand them

Here I understand the self – as represented in figure 2 - as an open and transparent profile, taking on personas that each have their own styles of cognition and points of reference. These I-positions provide a structure through which the self enters relations with others.

I first came across Ribeiro and Gonçalves' work early in my PhD study, and it resonated strongly with my emerging understanding of what the literature was saying about change in psychosomatic experience. The roles of illness narratives (Kirmayer et al., 2004; Launer, 2009), of sense making and contextualisation of symptoms (Kozłowska and Khan, 2011; Toren and Luca, 2017) and of illness beliefs and illness identities (Allen and Woolfolk, 2006; Town et al., 2017) were associated not just with the person's quality of life whilst living with medically unexplained conditions, but also in some cases their symptom experience and prognosis for recovery. Kaplan (2016) observed that where her patients were able to tell a story about their psychosomatic symptoms these could be built upon in psychotherapy, and conversely that where they presented with a

list of complaints without a coherent narrative that this was associated with a poor prognosis. More recent research, for example McNaughton et al. (2018), appears to challenge the association between the lack of aetiology (an explanation for the cause or origins of symptoms) and subjective distress associated with physical symptoms. However in their randomised controlled trial comparing distress amongst people living with medically unexplained and medically explained pain, McNaughton et al. did observe an association between low self-efficacy, activity avoidance and somatic focus. I return to self-efficacy and its related concept subjective competence later in this chapter but it was and remains my understanding that where clients were able to tell a story about their somatic experience that this enhanced their experience of self-efficacy or agency i.e. that the development of a self-narrative was a moderating factor in the development of self-efficacy, as is evidenced across the four cases in this study. No more cogently has the concept of the illness narrative been delivered than through Arthur Frank's *The Wounded Storyteller* (1995). Frank was able to identify within ways we make sense of our embodied experience four different 'ideal body types'. The first three – the disciplined, the mirroring, and dominating body types - typified by dissociation and alienation – were superseded by the *communicative body*, which was for Frank an image of psychosomatic unity and was fundamentally dyadic in nature; coming into being through relationships with others. Physical illness for Frank thus manifested within a narrative-dialogical field.

During 2017 a model of change began to take form that proved the basis for all the successive theoretical developments I would make. I came to believe, as a working hypothesis, that if clients were able to renegotiate a new, more adaptive version of self in their relational worlds that this would correspond to a relief from psychosomatic symptoms. I became increasingly attracted towards a narrative-dialogical approach to working with my clients believing it was well supported by evidence from the literature about what had been helpful for people seeking therapy for somatic presentations and would be most congruent with my emergent hypothesis about what change would look like and how it would be facilitated, as discussed later in this chapter. However also at the beginning of my PhD study I began the production of a qualitative (meta) synthesis of existing case studies describing therapeutic work with this client group, with a view to having this published as a stand-alone piece of research (Hills et al., 2020). The theoretical interest driving the meta-synthesis was to identify mechanisms of change (Kazdin, 2007; 2009) which appear to have been attributed to successful therapy in the

selected case studies. The concept of mechanisms of change spoke to my seminal interest in this study about how change is facilitated. To enquire about mechanisms was to enquire as to specifically which therapeutic (or extra-therapeutic) events or processes may be attributable to change within the overall narrative of the therapy; the idea being that these mechanisms may be observed to transcend the particular theoretical discourses the accounts of change were wrapped up in. I was as such searching for transtheoretical mechanisms of change which might be observed to be at work across different modalities in therapy for this client group. In the following section I review what I learned from reading and reviewing case studies and other qualitative research in the production of the meta-synthesis; the interim findings of which also heavily influenced the approach and the interventions I took into the room during the period of data collection.

1.3.1 Mechanisms of change in existing case study and qualitative research

In identifying mechanisms of change that appear to have been at work in existent qualitative evidence, several general mechanisms emerge in which clients living with somatic symptoms, or embodied distress as described in this thesis, are observed to be:

- Developing competence in symptom management: deepening understanding of somatic experience, and development of techniques, associated with less fear and reactivity to symptom flare-ups
- Psychosocial linking: Learning to link their somatic experience within wider psychosocial contexts – either in present relational systems, or to associate them with historical traumas
- Developing relational competence: and/or the capacity to mentalize, which in some cases resulted in changes within a relational system to which the person belonged
- Transcending physical experience: through the discovery of higher meanings or purpose

In this section I will review evidence for each of these general mechanisms and through application to particular cases demonstrate further how these mechanisms may work in therapeutic reality.

Developing competence in symptom management

In Kozłowska et al.'s (2016) case study of Evan, a 10 year-old boy who was suffering from Psychogenic Non-Epileptic Seizures (PNES), a key component in Evan's successful therapy was when he learned a technique which he came to know as 'riding the wave'. Evan was informed that it might not always be possible to catch and stop a PNES but rather when one came he would try to ride it out as one would a large and rough wave. This the authors credit with the client being able to retain a sense of control in situations where the PNES surges but furthermore not to feel demoralised or guilty.

Acquiring a sense of mastery was also observed in in Payne (2015) who offered a case study of 20 year old woman participant who was encouraged by the facilitator of the BodyMind[®] group for clients in the UK with medically unexplained symptoms (MUS) to leave her wheelchair and to take part in sensory-motor exercises on the floor. Using her hands and feet she was able to make contact with other members of the group and even to lead exercises, mirroring those movements that she chose to. This experience Payne credits with enabling the client to abandon her 'victim position' and to 'enter a more active space' where 'pain is not in charge' (Payne 2015, p.25).

Doran (2014) observed sixteen participants with persistent back pain who were learning pain management techniques through a mindfulness course and interviewed them at completion of the course. The theme of "embodied awareness" emerged as the core finding of Doran's study as all sixteen participants experienced change in how they experienced their pain. Through meditative practice participants learned that they could intervene in the 'vicious circles' of their pain, learning to be less reactive to pain flare-ups, instead to accommodate pain and to remain present-focused. *Sarah's* quote, for example, reflects the way participants learned to transition from a passive to a more active or competent position when confronted with pain flare-ups: "I found if you give pain space it's a lot better, rather than trying to get rid of it, because then you build emotions up and things tense, and this brings more pain on" (Doran 2014, p.753).

Across a number of studies clients achieved a sense of mastery through therapeutic exposures, traditionally the domain of cognitive behavioural therapies. The cognitive behavioural protocol offered by Allen and Woolfolk (2006) for working with clients with medically unexplained symptoms includes recommendations including the client being encouraged to delay a visit to see their physician (which would ordinarily be motivated by anxiety about symptoms) in order to test out the consequences. Colognori et al. (2014) reported on the case of Andrew, a 17 year-old student who was suffering from chronic headaches which were found to be related to high school tests and assignments – Andrew being very anxious about getting into an Ivy League college. In this study Andrew worked with his therapist in developing an exposure technique in which he was encouraged to make a deliberate mistake in his homework and arrive for class five minutes late. In this way Andrew transitioned from a state of relative passivity in his anxiety to one of relative control and experienced significant relief in the intensity and frequency of his headaches. Likewise in Okita et al (2013) Yu, a 14 year old boy suffering with chest pains developed a distraction technique whereby when he felt his pain coming on he would run through the names and shirt numbers of all the players of his favourite baseball team. His success in controlling his flare-ups in this way the authors credit as enabling him to recognise that his symptoms had a psychological basis.

Exposure-based mechanisms are also observed in third-wave treatments for embodied distress presentations. In Graham et al. (2015) a client named John began a course of Acceptance and Commitment Therapy (ACT) after suffering with anxiety associated with chest pain and dizziness following a stroke in his early forties. He was encouraged to become mindful of his own thoughts and thus to foster a sense of distance from them, e.g. by framing his observations as 'There goes that old story X again'. Furthermore, John was encouraged to personify his chest pain and settled on it being an annoying television character. In so doing, John learned to accommodate his anxiety without experiencing being merged or inseparable from it. In another case study from the same research group, Claire also began ACT in her early twenties, presenting with pelvic spasms and muscle weakness (Graham et al., 2017). She was encouraged to develop a metaphor within her therapy that her unwanted thoughts and feelings were like passengers on a bus that she was trying to drive in the direction of her values. Through extended use of the metaphor, Claire came to recognise that she could continue to travel in a personally meaningful direction, even with those unwanted passengers as part of her experience.

Cooper et al. (2017) observed the importance of emotional expression as a mechanism underpinning successful psychotherapeutic work in a specially created service for clients (patients) with MUS in two primary care settings in Canada. Cooper et al. emphasised the importance of clients realising the negative impacts of emotional suppression on their symptom experience. Where clients embraced this new way of thinking and learned to express their emotions they were presented with 'infallible evidence' of the importance of emotional expression by way of immediate change in somatic experience in their own bodies. As a practitioner encountering this evidence I was left wondering whether emotional expression per se was the mechanism of change driving the success of these therapies, or whether framing somatic experience within the terms of emotional expression permitted clients a sense of mastery (or subjective competence) over the somatic experience where they had felt passive and disempowered before. I return to the concept of subjective (in)competence in section 1.8.

Psychosocial linking

In the first decade of the new century, there was a widely held understanding within family medicine, in the UK as in other nations, that one of the challenges faced by GPs in working with people suffering with medically unexplained symptoms was their resistance to the possibility that psychological or psychosocial factors could be associated with symptom flare-ups (Edwards et al., 2010; Gask et al., 2011). The subsequent development of the *retribution model* was a structured, cognitive approach practised by GPs to help them guide their patients to 'reattribute' their physical symptoms to psychological causes such as stress or anxiety, however this approach met with only limited success in practice (Gask et al., 2011). Allen and Woolfolk (2006) in advancing their cognitive behavioural protocol emphasised that the therapist must avoid directly challenging the client's own beliefs about where their medically unexplained symptoms come from. Recognising that a direct challenge would simply reproduce the client's perennial experience of being disbelieved or their views being invalidated, instead Allen and Woolfolk advanced an approach of adding to the client's own formulation. Whatever cause the client attributes to the symptoms the therapist is always in a position of being able to demonstrate how dynamics such as stress or beliefs about symptoms can aggravate and amplify the person's experience of their somatic symptoms. This consensual approach to formulation was also advocated

by Luyten et al. (2012) in their mentalization-based approach for clients with functional somatic disorders. Notwithstanding therapists' tentativeness in offering these alternative formulations, I found within the literature qualitative evidence indicating success in the linkage of somatic experience to psychological and psychosocial factors, where people were in psychological therapy, and that where they were able to make these connections they could recontextualise their symptoms and experience them differently.

Abbass (2005) described a process of therapeutic reattribution that occurred within the here and now of therapeutic process in which the therapist draws attention to psychosomatic experience as clients appear to be talking about certain relationships, offering the example of a client whose symptoms of heartburn flared up talking about her fiancé.

There are frequent examples of successful events of linking which appear as epiphany moments within contemporary psychotherapy case studies. For instance, Kozłowska et al (2016) identified Evan's PNES (see previous section) as a consequence of hyperventilation and observed Evan hyperventilating when talking about bullying that he'd experienced since the second year of school. Furthermore Evan identified a particular experience when he had been hit by a fellow student and knocked to the floor bumping his head. He had not told his parents about this incident.

Similarly in Dimaggio et al. (2013)'s case study Angelo, a 38 year-old male presented with urinary and faecal incontinence. During his therapy Angelo recalled childhood humiliation and physical abuse at the hands of his father, the encounters were so frightening that as a boy Angelo felt a pressing need to urinate and anxiety about not getting to the toilet in time – a pattern that had continued into adulthood.

Quinn et al. (2012) presented the case of Peter, a 42 year-old man, who had recovered from his PNES during psychotherapy. A significant therapeutic event as reported in the study was when Peter's therapist suggested an apparent similarity between Peter's childhood tendency to curl up in the foetal position and shake during his parents' arguments, and the physical expression of his PNES in adulthood. When his therapist encouraged him to explore the affect associated with the physical expression, Peter was able to associate how he felt during childhood with present-day experiences of workplace bullying.

Developing relational competence

As clients learn to manage their symptoms better, identify their feelings, and the psychosocial contexts of these Allen and Woolfolk (2006) go on to advocate building the client's relational skills as the next stage of their cognitive behavioural approach. This rests upon techniques such as encouraging clients to use 'I statements' in relational scenarios associated with affect. For Allen and Woolfolk this had a number of benefits including clients learning to assert themselves, being less likely to be repudiated by others as they are owning their subjectivity in those scenarios, and being able to take personal responsibility for their experience. These approaches are again mirrored in Luyten et al.'s (2012) mentalization-based approach in which the client also builds relational competence with a more direct focus on taking ownership of their own experience and appreciating the experiences of others.

This mechanism lends itself to systemic approaches to working with this client group and there are a number of examples in contemporary psychotherapy case studies where individual change was embedded in systemic change and/or depended on the individual repositioning themselves within the system. For example, in Theodoratou-Bekou et al. (2012) a 15 year-old girl presented with severe asthma attacks over which she felt she had no control. During therapy an 'alliance' was uncovered between the girl and her mother, she feeling as though she had to protect her mother from her father's criticisms by herself taking responsibilities for the upkeep of the house. As her grades slipped, she endured criticism from both her parents, who also blamed her for their own fatigue – she was undertaking her duties around the house too slowly. In therapy the girl was encouraged to look at specific examples of where the girl had tried to influence exchanges between her parents but had ultimately been ineffective. Furthermore she began to understand that a teenager should not sacrifice their own health for the sake of her parents, particularly as she wasn't able to make a difference. In the case study the girl's achievement of a greater degree of relational competence is associated with an enhanced ability to manage her own asthma attacks.

The relationship between mother and daughter was observed to be instrumental in the case of Sarah, an 11 year-old girl presented by Colognori et al. (2014) who was suffering with daily nausea, gas and abdominal pain, meaning that she was missing school given anxieties about having an accident, not getting to the toilet in time. Meeting with the

paediatrician Sarah clung tightly to her mother, and her mother sought constant reassurance about her parenting skills. The paediatrician made several behavioural interventions and Sarah made progress however her school attendance was still very poor. When asked about this her mother explained that she didn't want to push Sarah into going to school when she was anxious. The paediatrician explained to the mother that she was validating Sarah's anxieties and instead she was encouraged to praise Sarah when she showed bravery and was able to manage her symptoms independently. The paediatrician understood this to be an example of an overprotective parenting style in the mother that fed Sarah's separation anxiety.

Transcending physical experience

Finally, several sources of evidence supported the idea advanced through third wave approaches such as Acceptance and Commitment Therapy that the client may shift in relation to their embodied experience – where originally it is centrally-defining in one's sense of self and the quality of life that they can lead, through a process of repositioning clients are able to access different states of selfhood and realise a different quality of life in which physical symptoms are still present but no longer the same centrally defining influence. Kornelsen et al. (2015) reported their findings on a phenomenological study interviewing thirty-eight Canadians living with medically unexplained symptoms. Amongst their findings they observed a distinction between states of resignation and states of acceptance in participants. Whilst on the surface of it this distinction might appear to be a nuanced one, it had tangible impacts upon quality of life. Participants who were accepting of their condition were in a psychological position to look beyond their diagnosis and take active steps towards increasing their quality of life; whereas resigned participants felt defeated by their conditions.

Liersch and Maher-Edwards (2017) advance the idea that selfhood is to be treated (and modelled therapeutically) as a process rather than a state. They describe therapeutic working with Paul in which emphasis is placed on choice: not the capacity of Paul to choose his chronic pain, but rather his choice of the kind of life that he would live with chronic pain. Would Paul be the loving grandparent cradling the newborn baby despite his chronic pain or would he choose to sit staring into an empty room given the limitations of his pain?

By a similar token Patel (2016) describes her therapeutic work with Louise whom had found her life increasingly dominated and defined by her chronic pain. In the therapy, Louise gradually took steps to reclaim her life: beginning with household chores and graded exposure to exercise, she expressed an increasing determination. Louise also took proactive steps to address her loneliness and negotiated with her GP a gradual tapering of her pain medication. The meaning of these behavioural steps for Louise was to redefine herself as a strong and independent woman whilst living with chronic pain.

Returning to the study by Doran (2014) who observed and interviewed participants of a mindfulness course living with chronic back pain, she advanced an interesting concept of *the resolution of liminality* based on her observations of participants that appeared to be 'stuck' on or suspended in their pain, and those who had managed to break through and become unstuck. Doran's descriptions of liminality appear to point towards the participants' ability to take existential responsibility for their lives: ambiguity and uncertainty give way to insight and self-definition; thus recontextualising the meaning of their pain and being able to regain a sense of control.

Thus the review of existent evidence from case studies and other qualitative studies highlights four general mechanisms of change which supplement the theories of therapeutic change when working with this client group that were summarised in section 1.3. During my study I was fascinated by the potential of mechanisms of change as offering translatable and transtheoretical concepts of change across diverse therapeutic styles and approaches. However I was also motivated by the question of whether a consistent synthesis between these mechanisms was available, or alternatively whether it was possible to identify a higher-order mechanism. In section 1.8 I introduce the works of Allen, Fonagy and Bateman (2008) who advanced *mentalization* as a higher-order mechanism of change, and those of Dimaggio et al. (2007) for whom *metacognition* was that higher-order mechanism. Whilst as a practitioner during the period of data collection I was still only getting to grips with these big ideas in psychotherapy, in retrospect I believe they may be observed to offer the theoretical foundations for the model of change which I took into data collection and which continued to evolve over that year.

1.3.2 Innovative Moments and Change

As previously observed, the concept of the *innovative moment* (Gonçalves et al., 2009a; Ribeiro and Gonçalves, 2010), developed by Miguel M. Gonçalves and colleagues at the University of Minho, offered me an exciting theoretical bridge between practice and research at the beginning of my data collection period. An innovative moment was defined as an event in therapy that would have not have been predicted by the client's problem-saturated or dominant self-narrative (Gonçalves et al., 2009a). The innovative moment concept was born out of an emerging understanding amongst Gonçalves and colleagues that the earlier concept of *unique outcomes*, denoting those same moments of departure in narrative therapy, could take on one of five qualitatively distinct forms: action, reflection, protest, reconceptualization, and performing change (Gonçalves et al., 2009a), which I will return to later. Gonçalves and colleagues thus developed the *innovative moments coding system* (IMCS) to track the emergence of these qualitatively different innovative moments in psychotherapy change process research (Gonçalves et al., 2011).

The reason the innovative moments concept was so attractive to me as a practitioner researcher was that it was immediately accessible to me in the real-time of therapeutic process with my clients. Often within sessions I would observe those subtle but perceptible shifts in the client's self-narrative, would see potential in these and hope to bring these into my clients' conscious awareness. I associated innovative moments with the concept of *indexicality*, one of the three sign-functions as advanced by Charles Sanders Peirce (1903) as part of his semiotic theory, which had since my undergraduate degree been a fascinating idea for me. Indexicality denotes those properties of a thing that convey information about a phenomenon to which the thing belongs. For example, the hoof prints of an animal in the sand might be 'read': the tracker may discern the species of the animal, which direction they were headed, even the speed they were travelling. Likewise a blood test which identifies levels of certain chemicals in the blood may contain information about a person's underlying health conditions, their diet, alcohol intake or medicine use. As an early-career therapist I placed a lot of stock on the idea that my clients may present with indices of change, which may be so subtle that if I was not paying enough attention I might miss, but if I could alight upon the significance of these indices then I could offer powerful and potentially very useful observations for

my clients (Hills et al., 2018a). The concept of innovative moments then seemed to offer a clever and established means of researching indices of change, comfortably straddling research and practice. In those months leading up to the beginning of data collection I conceived of the therapeutic process as the first stage of a qualitative analysis – with both client and therapist observing innovative moments in real time which could then be coded more formally in the playback of recorded sessions.

Beginning my PhD study in late 2016, Gonçalves and colleagues had already embarked on a program of study investigating the validity of the innovative moments concept of psychotherapeutic change and the usefulness of the IMCS, and their program continued throughout my own study. Through a series of hypothesis-testing and case study comparisons of good outcome and unchanged cases the Minho group were able to discern the different patterned appearances of innovative moments in these different outcome groups. Innovative moments that could be coded in the following ways were observed to appear in the initial stages of both good outcome and unchanged cases:

- Action – the client performs an action (e.g. in the seven days between sessions) which would not have been anticipated by their dominant self-narrative
- Reflection – the client comes to a new understanding that contradicts their dominant narrative
- Protest – the client proactively rejects the dominant self-narrative or its inherent assumptions (Gonçalves et al., 2010; Gonçalves et al., 2016)

The consistent differences between good outcome and unchanged studies was observed in middle to latter stages of the person's therapy. In these stages innovative moments categorised as reconceptualisation (and in some case performing change) would be observed in the good outcome cases, but these latter forms of innovative moments would be virtually non-existent in unchanged cases (Gonçalves et al., 2016). A client performing change means that they are engaging in projects or experiences that would have been impossible before given the prevailing dominant narrative (Gonçalves et al., 2010). A reconceptualisation is that category of innovative moment in which the client is able to take a metacognitive position of not only being able to contrast what life was like then (e.g. at the beginning of therapy) with how it is now, but also to comment upon the process of change e.g. how the client managed to make this progress (Gonçalves et al., 2010). I return to the concept of metacognition later in this chapter in section 1.8. Additionally the Minho group were able to evidence that the emergence of innovative

moments was a stronger predictor of symptom relief as reported in the following session than the converse situation in which one might expect more innovative moments following an experience of symptom relief (Gonçalves et al., 2016). Here too the improvements in symptoms were associated with the emergence of particular innovative moments, namely: reflection, reconceptualization and performing change.

In this program of study the role of ambivalence in the therapeutic process was also highlighted. Ambivalence as conceived of through innovative moments reflected the client's ambivalence about the relative lack of predictability and thus discomfort associated with the emerging alternative self-narrative. Clients may be observed to resolve this discomfort through an attenuation of the dominant (problematic) narrative, doubling down on that which was more predictable, even if painful and undermining, at the expense of the alternative self-narrative. In early studies this approach to resolution of that ambivalence, in favour of stability, was associated with poor outcome cases (Ribeiro and Gonçalves, 2010). In keeping with their other research on the association of innovative moments with symptoms, the Minho group were able to evidence that the appearance of ambivalence markers was a stronger predictor of symptom aggravation as recorded the following session rather than the converse case in which ambivalence might be expected to be expressed following an aggravation of symptoms (Gonçalves and Ribeiro, 2017). There is therefore a case to be made for the role of the therapist in reinforcing and amplifying performances of the alternative self-narrative. As such the Minho group also investigated the therapeutic collaboration in the facilitation of change. Conceiving of narrative change in psychotherapy as a developmental process, Ribeiro et al. (2013) developed the *therapeutic collaboration coding system* to track this correspondence of the relational dynamic with the client's migration between self-narratives. Through analysis of client and therapist interactions in both good and poor outcome cases Ribeiro et al. observed that therapist interventions were pitched at an appropriate developmental level -with reference to Stiles' (2001, 2011) stages in the *assimilation of problematic experiences* - in order to facilitate narrative change rather than the client doubling down on the original, problem-saturated narrative. I consider further some of the findings of this study in the mini-study at the end of chapter four.

By 2017, during the early stages of my PhD, the recognition that the different types of innovative moment were associated with different levels of sustainability in therapeutic change led to the Minho group enacting a significant change to the innovative moments

coding system. The original five forms of innovative moments were to be superseded by (and subsumed within) a new taxonomy in which innovative moments were coded according to three different levels: Level 1, Level 2, and Level 3 (Gonçalves and Ribeiro, 2017). The three innovative moments more typically associated with the early stages of therapeutic process: action, reflection and protest events would be coded as Level 1 and Level 2 innovative moments, whereas reconceptualization and performing change events would be coded as Level 3 innovative moments. However the subsequent definitions of the three levels might be summarised thus:

Level 1 These passages are the first signs of novelty: a client is able to stand apart from their dominant narrative e.g. to observe its effects, or its lack of coherence, or otherwise to express a need to move beyond it. Alternatively a client might report on an event outside of therapy which would not have been predicted by the dominant self-narrative.

Level 2 These passages either reflect an understanding by the client that the novelties that are emerging are part of a *process*, or that the client makes a *contrast* with their experience now compared with their experience before without observing the process underpinning that shift. In other words Level 2 IMs are defined by *Process or Contrast*.

Level 3 In these passages clients both demonstrate an understanding of the process through which novelties are emerging and are able to make comparisons between their experience now and how it was. These utterances tend to be the most elaborate representations of the client's alternative self-narrative. As such Level 3 IMs are defined by *Process and Contrast*.

(Gonçalves and Ribeiro, 2017; Nasim et al., 2018)

Note that as reflected visually in figure 3, Level 1 innovative moments are the first indicators of an emergent self-narrative, on Level 2 that self-narrative takes its form, and on Level 3 the same pattern is proliferated and is contrastable with other self-narratives

It was this revised approach to coding for innovations which informed my own approach to coding during the period of data collection. In keeping with earlier research on the association of different types of innovation with change, Level 1 innovative moments were observed at the same frequency in both successful and unchanged therapy cases,

but Level 3 innovative moments had the stronger association with symptom improvement (Fernández-Navarro et al., 2019).



Figure 3: A visual analogy of the three levels of innovative moment

1.3.3 A narrative-dialogical approach to practice

A fly on the wall view of me in practice at the start of data collection in November 2017 would see me applying core skills picked up during my training in Counselling and Psychotherapy – essentially the ways in which I held the core conditions with my clients (Rogers, 1961) - and introducing additional elements into the work, most notably during this period a narrative-dialogical form of practice. The narrative-dialogical approach began with a sensitivity to a certain quality of the content of what my client was telling me. Beyond encouraging my clients to reflect on what they felt, thought, or did, I would listen out for indications of *who* was doing the feeling, thinking, doing etc. For example was my client occupying a socially confident or assertive I-position, or one that was withdrawn or passive? Was my client the responsible adult, perhaps feeling they had to hold everything together, or a vulnerable child, calling out for someone to sweep them up and take care of them? In modelling my identification with this concept of I-positions I would suggest to my clients these impressions e.g. *it sounds like in this situation you feel to be an imposter, and you're working so hard to ensure that nobody finds you out.* At other times I would encourage my clients to try to describe that I-position – who they are in these moments they are telling me about – was it like a certain character from a

story, or from a TV programme? Could we give this character a name, so that we can easily refer to him/her/it? The most significant therapeutic advantage for my clients – whether they presented with embodied distress or not – was that by identifying with an I-position they were able to step apart from it, sometimes for the first time in their lives, and start to understand that they weren't merged with it, or fated to play out the same patterns forevermore. This process of standing apart was termed in by White (2007), the founder of narrative therapy, as 'externalising the problem'.

Identification with an I-position thus became the vehicle for my clients with which they started to consciously construct their 'illness narratives' – a therapeutic process associated with improved prognoses and outcomes as discussed in the previous section. An I-position doesn't just emerge in contemporary experience but itself has a history. One question that can be helpful for clients is 'how old is this version of you', or 'at what age did this version of you appear'? This line of enquiry offered my clients a relatively lucid way to link their contemporary experience to their life history.

However the I-positions frame offered another opportunity for my clients. Where a client was able to identify with an I-position as being just one part of them, the opportunity that then arises is to be able to make contact with alternative versions of oneself, indeed alternative versions of self that a client might 'perform' in certain situations that might be associated with distress. *Michael* and *Jennifer* particularly embraced this way of thinking of therapeutic change. The theoretical possibility of I-positions meant I had to develop as a therapist a particular sensitivity to what are described in narrative therapy as 'unique outcomes' (Freedman and Combs, 1996), which provided the theoretical basis for Ribeiro and Gonçalves' later concept of the innovative moment (2010). A unique outcome is essentially any utterance or report from the client that would not have been predicted within their dominant – typically problematic – self-narrative. My responsibility as a therapist was to be sensitive to the emergence of these unique outcomes, some of which could be very subtle, and draw attention to them – what can we learn from that, and who were you in that moment? Work on a unique outcome is regarded in narrative therapy a little bit like the first suggestion of land spotted by sailors out at sea – it might just be a piece of seaweed floating in the water, or a flock of birds flying in a purposeful direction. Pursuing a unique outcome, more data begin to appear and a pattern starts to emerge in the form of an alternative self-narrative. The more detailed this self-narrative becomes, the

easier it is to recall and perform in the seven days between sessions. This was the basis of my practitioner approach to change and I had some good results with both participant and non-participant clients during that period.

1.3.4 Pluralism

As will become clear from my accounts of the therapeutic work with the four participant clients, as documented from chapters three through seven, my practice might also be described as *pluralistic* in nature (Cooper and Dryden, 2016; McLeod, 2018). This was an observation made by John McLeod when I presented my thesis at the British Association for Counselling and Psychotherapy (BACP) Research Conference in Belfast, May 2019. Across the four cases a range of strategies were deployed where they were helpful for the client, including cognitive behavioural exposure-type work in work with *Michael*, and psychodynamic linking and systemic hypothesising in work with *Lou* and *Myrtle*. Pluralism as an approach to psychotherapy integration had only been on the edge of my awareness up to this point however following Belfast and the subsequent reading I did, I came to understand that my counselling practice was at least partially congruent with key principles underpinning pluralism. What I offered to each of the four participants was a bespoke approach that best fit with their needs as I understood them (Cooper and Dryden, 2016). One of the advantages of the regular reviews designed into my approach during this period - especially in the work with *Lou* - was that clients were able to make their own decisions about where the priorities for the therapy should lie – thus that the coming ‘block’ of sessions felt at least partially co-designed (Cooper and Dryden, 2016). As will be seen in the work with *Michael* I put options in front of my client – therapeutic strategies such as the hierarchy of exposure – for our consideration together. When *Michael* made a commitment to the hierarchy of exposure approach he was pro-active in its design because he had consciously decided it might be what he needed. McLeod (2018) likened this process to putting a ‘menu’ of options in front of the client so that they can make up their own minds about what could work best for them. The way the four cases here are formulated also models a pluralistic approach – understandings of how the problem came to be and how it might be worked through were generated collaboratively between the client and myself and importantly were rooted in the client’s narrative (McLeod and McLeod, 2016).

Whilst the therapeutic methods were diverse, during the period of data collection I held a consistent and clear philosophy of therapeutic change – the evolution of which is described in chapters four through seven - that was centred around what I have described here as the narrative-dialogical approach. Importantly for the purposes of this thesis, the participant clients each began to make somatic associations with their different I-positions. Furthermore, as we will see in the coming analytic chapters, as clients occupied different I-positions their somatic experience also shifted.

1.4 Thus, my hypotheses going into the data collection period

Going into the data collection period and the recruitment of my participant clients I took a working hypothesis in the form of a rudimentary model of change. Through chapters four to seven I chart the continued evolution of this model of change given reflection on my work with the clients and reference to different strands of psychotherapy theory in each phase.

Through my application of Ribeiro and Gonçalves' (2010) narrative-dialogical concept of therapeutic change to existing theory on somatic presentations in psychotherapy, I derived my working hypotheses. My participant clients would come to locate their somatic experience within a superordinate construct called an I-position which would be understood as a 'version' of themselves. Through attention to the patterned flare-ups of symptoms we would observe that it was in those contexts where a certain I-position was 'activated' that these would be accompanied by associated somatic symptoms.

In reference back to Totton's (2014) hierarchy, in which physiology gives way to fantasies, fantasies give way to feelings, and feelings give way to 'thoughts and beliefs', I came to believe that I-positions offered another tier: an I-position being the synthesis and emergent property of the lower tiers. Whilst Totton was envisaging a bottom-up approach in which work beginning on the physiological level would eventually lead to evolutions in thoughts and beliefs, I came to believe that the client's evolving I-positions might also have a top-down influence over their physiological experience. This approach – which centred on working with my clients to facilitate a migration from one I-position to an alternative I-position – became the basis of the model of change I took into

practice at the beginning of data collection. As my clients learned to perform a different version of themselves in the relational contexts which were of particular therapeutic focus they would experience a corresponding relief from their somatic symptoms, either 'objectively' e.g. in terms of their frequency, or subjectively e.g. in terms of perceptions of their intensity or their effect over the client's quality of life.



Figure 4: My adaptation of Totton's hierarchical model

As well as the I-position appearing to be the emergent property of the 'thoughts and beliefs', and thus the synthesis of each of the earlier stages of Totton's hierarchical model, I believe the I-positions concept also offered the appropriate synthesis for the general mechanisms of change identified during the work of reviewing the existing qualitative evidence on change for this client groups (as reviewed in section 1.3.1):

- By observing patterns and encouraging reflection on somatic experience my clients would have a therapeutic space in which to develop embodied awareness, and thus potentially to be less reactive and fearful in the face of symptoms

- The location of these observed patterns within I-positions would provide for my clients a framework in which they might link their somatic experience to psychosocial contexts
- My clients would develop a greater degree of relational competence through the conscious ‘performance’ of these I-positions.
- Finally, by associating somatic experience with I-positions, my clients would have a vehicle through which they might transcend their physical experience – through the migration from one I-position into an alternative I-position .

Steve, my clinical supervisor, mused on what he described a ‘multiple systems model’ which in some respects is congruent with the top-down approach theorised here.

Whenever we meet a client in their wholeness, as embodied beings, we encounter not just a mind but multiple systems, which include the circulatory system, immune system, endocrine system etc. As Steve went on to reflect:

Once we accept that we are set of interrelating systems, we are not a body that floats around somewhere, or emotions that float around somewhere, there’s a physiological system, there’s a psychological system, there’s a neurological system, rather, that we try to gain access through.

The idea of ‘gaining access’ lands as particularly reflective of my approach. In Steve’s multiple systems model, the counsellor’s influence is subtle and that work may go on to influence in turn those other systems that run in parallel, but the access that we have is via the therapeutic conversation. Steve ventured this model as an implicit means of appreciating the small and limited, but also tangible influence that the therapy can make within that image of embodiment, and thus that it is helpful for me as the therapist to be clear and explicit about where and how the therapeutic work can make a difference.

1.5 The visibility of the therapist

In Sedgwick’s (1994) account of *the Wounded Healer*, the client can only progress as far as the therapist has. This is not to say that I will only be able to help those clients who are going through life situations that I myself have lived. Rather I conceive of this that

the client will only be able to realise a degree of metacognition⁵ to the extent that the therapist has realised this capacity. In Sedgwick's account the client 'looks into the soul' of her therapist to see how she works through her own problems; to learn implicitly from her therapist. Therefore the visibility of the therapist is a topic that is particularly pertinent within contemporary case study research. As Meganck et al. (2017) found in their review of 93 psychoanalytic case studies, in most studies even basic descriptions of the therapist were almost entirely lacking. This is a surprising finding given the emphasis placed in analytic approaches on use of transference. However this observation fits with my own experience reviewing about the same number of case studies, from different modalities, for the purposes of producing the qualitative synthesis (Hills et al., 2020). In accounts of psychotherapies for clients presenting with embodied distress, the case study authors typically volunteered little or nothing of their experiences from within the dyad. Whilst use of transference is not a central feature of my own clinical approach and modelling of change, nonetheless I have striven to be visible throughout the present thesis and multi-case study, in accounting for the emergence of my theories.

1.6 The self as research instrument

Timulak and Elliott (2018) warn against the tendency of qualitative researchers to present their undertaking of a certain research method rigidly and inflexibly as a means of establishing the validity of a piece of research. They go on to raise doubts about whether the bracketing off of researcher subjectivity is a realistic way of framing the research process. One of the epistemological positions that I occupy in the production of this thesis is that researcher subjectivity is more than just an additional consideration. When investigating appropriate qualitative methods to perform my research I found that they were typically presented in a highly systematised, step-by-step format with instructions for events such as deriving descriptive themes, and moreover finding syntheses between these descriptive themes. However I believed there was a conceptual problem in presenting analysis in this way. Such systematic approaches appeared to under-emphasise what I understood was the central vehicle in the analytic

⁵ E.g. the capacity to think about how one is thinking; to reflect on one's own psychological state.

process which is the subjectivity of the researcher as the pattern discerning 'machine'. In an account of how the brain comes to perceive a visual object, DiCarlo et al. (2012) propose that the 'identity' of an object increases in complexity through successive stages: as contextual links are established between visual cues, layers of meaning are applied. I believe this image of processing according to contextual layers may be applicable beyond perception of visual objects and account for the processes by which humans come to perceive patterns, and the contextual significance of them, more generally. This layered account of processing reflects the structuring of my analytic chapters four to seven.

The factors underpinning the pattern discovery processes in qualitative research are an order of magnitude more important (and interesting) than the routine through which the researchers structure their formal period of analysis, and yet I observed that often in the write-ups to qualitative research projects they were addressed through a single, separate paragraph accounting for 'researcher reflexivity'. This sensibility is echoed by theorists of first-person research such as Roth (2012) who argued that we should not be bound by methodology, but rather we should begin with the question and develop and evolve a method suitable to answer that question. One objection that might be raised to Roth's argument comes by way of Holloway and Todres (2003) that we are in danger of 'method slurring' which is 'the problem of blurring distinctions between qualitative approaches' e.g. to suit our requirements (Holloway and Todres, 2013, p.93). Freshwater and Rolfe (2001) offered I believe a suitable theoretical response where they framed reflexivity as a *meta-methodology*; 'scrutinising and critiquing itself as it progresses' (Freshwater and Rolfe, 2001, p.532) and this indeed captures my attitude in this project. The method-slurrer is the researcher who drifts across the methodological landscape without consciously reflecting on their positioning within it. By being a visible therapist and researcher, my intent is to capture my dynamic and subjective positioning at all stages of the research, including in the analyses as the pattern generating 'machine'.

1.7 The constructivist and dialogical nature of practitioner research

From a recognition of the importance of the visibility of the therapist and researcher another theoretical pillar of this research follows. My epistemological position within this research is to stand within a ‘constructivist-interpretivist’ rather than a ‘post-positivist’ account of knowledge. This epistemological dichotomy is recognised by both Balkin and Kliet (2017) in their own account of *Counseling Research*, and Levitt et al. (2017) in their *Recommendations for Designing and Reviewing Qualitative Research in Psychology*, as being one of the genuine philosophical fault-lines within contemporary psychotherapy research. For the first half of my PhD I was only vaguely aware of this dichotomy and yet as I will demonstrate through my autoethnographic accounts I was caught up in these tribalistic debates in a way that I was totally unprepared for and which I needed to do some soul-searching within to locate my own position.

It would be helpful then for me to be clear about what I understand by these epistemologies. A positivist seeks to uncover objective truths that can be applied across contexts. Positivism is led by evidence and is empirical in the traditional sense of the word, it seeks proof through the logical appraisal of the evidence available (Levitt et al., 2017). Positivists do not reflect upon the framing of theory, if a theory is logically consistent and fits with the evidence available, the contextual frame is not relevant. The later development of post-positivism seeks to accommodate the subjectivity of involved researchers – that they are not and can never be impartial beings – and thus in a post-positivist approach researchers’ subjectivity is accounted for with the intent of filtering out its distortions in the pursuit of objective knowledge (Trainor and Graue, 2014). Constructivist-interpretivism is as such radically different in the way in which it handles subjectivity. Constructivists seek to uncover constructions of knowledge that depend upon a context-sensitive appreciation and application (Balkin and Kliet, 2017). As Levitt et al. (2017) observed, a constructivist approach to knowledge is dialogical in that it emerges out of dialogue between the researchers and other participants, not just to draw out but also to co-construct meanings through that dialogue. A constructivist approach to subjectivity rests upon transparency in the analytic and interpretive processes. The more transparent these accounts are, the clearer it will be how different voices contributed to the emergence of new constructions of knowledge. Whilst both positivists and constructivists tend to believe in an objective reality, for positivists

knowledge is achieved by stripping away subjectivity, whilst for constructivists we only come to know of the world via subjectivity, and the constructions of knowledge enable us to gain richer, deeper appreciations of the world.

A critique that might be made of the positivistic concept of ‘independence’ – the filtering out of subjectivity in research designs - is that itself is a construction. Where I have looked at positivistic influence of methods such as the *innovative moments coding system* (Gonçalves et al., 2009b; 2011), *task analysis* (Greenberg, 2007), or the *qualitative (hermeneutic) analysis* of causality and change claims made in case studies (Elliott, 2002; Bohart et al., 2011) each of these research methods is incorporated with similar devices in order to root out the dangers of researcher subjectivity and bias. In each protocol a team of analysts who were themselves uninvolved in the therapeutic work apply the methods to the data. The assumption thus underpinning this decision is that analysts who are ‘independent’ of the therapeutic work will perform an analysis which more truthfully and accurately reflects the reality of the work. I use the word ‘assumption’ because this implicit idea is typically unchallenged in the existent literature relating to these methods. Independent researchers may have access to transcripts of the therapeutic work, and may even listen to audio recordings, however they cannot know the work in all its contextual complexity as well as the therapist and the client actually sat in the room. Indeed there is a danger that analytic depth is sacrificed in order to preserve a scientific veneer. Who knows the significance and the meaning of the data better than the therapist and the client? McLeod (2017) observed a further difficulty with claims of independence in the science of psychotherapy which is that psychotherapy researchers also tend to be practitioners, who may explicitly and consciously be prepared to critique their own cherished theories but nonetheless have metabolised and internalised theory in doing their practice work which structures their appraisals of the data. Dragioti et al. (2015), for example, found significant allegiance effects of psychotherapy researchers even in randomised controlled studies of the effects sizes of different therapies. It might be said therefore that a truly independent analysis ought then to be provided by non-practitioner researchers, but a further trade-off might then be being made between analytic purity on the one hand, and the capacity of a researcher to appreciate the significance of data on the other.

I have adopted each of the above research methods in the production of three mini-studies that appear in each of chapters four to six. However faithful to my own critique I have sought an alternative means of catching my own potential blind spots as

a therapist by venturing a layered approach to transparency: my analyses are supplemented by commentaries by the clients themselves who each commented on the case reports and had opportunities to comment on drafts of the thesis, from my research supervisors in seeing the case reports and other writing, and my clinical supervisor whose own voice enters the analytic dialogue. John is a clinician still in practice, Dawn has experience as both practising psychotherapist and supervisor, whilst Jane brings a non-practitioner perspective as a psychologist and scientist. This approach is intended not to replicate the analysis performed by myself as the primary researcher but rather adds further layers of transparency and scrutiny. In the production of a multi-case study and autoethnography my research may be conventionally regarded as standing at the bottom rung of a hierarchy of evidence (McLeod, 2017). However recognising the existing epistemological trade-offs including those discussed here, I would suggest that a better and more helpful image of the evidence is that of a multiplicity of research methods, and the triangulation of their findings. Within an ongoing dialogue within our practitioner-scientist community we may develop a richer, more coherent, and ultimately more clinically useful picture of what works in psychotherapy and what therapeutic change looks like.

The constructivist and dialogical approach to the production of psychotherapy case studies is no more cogently advanced than through Stiles' (2007, 2009) concept of the *theory building case study*. Stiles argued that practitioners accumulate and share clinical experience through communication. In a theory-building case study the case author provides a rich description of the therapeutic work and in particular demonstrates multiple points of contact with the existing theory. Crucially Stiles envisages a dialectic between the circumstances of the individual case and the existing theory – does theory need to evolve in order to accommodate the circumstances of the individual case? For Stiles then the theory-building case study is a departure from the classic approach to clinical case studies as practised by therapists from Freud onwards. In the production of a clinical case study the data are considered in the light of the theory; whereas in the theory building case study, whilst theory may inform the original framing of the data, theory in turn may be revised in the light of the data. Stiles thus advocates an iterative approach to the development of theory which better reflects the reality of the influence of theory over every-day clinical practice.

In a similar line Miller (2011) argues that experiential knowledge is already 'out there' in practice but is often inchoate and needs to be made explicit. Miller frames a formal case study as a natural extension of the epistemological processes practitioners undertake every day. As practitioners we ask questions of our practice and derive our answers through ongoing clinical application and reflection. Thus Miller argues, practitioners need their own methodology. One of the aspirations of this present thesis is that it serves as a demonstrative case for how practitioners might formalise the questions they are asking about their practice and thus undertake a piece of practitioner research. Likewise, Hinshelwood (2013), writing from a psychoanalytic perspective, argues that psychoanalytic knowledge is what psychoanalysts believe is valid knowledge: validity is not objectively determined but is conferred through use and usefulness in a 'self-sustaining culture'. Hinshelwood offers a helpful theoretical response to the positivistic challenge that in these practice-based approaches we may simply just project our own imagined patterns onto the data of our case work. It is the capacity of emergent hypotheses to become predictive that gives them knowledge value, as indeed this is how they become useful as such to practitioners.

1.8 Locating the key concepts

In developing the thesis over the coming chapters I refer to *templates* and to *cognitive maps*, and thus it would be appropriate at this point to locate these terms within the existing literature. The word template is used by neuropsychologists Brown (2004) in theorising psychological mechanisms underpinning medically unexplained symptoms, and Figueiredo and Griffith (2016) in exploring the mediating role of perceptions of *subjective incompetence* over a person's experience of chronic pain. In this context a template is a neurocognitive structure through which the central nervous system processes new sensations or experiences by reference to previous processing of apparently equivalent sensations or experiences. Because we are familiar with the letter 'R' or with the word 'red' having seen these forms many times before, we can rapidly process these in a way that a three year-old would need to take their time over. If a person felt dizzy or light-headed they may learn to index this back to that one time that they collapsed at school, and thus that original experience becomes the template

through which they perceive meaning in each equivalent recurrence of light-headedness. Templates thus allow us to make rapid cognitions of the world around us and to build up constructions of meaning out of raw perceptual data. However as Brown (2004) recognises, they can take the form of ‘rogue representations’ such that we process perceptual data in a maladaptive and unhelpful way; which Brown associates with the development of medically unexplained symptoms. Importantly in addition to cognitions, templates also include what Figueiredo and Griffith call ‘behavioural algorithms’ which might include a person’s reactions to feeling dizzy or light-headed e.g. that they withdraw from the situation by the most direct route.

The concept of the cognitive map was first advanced by American psychologist Tolman (1948) in explaining the findings of his research team observing rats navigating through mazes under varying conditions. Tolman and colleagues were able to demonstrate that in order to successfully navigate it was necessary for rats to go beyond learning a sequence of steps based on cues along the way; that the rats needed to internalise an overall cognitive map of the space. If the conditions of the maze were changed, for example new blockages added, the continued success of the rat depended not (merely) on redesigning a new sequence of steps, but rather referring back to additional layers of contextual information in the existent map with which the rat could reappraise the situation. Thus Tolman argued that the adaptiveness of rats to their environment rested on building up a *comprehensive* cognitive map, as opposed to one that was *narrow*, and *strip-like*. Tolman goes on to conjecture that ‘individual and social maladjustments’ in human beings may be explained by cognitive maps that are too narrow and strip-like and thus non-adaptive. Tolman invokes Freud’s Reality Principle – the healthy construction of ego being the necessary interface through which the individual realises their impulses within the social world – thus appearing to associate it with his own concept. However whilst the Reality Principle appears to emphasise constructions of self, a cognitive map emphasises constructions of environment (or world). Also invoking Freudian theory, Tolman advances *repression* and *fixation* as psychological mechanisms through which cognitive maps remain in a narrow, strip-like state. The cognitive map was also invoked by Bowlby (1971) as a precursor to his attachment-based *Internal Working Model*. He described a cognitive map as a person’s ‘knowledge of the world’ through which they were able to ‘frame effective plans’ and know their own capabilities (Bowlby, 1971, p.110). For Bowlby therefore cognitive maps include representation of self as well as representation of environments. The cognitive map is also invoked by

Figueiredo and Griffith (2016) to describe a more complex configuration of cognitions and behaviours through which we navigate through particular situations in our lives. If I may venture a synthesis of these different accounts of the cognitive map, they appear to describe internalised constructions of self and world, which are highly contextualised, and have their own embedded rules and sources of valuing. These maps are the fields of reference through which we might perform relatively basic motor functions, but are also on higher levels of organisation fields (or frames) of reference that mediate our performances within complex social interactions. One might imagine that if a map lacks sufficient contextual layering – the pathological case as Tolman saw it – that a person might transfer and project relational configurations from one setting, for example the childhood environment, into another, for example a person's relationship with their partner, employer, or therapist.

Some conceptual overlap may be observed here with *schemas* – also advanced by Bowlby (1971), and which have been more directly associated with I-positions by Hermans (1996) and Dimaggio and Stiles (2007) as affective and behavioural repertoires we play out in different relational situations – and *scripts*, at the theoretical heart of Transactional Analysis, which Stuthridge describes as 'unconscious embodied self-narratives that organise and attribute meaning to life experience' (2017, p.23). However for the sake of conceptual clarity I have avoided reference to schemas and scripts.

Cognitive maps as representational systems operate on different levels of perception and activity. Whilst Dallos and Draper (2015) do not use the term cognitive map, they identified five categories of representational system which they locate theoretically within Bowlby's development of the internal working model:

- 1) Procedural: which is an embodied system acquired before language
- 2) Sensory: being able to represent experience in terms of sensory information
- 3) Semantic: being our capacity to attach meaning to experiences
- 4) Episodic: in which individual events are joined together to create a story
- 5) Integrative: which is our capacity to reflect on and become aware of our representational systems, in particular being able to locate our selves and our relationships with others within those systems.

In talking therapy then we have a more direct access to the 3rd, 4th and 5th of these systems through the reflective conversation. I also believe we have secondary access to

the first two systems through experiential work within sessions, and the client's exposure to different experiences between sessions. The fifth of these systems appears to fit most closely with the descriptions of mentalization and metacognition advanced here in which the person becomes aware of thinking from within a representational system. In this study therefore when I write about a cognitive map I implicitly refer to integrative representational systems, however will observe the different perceptual and semantic rules that appear to be embedded within these systems, which may operate from within each of the first four domains.

There is no obvious dividing line between what constitutes a template and what a cognitive map. Both concepts represent configurations of affect, cognition and behaviour that allow for rapid processing of perceptual data; both concepts represent constructions of reality as experienced subjectively. The difference appears to be one of magnitude or complexity. Templates appear to run on shorter time scales and occur mostly unconsciously and automatically; a cognitive map on the other hand may enter into conscious consideration e.g. as a frame of reference by which a person can actively start to make meaning or make plans. I have described each phase of the emergence of my model of change as the development of a new *template*, and have described the superimposition of these templates onto one another as the development of a *map* of change.

Subjective incompetence is the experience of lacking the capacity to navigate through psychosocial situations; of feeling incapable of undertaking the tasks one perceives as necessary to realise within those scenarios (Figueiredo and Frank, 1982). In a more recent paper, Figueiredo and Griffith (2016) associate subjective incompetence with flare-ups in chronic pain, which was my first introduction to association between cognitive maps and psychosomatic experience. Some theoretical overlap may be observed with the concept of self-efficacy advanced by Bandura throughout his career (2007). Bandura considers self-efficacy to be a cornerstone of human health and flourishing, associating self-efficacy – and agency, by extension – with better quality emotional life, health behaviours and resilience. Figueiredo and Frank (1982) argued that their concept of subjective (in)competence was a more complete theory and superior to the concept of self-efficacy because it accounted not just for an individual's associations between their behaviours and expected outcomes, but rather also contained the underlying assumptions behind these associations e.g. beliefs about self. I

suspect that Bandura would challenge this framing of his own treasured theory however I can find no such rebuttal. Because of the association that Figueiredo and Griffith went on to make between subjective incompetence and maladaptive cognitive maps, and in turn with psychosomatic experience, this is the term I have used within this thesis.

Also in this thesis I have preferred to use the term *metacognition* in descriptions of myself or my clients developing psychological mindedness. I recognise a significant theoretical overlap with the conceptions of mentalization. Mentalization, as defined by Allen, Fonagy and Bateman (2008), is the action of 'attending to the mental states of self and others', is the process of 'understanding misunderstandings', or alternatively of 'seeing yourself from the outside and others from the inside' (Allen et al., 2008, p.3). Metacognition likewise is defined by Dimaggio et al. (2007) as 'the capacity to understand mental phenomena, to think about one's own thinking and the thinking of others' (Dimaggio et al., 2007, p.386), and includes 'the set of skills needed to [...] identify behaviour in terms of intentions, desires, and affects' (Dimaggio et al. 2010, p. 366). Allen, Fonagy and Bateman (2008) recognised the overlap between these concepts, with the primary distinction appearing to be the emphasis of the latter on the self. Fernández-Navarro et al. (2019) writing from a dialogical frame similarly observed the conceptual overlap between mentalization and metacognition with the essence of both activities being that of taking a meta-position within one's psychological experience. My preference for metacognition falls ultimately on the emphasis within metacognition on the capacity to appreciate the *organisation* of processes underpinning cognition, e.g. how they work together as a system, a conceptual quality recognised by Wells and Purdon (1999). Metacognition is thus more congruent with the cognitive maps described in this thesis. It is also helpful to recognise that although my participants do demonstrate some evolutions in their capacity to reflect on the mental states of others - these are evidenced in the cases of *Michael* and *Jennifer* - this aspect, more typical of mentalization, is under-emphasised across my analysis of the cases. A narrative-dialogical approach which emphasises evolutions in I-positions and self-narratives is conceptually more compatible with metacognition.

1.9 Conclusion

In this chapter therefore the research is located within the world – a world of practice, of researcher standpoints, and of theory. I have described what I understand as a dialogical and constructivist approach to knowledge production and how I thus find myself as standing within certain epistemological ‘tribes’. In this chapter I also establish the hypothesised model of change that I took into my practice during the data collection window which opened in November 2017. This hypothesised model informs the first cycle of analysis which is reported in chapter four. However the following chapter builds upon the theoretical positions established here. In chapter two I provide justifications for the methodology and research design that I identified as appropriate for answering my research question, before going on to provide a ‘nuts and bolts’ description of how the research was conducted week by week. The following chapter also develops the concept of ‘mini-studies’ in which existing research methods have been used experimentally to draw out different analyses from the data. In the following chapter I also explore some of the ethical themes that emerged and were managed during the course of this project.

1.10 Amsterdam

Thursday, 28th June 2018

I'd woken up nervous in my hotel room, feeling a little disorientated and lonely. I imagined all the people that would already be gathering for the morning's meetings at the University down the road: I would be presenting later and I was struck by this powerful sense that I didn't belong. However the afternoon came, I made my presentation – the room was pretty full and I even got a few laughs. Afterwards a couple of enthusiastic Australians approached me to ask about some of the theory that I'd invoked and I gave them some references to chase up. I had survived, and felt lighter afterwards. My next appointment was in another room to be formally presented with a Student Travel Award which had covered the costs of me getting to the conference. I was smiling and confident then. Once the meetings were over I stepped back out into the Amsterdam evening. We weren't set to meet at the restaurant for an hour or so, so I went for a wander, window shopping; trying to get a feel for the city. It was a gloriously hot and bright day and so everyone was outside enjoying the sunshine.

By the time I arrived at *De Knijp* – The Pinch – on Van Baerlestraat, most of them were already there. They being the UK Council of the Society for Psychotherapy Research (SPR). I had joined the Council last year and had thrown myself into their activities, enthusiastically contributing to the SPR's response to the problematic National Institute of Clinical Excellence (NICE) Guideline on Treatment for Depression in Adults. I sat on a table with a mixture of early career researchers and more esteemed academics. One such academic, an influential and esteemed Professor in psychotherapy research was on my table. I'd noticed the Professor earlier when I was presented with the award. He was one of the rock stars at the SPR conference, who everyone knows and recognises, like Robert Elliott and Bill Stiles. He asked me what I was researching – so far so good, an esteemed professor taking an interest in a student and bringing them in. I told him I was producing a multi-case study of my own work with clients who had presented with somatic symptoms. He asked me how I preserved independence in that design. I knew what he meant but hadn't got a coherent answer so tried to buy a little time. I said "how do you mean?". Playing dumb never a very effective strategy in a discussion with a combative academic. He went on to explain the dangers of bias and entanglement inherent in a therapist researching their own clinical work, highlighting dynamics I was already well aware of. However I just couldn't frame my defence. I tried to keep calm

but my hackles were clearly up. I argued that this was a piece of practitioner research and the Professor insisted that I was doing a research degree not a prof doc. I tried again: but it depends upon the purpose of the research. The Professor wouldn't have it: he looked over his shoulder at Robert Elliott who was sat on another table – "I'm sure Robert would have a thing or two to say about how to maintain independence". Then one of his colleagues got involved, including other big names in the business. One explained to me – in my ignorance – about protocols that existed to evidence causality and effectiveness claims made. I recognised that she was describing Robert (Elliott)'s (2002) *Hermeneutic Single Case Efficacy Design* and I spluttered out: "Oh you mean H-SCEDS...!". (I don't know why I added that S on at the end, everybody refers to it as H-SCED!) "...Well yes I'm using it already". But she didn't acknowledge my reply and looked back at her dinner. The Professor – whilst always with a smile on his face – decided "there's no scientific value in this research design" and said several times "do not have me as your external examiner". Eventually the conversation moved on; I had been demolished. It was one of those times where you know something is really going to hurt but the full magnitude of it hasn't registered yet – like when you stub your toe and there's that brief half a second between the event and when the pain lands. Unfortunately it was at the beginning of the dinner so I had to eat the food and drink the wine when all the time I just wanted to get away, which I did at the earliest opportunity. As I got up to leave he made a point of calling out to me, still smiling, "you'll be ok... you'll be ok". I didn't return the smile.

The next evening, from my hotel room, I wrote in my diary: 'When I woke up this morning, I felt a fear in my chest [...] My confidence is crashing. I'm absolutely gutted [...] I held myself back today, I held my tongue, I was frightened of being attacked/exposed further. [...] I'm such a fraud, I don't deserve to be here – all these other people are so brilliant and my stuff is so patchy and ill focused in comparison.' When I returned from Amsterdam and over the following few days I started to experience waves of ectopic heartbeats and dizzy spells, which I hadn't experienced for years. I knew that I had to use the experience constructively and indeed spent time reflecting on it with Jane, John, Dawn and Steve. What I realised acutely was that sat at that dinner table I felt to be a completely rogue element - I felt alone, and thus ashamed, as though I'd been 'found out'. What I'd lost contact with at that time were the epistemological communities within which I stood; that might have had my back. As explained in chapter one, I don't make a claim to 'independence' in this research.

Instead, I account for my subjectivity as a viable research instrument through transparency, through dialogue with many different voices in the construction of meaning, and the reflexivity which is a thread running throughout this thesis. A relatively sterile, clinical and audited research design might have saved me from The Professor's condemnation that evening, but it would have only created a pretence of objectivity. However I needed to learn how to account for my work better than I did that evening.



Chapter Two: Methodology, Methods and Mini-studies

In chapter one I located the place of this research in the world, including making the case for the visibility of the therapist and the epistemology in which the present research is grounded. In this chapter I expand upon the methodological issues thus raised, including making sense of what Stake (1978) called ‘naturalistic generalisation’ – a concept that goes to the heart of the knowledge value of practitioner research; as well as demonstrating how my utilisation of mini-studies as tools in drawing out insights from my data stems from my epistemological position. This chapter also features a ‘nuts and bolts’ account of how the research was actually conducted.

2.1 Methodology

As observed in chapter one the methodological roots of this research are in constructivism and dialogism. Knowledge generated in practitioner research is to be treated as provisional knowledge; a contribution to an ongoing dialogue between practitioners whose own framework for practice and their concepts of psychotherapeutic change, are continually evolving. My objective was to generate a theoretical model of change that would be applicable to psychotherapeutic work with

clients that presented with somatic symptoms. This piece of research I understood would be qualitative in nature. Developing a model of change would be hypothesis generating rather than hypothesis testing and a piece of qualitative research would permit me the scope to generate syntheses between existing concepts, and continually develop new hypotheses throughout the course of the project. I understood implicitly that the purpose of my research was not to provide a proof e.g. that might be verified statistically or by sheer weight of evidence. Rather, and in keeping with the dialogical nature of my research background, the purpose was to advance new theory, or a set of theories, that may be relatable to other practitioners within our community – a phenomenon known as naturalistic generalisation, which I will explore in the coming section of this name. Therefore at the beginning of my PhD I envisaged two research designs that might be appropriate for the realisation of this objective:

- 1) An ethnographic action research project involving a group of participant therapists who would over the course of monthly group supervision sessions reflect on their own work with clients presenting with somatic symptoms, and co-create a model or models of change – a process which I as primary investigator would facilitate.
- 2) A multi-case study of my own practice work with clients presenting with somatic symptoms, in which I would engage with existing theory, generate new syntheses between theory in an iterative approach through which my provisional models of change would evolve through their clinical application.

There were pros and cons for going down either of these paths. The ethnographic project might have carried weight and validity within our professional community as it would have been developed collaboratively with multiple practitioners. The co-creative process may have generated richer theory in a collaborative environment, or it may have broken down threatened by theoretical differences or other interpersonal conflicts. Analysis of the group dynamics as the vehicle of theory generation would have offered an interesting parallel thesis and set a precedent for similar projects in the future. However I had doubts about this approach. My primary doubt was that the latitude gained from a group perspective might come at the cost of theoretical depth and contextual richness, and we would end up with a list of mostly generic themes, or a generic model, at the end of the project. I also understood that the client's voice was important too and it was difficult to conceive of a research design that would be

ethically sound in which the client would have the opportunity to contribute directly to the project. Furthermore at the time of beginning my PhD project I still felt to be a relatively junior, non-accredited therapist myself, with no experience in leading group work or indeed managing complex group dynamics.

The multi-case study design on first glances may have seemed to have offered less in terms of knowledge value. Hardly being a master therapist myself, it was not at all clear that I would make a substantial or innovative contribution to practice in this area. Without other voices to triangulate against – as there would have been in an action research project – there would have been a danger of the work becoming solipsistic and self-referential. However I understood that my project was not an attempt to reinvent the wheel – there are in existence descriptions of multiple psychotherapeutic approaches to working with somatic presentations. As I learned through the production of the qualitative synthesis (Hills et al., 2020) there are also available hundreds of peer reviewed published case studies on the topic of psychotherapy for somatic presentations⁶. However I could find very little in the existing literature about what change actually looked like and how it was facilitated, beyond the identification of general mechanisms. Through a multi-case study design what I believed I could achieve that wasn't established in the literature was to provide rich descriptions of change, and more integrated theories of change. I could demonstrate my engagement as an ordinary therapist with the existing concepts of change in the literature and how they worked in application to different client work.

There was another compelling argument for production of a multi-case study which was that I would have been able to provide direct and first-hand accounts of my own experiences as a therapist doing the work, and potentially of my own lived experience beyond the therapeutic working, particularly as a person myself living with chronic pain and other somatic symptoms. I also discovered early on – through reading McLeod (2010), which had inspired me to pursue a case study design – that there were ways to offset the dangers of case study research as being self-referential. Most significantly in my research design I would consult with my clients at multiple stages – including and especially in the production of the case report at the end of their therapy – for their own views on change, and what was meaningful and helpful to them. Involving my clients in

⁶ E.g. A search performed through the www.singlecasearchive.com on 17th May 2020 identified 216 psychotherapy case studies published since 1955 which were catalogued according to a diagnosis of somatoform disorder.

this way would distinguish my case studies from the overwhelming majority of published cases in this area, in which the client is written about retrospectively and the work is framed entirely on the grounds of the therapist's own theoretical platform.

Furthermore in my own case study writing I would have the opportunity to write transparently – about the things that did not work as well as about the things that did – and about my own learning process - the evolution of my practice throughout the period - another quality that was lacking from the existing literature. For these reasons I decided early in my project to undertake a multi-case study.

2.1.1 Case study as a unit of analysis

Stake (2006) advanced the unique opportunities presented to knowledge generation through the production of the multiple case study across academic disciplines. He invented a word to refer to the groups of cases as a 'quintain'⁷, which in the multiple case study became the focus of analysis. Whilst in single case studies the emergent theory helps to advance understanding of the case in and of itself, in a multiple case study the emergent theory advances understanding about the quintain. In generating theory that transcends a particular case and is potentially true of the quintain as a whole, Stake proposed a 'case-quintain dialectic' in which theory that emerges from analysis of a single case in the group is then tested for fit in application to the quintain and vice-versa. I note that Stake's concept of the 'case-quintain dialectic' has some theoretical congruence with Stiles' (2007, 2009) concept of the *theory-building case study* for counselling and psychotherapy (discussed in chapter one) in which theory needs to evolve in order to accommodate the circumstances of the individual case. Recognising that production of a multiple case study effectively played off the uniqueness and complexity of a single case against potential interactivity that might be observed between cases, Stake argued that the inclusion of 4 to 10 cases is the ideal

⁷ The word quintain appears to originate in jousting referring to a target which a competitor would aim to strike with their lance, for example a shield or mannequin. To explain the concept Stake (2006) invoked the Buddhist parable of the blind men and the elephant – the quintain is the elephant, suggesting that it is never fully knowable in and of itself but is constituted out of all its members, or qualities.

number. This indeed was the range of cases I set out to include at the beginning of my study, and was achieved with my inclusion of four cases. Stake argued that member checking was vital not just for achieving validity in findings, but also for adding new data and strengthening interpretations – I would realise this through inviting the participant clients to comment on their case reports.

2.1.2 Naturalistic generalisation

Perhaps the primary criticism of the use of case study as a unit of analysis is the lack of generalisability in $n=1$ studies. So the argument goes, we can never be sure which theoretical observations of a certain case may be transferrable to different situations with their own unique contextual circumstances. Indeed McLeod (2013) lamented the almost universal tendency of contemporary case study authors to undermine the validity of their findings by emphasising the limitations of producing an $n=1$ study in their discussion sections, before calling for an Randomised Controlled Trial to deliver that validation. McLeod argued that rather a dialogue should be had about this assumption that generalisations cannot be made from case studies; critics should be clearer about their objections to generalisation with reference to the actual case and theory they are criticising, and authors should be more assertive in advocating the knowledge value of their work – appealing to concepts such as Stake's (1978) 'naturalistic generalisation'.

Stake (1978) advanced the concept of naturalistic generalisation for case studies in the social sciences. This form of generalisation is achieved through the recognition of 'similarities of objects and issues' between different contextual settings. Crucially for practitioner research purposes, naturalistic generalisations 'develop within a person and as a product of experience'.

Lincoln and Guba (2009) objected to the concept of naturalistic generalisation, because they argued that local contextual conditions made generalisation impossible. However their issue with the concept appears to fall more of semantic grounds. Rather than generalisation they preferred the concept of a working hypothesis. They advanced a concept they called 'fittingness' which is an appraisal of the degree of transferability from one context to another. Thus if context A and context B are 'sufficiently congruent'

then the working hypothesis may be transferrable. In reality Lincoln and Guba's fittingness may be seen as an extension or formalisation of the original concept of naturalistic generalisation rather than a challenge to it. I believe that what Stake originally had in mind – as echoed by later theorists such as Donmoyer (2009) on 'experiential knowledge' – is that the fittingness is appraised implicitly, and perhaps unconsciously, by the practitioner in considering the fit of their existent theoretical ideas to the present contextual situation. Lincoln and Guba appear to call for a more explicit analysis of the contextual factors that determine the fit of a theory to a particular circumstance.

Forrester (1996) in advocating for the knowledge value of the case study advanced the concept of 'practical wisdom' which also appears to have theoretical overlap with Stake's naturalistic generalisation and Donmoyer's experiential knowledge. Forrester advances the interesting argument that generalisation is actually a 'shorthand' for our knowledge of particulars. For example if I think about theorised stages of change in my clinical work, I think about actual instances of clinical working that appeared to be articulated by the generalisation. This is what Forrester described as 'thinking in cases'. Incidentally as a therapist I think my clients too think in particulars rather than abstracts, which is one of the reasons why I believe it's important to use their own language whenever possible – certain words and phrases point directly to the heart of the matter, when abstractions and interpretations may leave us standing on the outside. According to Forrester, thought is generally structured around prototypes (e.g. an ideal or typical case) rather than around abstract classifications. The case method then fits with what Forrester calls 'professional knowledge' as opposed to abstracted knowledge - as in law, medicine or business. This idea of psychotherapy case studies as echoing the process by which case law is built up in jurisprudence is taken up later by Elliott (2002) and Bohart et al. (2011) in developing their protocols for appraising the effectiveness and causality claims of case studies.

Kvale (1999) advanced the idea that the psychotherapeutic interview may be considered a form of qualitative research in its own right. In opposition to the positivist emphasis on observer neutrality, psychoanalytic knowledge emerged through 'knowledge producing relationships'. These relationships can sometimes last for years and can reveal a depth of disclosure not possible in ordinary qualitative interview approaches; original meanings and statements may be challenged and deconstructed collaboratively

with the client. Whilst my own clinical work was not grounded in a psychoanalytic framework, and whilst I worked with my participant clients for weeks and months rather than years, nonetheless the same arguments apply. Kvale coins the term 'analytic generalisation' – offering again much theoretical overlap with other concepts of generalisation in the case study genre. For Kvale, and echoing the dialogical sentiments expressed by later writers such as Stiles and McLeod, the knowledge value of case study research may be appraised through its 'communicative validity' – that knowledge is produced through communication with other practitioner researchers – and its 'pragmatic validation' – literally how useful and applicable are emergent theories in practice.

McLeod (2010) in reviewing the existent literature, observed that the event of naturalistic generalisation occurred at the 'points of contact between the detail and description of the case study and the pre-existing schema of the reader' (McLeod, 2010, p.35). This perspective on generalisability thus emphasises the importance not just of *who* is communicating, but also of who is being communicated *to* – how will they receive the insights from a piece of case study research as they are in a continual state of development in their own practices.

Thus a solid case is made for the knowledge value of case study research on the basis of naturalistic generalisation and subsequent concepts that build upon it. This is the theoretical basis on which I argue for the knowledge value of my own project –for practitioners interested in clinical working with somatic presentations, and/or in discerning patterns of therapeutic change.

2.2 Methods

The data collection window opened in November 2017 and closed in November 2018 during which time I was in practice at the charity. Clients would arrive at the charity either via self-referral in most cases or occasionally via their GP. They were assessed by another therapist working within the organisation who would make a referral to a particular therapist based on the client's presenting problems. Because therapy sessions at our charity were heavily subsidised most therapeutic work was structured in

six weekly blocks – with a review session at end of a block to consider whether and how the clients had met their identified therapeutic goals and to make a decision about whether or not to book in another block of sessions.

2.2.1 Recruitment of participant clients

Clients were provided with an initial assessment at the charity in which they met with a different psychotherapist who asked them a series of questions to determine their needs. Because of my long-standing interest in the area, clients who talked about having somatic (physical) symptoms in their assessment were ordinarily referred to me. If a client I started with, either during their assessment or in their first session, identified somatic symptoms that were relevant in any way to their reasons for coming for talking therapy, then they were invited to join the study. In the first therapy session there was paperwork relating to the service to be gone through together with the client, and once the client had had all their questions about this normal paperwork clarified we would sign the documents together. I would then introduce the idea of the research project during that first session once the normal paperwork has been signed off. I'd say a couple of sentences about it, and then give the client the participant information sheet which they would then take away with them to read over the coming week. My contact details were provided on the information sheet and they could contact me during the ensuing week with any questions, or ask me these questions in the next therapy session (the second session).

Whilst a client may be determined to be capable of giving their informed consent to participate in the therapeutic relationship – for example in considerations of confidentiality and data storage – the principles that underpin their capacity to consent to participate in research required further considerations. Primarily consent to participate in research hinged upon the client understanding why they were invited to participate in the study, the possible benefits and drawbacks of being a participant, any extra commitments on their time, what their opportunities for withdrawal from the study were, and how research findings would be disseminated. These extra considerations were set out in the Participant Information Sheet which the potential participant was urged to read and consider carefully.

At the beginning of the second session the client was reminded about the research study, and prompted to raise any questions they had. Once the client and I were satisfied that the questions had been answered, I asked the client whether they wished to participate. If they did we ran through the individual items on the consent form and signed that form together. These built in safeguards and explicit considerations of research participation all served to ensure that the participant had been able to provide their informed consent. Once the consent form was signed audio recording would begin.

Continued consent was sought from participant clients under a patient-centred principle – that the power was in their hands to determine the frequency (a minimum of once every six weeks), and the mode (e.g. verbal, written, email etc.) through which continued consent was obtained from the client. These options were set out in the Participant Consent Form and were thus agreed upon at the beginning of their participation in the research.

In total six clients were invited to join the study, and all accepted that invitation. However one of these clients dropped out of therapy after two sessions and could not be contacted so I decided to withdraw data from their therapy from the study. Another client joined the study and saw their participation through to the latter stages, withdrawing following the production of the first draft of the thesis. I provide commentary upon the presence and subsequent loss of this client in the coming chapter three.

2.2.2 Data collection and analysis

It is important to recognise that the first stage of data analysis should properly be regarded as the therapy session itself, in which discourse between client and therapist is also reflected upon by the client and therapist, and individual passages and events are understood either implicitly or explicitly as significant and containing meaning and information about patterns of change to which they belonged: a semiotic property of individual signs known as indexicality (as explained in section 1.3.2). Every session from the second until the end of a client's therapy was audio recorded. Following a day's therapeutic work I would upload the audio recordings onto the University drive, and

listen back through to the recordings coding the entirety of each session using NVivo software. The coding I performed on those audio recordings in the days following a session was influenced by my understanding of the meanings of individual passages that had been explored by the client and myself i.e. that the implicit and explicit meaning of these data remained fresh in my mind at the point of coding. As I coded passages of the session I supplemented these with session notes which were also stored on NVivo to explain the context and the thoughts associated with the coding of particular passages.

The coding process – properly understood as the second stage of data analysis - was guided by my interest at the time in innovative moments as indices of change (see section 1.3.2). Put plainly, passages of speech were coded where they appeared to contain information about change processes: that the client was departing from their problematic self-narrative, and performing an alternative I-position, either in-session or reporting these performances in the seven days between sessions – what Ribeiro and Gonçalves (2010) would conceptualise as *innovative moments*. Likewise passages of speech were coded where they appeared to represent a client returning to their original problem-saturated narrative, or otherwise speaking from their dominant I-position, what Ribeiro and Gonçalves might have described as *return to problem markers* (e.g. Ribeiro et al., 2016a & 2016b). These codes were as a consequence visually overlaid onto the waveform – the graphical representation of the sound – in different coloured stripes. The primary practical usefulness of this was that I could quickly locate significant passages from the client’s therapy that I needed to listen to again, or indeed to transcribe as was necessary.

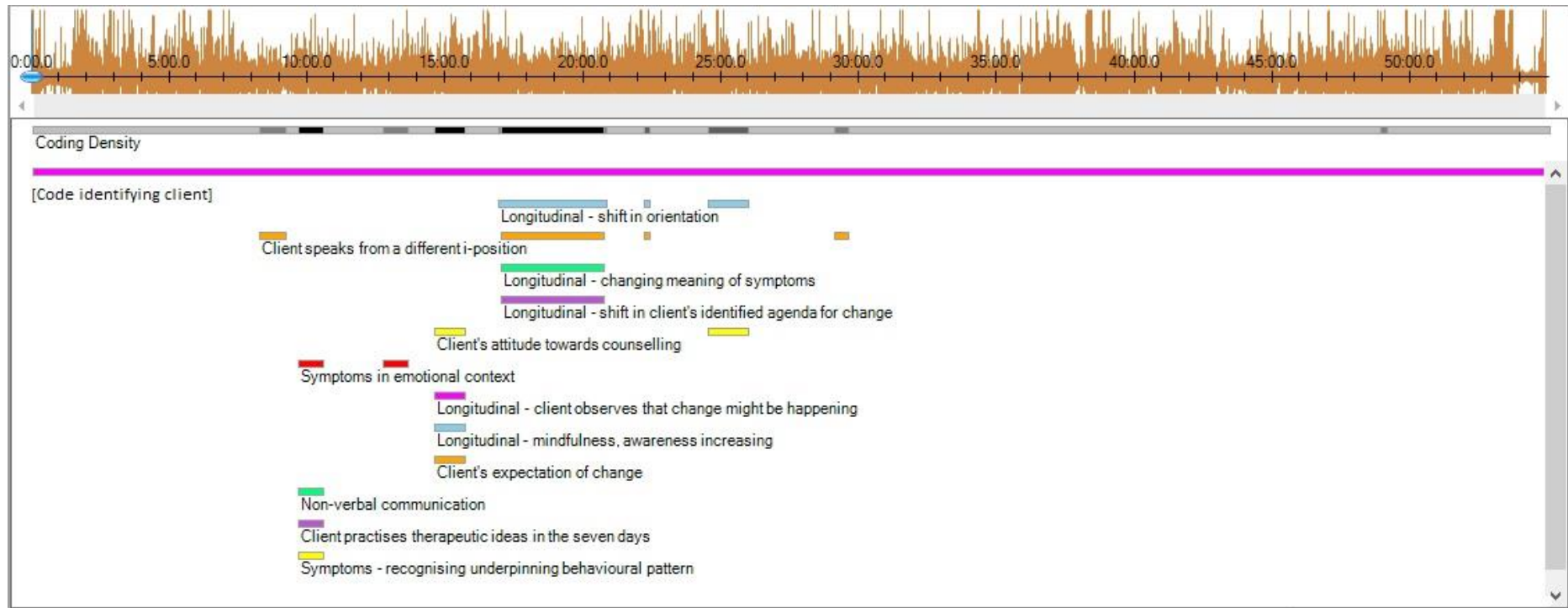


Figure 5: Screenshot of coding stripes as applied to Jennifer's third session

Examples of early codes therefore included: 'client speaks from alternative I-position in session', and 'client acts from alternative I-position in seven days between sessions'. However I did not decide at that stage to code passages according to the different classifications of innovative moment as described in 1.3.2. Rather, my reasoning at the time was that it was more important to generate theories about the different 'shapes' that apparent indexicality (Peirce, 1903) within the data could take, for example observing signs of longitudinal change, or of behavioural change in the seven days between sessions.

Throughout the data collection period I continued to receive clinical supervision from Steve once a month where we would discuss my work with both participants and non-participant clients. I made a later decision to record my sessions with Steve to try to capture some data on how I was using the supervision sessions in the context of facilitating change, and as such the final five supervision sessions also contributed data. Also during the data collection window I kept a regular reflective diary exploring my emergent feelings about my client work and also my evolving personal experience – this too provided a rich source of data.



Figure 6: A visual representation of the weekly data processing cycle, in which sense making is supplemented by reflective diarying and clinical supervision

In figure 6 note how each cycle culminates in an evolution of my 'blueprint' – my emergent map of change – which I take back into clinical practice in the coming week.

In later stages of analysis I selected passages of dialogue for transcription where they helped to elucidate ideas that were understood to be important between myself and my client at the point of producing the case report. I saw precedent for this in the work of Sullivan (2012) who advocated the presentation of 'key moments' or 'key extracts' in the dialogical analysis of qualitative data – these were the passages that best captured the meanings that were intrinsic to the dialogue.

For the purposes of producing the mini-studies (see sections 4.3, 5.6, and 6.7) additional passages were transcribed where they offered particularly rich evidence. This was directed by the research inquiry. I selected particularly good examples of how innovative moments emerged in case work with *Michael* and how I responded to Michael's responses to ambivalence. Likewise for the mini-study on task analysis I was guided by the 'purest example' principle through which Greenberg (2007) selected passages of therapeutic dialogue for analysis. My understanding of which were the purest examples was based on my knowledge of Lou's case as a whole as her therapist.

This last point is important – that my selection of passages of data, whether considered to be 'key extracts' (as described by Sullivan, 2012) or 'purest examples' (as described by Greenberg, 2007) – was guided by my knowledge of the case as a therapist, rather than being taken from the relatively disinterested position of researcher as independent analyst. As explained in section 1.7 the analytic structures underpinning each of the three mini-studies were taken from established approaches within the change process research tradition: the first takes its structure from the *innovative moments coding system* (Gonçalves et al., 2009b; 2011), the second from *task analysis* (Greenberg, 2007), and the third from the *qualitative (hermeneutic) analysis of causality and change claims* made in case studies (Elliott, 2002; Bohart et al., 2011). However where I used each of these analytic structures I have deviated from the established method in one significant way – I did not seek the participation of independent raters to analyse the same data using the same methods to discern the extent to which my analyses could be independently verified. I provide the epistemological arguments for taking that position in section 1.7 and these can be summarised as:

- A resistance to the idea that subjectivity can be filtered out of a qualitative analysis – even independent analysis can be shown as affected by ‘allegiance effects’ owing to the fact that analysts are themselves usually practitioners.
- An argument that rather than seeking independence a realistic ambition for qualitative research is transparency on the part of the analyst e.g. on the subjective position they take in relation to the data.
- And a positive case to be made for therapists (and their clients) as analysts knowing the true significance of data better than independent analysts.

Instead of the use of independent raters to ensure the quality of analyses in the mini-studies, instead I offer several layers of dialogue in this thesis in which analyses are tested out for fit and plausibility:

- The dialogue between myself as therapist and my client in the real-time of counselling sessions.
- The dialogue between myself as therapist and my client as we consider together the case reports after therapy has ended.
- The dialogue between myself as therapist and my clinical supervisor in ordinary supervision.
- The dialogue between myself as researcher and my three research supervisors, each of whom have substantial mental health, psychology and practitioner backgrounds.
- The dialogue between myself as practitioner-researcher and practitioner-researcher colleagues: to what extent do the findings of this study have congruence with their own experiential knowledge (Miller, 2011)?
- Finally, the dialogue between myself as practitioner during the years of my PhD study and the practitioner I will be in the years to come: to what extent to the findings of this study become predictive of future case work (Hinshelwood, 2013)?

The approach I advocate here therefore reflects an adaptation of these established research methods to suit the needs of the practitioner asking questions of and researching their own practices in the everyday work of theory-building (Miller, 2011).

2.2.3 Goal setting and review sessions

The charity that I delivered the therapy described in this thesis through practised as standard the identification of clients' goals for therapy when they first had an assessment session with a different therapist, before being referred to me. Thus an explicit 'checking in' on goals was part of my practice approach long before I engaged with the theory associated with pluralistic approaches to practice. It is worthwhile noting that clients were asked to identify their therapeutic goals in the assessment session before being referred to a therapist. The consequence of this way of working being that the therapeutic goals were not being negotiated with the therapist as such e.g. that the therapist might help the client to clarify their goals based on the kind of work that might be possible together which might reflect the therapist's own authentic styles of working and areas of expertise. Rather the client arrives for their first session with these goals already explicitly identified and in a sense it is the therapist who must catch up. Nonetheless the client's goals could form part of the discussion when I first met with a new client, including the four clients whose cases are reported in this thesis – I might at that point be able to offer some thoughts or clarification about how we might 'get there'.

As previously mentioned, approximately every sixth session was a review session in which participant clients would be asked about their goals – had they experienced any change in their identified areas and if so how did they think this had come about. What I found was that it was helpful to frame this discussion in a qualitative way, considering where change might have been observed and what the quality of that change might have been, rather than a relatively closed binary concept of goals as having been met or not met. Indeed, what I found with my clients, including the four participant clients whose cases are reported in this thesis is that they would more often than not wish to re-write their therapeutic goals given what they had learned about themselves, and new cognitive maps discovered during the therapeutic work so far.

John, my research supervisor, had doubts about my structuring my therapy with regular review sessions – he believed there was a danger of interrupting therapeutic momentum by scheduling in an unnecessary formality. I was sympathetic to this view and indeed in the member checking process *Lou* expressed her own opinion that the reviews had been too frequent and may even have had a disillusioning effect -

reminding her of where she hadn't achieved her stated goals. However regular reviews were the policy of the charity that these sessions were conducted within and I also felt there was a strong case to be made for regular reviewing mindful of evidence linking effectiveness of therapy to regular feedback to the therapist on how the work is going (Miller et al., 2007).

2.2.4 Outcome measures

The routine psychometrics recorded by the charity were the Patient Health Questionnaire-9 (PHQ9) (Kroenke and Spitzer, 2002) and Generalised Anxiety Disorder-7 (GAD7) (Spitzer et al., 2006) measures, typically recorded at pre-therapy, mid-stage and end of the client's therapy. The PHQ9 is understood to be a generalised measure of depression and the GAD7 a generalised measure of anxiety. The procedure for recording these at the charity were that the pre-therapy PHQ-9 and GAD-7 would be administered by another therapist who assessed the client before referring them to me. The client would be asked to fill out the forms with the assessing therapist present and then these completed forms would be included in the client's folder of notes which I would receive on the day of commencing work with the client.

During the time I worked with the clients it was standard practice to administer a mid-therapy PHQ-9 and GAD-7 measure after six sessions – ordinarily at the six-session review – and then also to administer these same measures during the client's final session. One of the principles underpinning my research design was an intent to make participation in the research as non-invasive and interfering as was possible which meant taking steps to ensure that participant clients experience of therapy was as close and as comparable to the normal service offered at our charity as possible. One consequence of designing to this principle was that I decided not to introduce additional psychometrics for my participant clients. In some respects I believe this decision retrospectively to have been a good one. My own belief having worked with a variety of measures and psychometrics over the years is that underneath the specificities of what is being asked by the psychometrics that they may serve as a more general barometer of the client's changing experience over time, indeed as providing some – tentative –

evidence of therapeutic change. What is significant is that as well as psychometric scores being treated as 'objective' measures of psychological wellbeing, additionally I have found therapeutic value in exploring together the client's subjective interpretations of individual items in the psychometric measures. In section 6.7.2 for example, I have highlighted that both *Jennifer* and *Myrtle* both observed relief and positive change in their answers to the item on the PHQ-9 which reads 'Feeling bad about yourself, or that you've let yourself or your family down'. Whilst both clients experienced a reduction in this 'symptom', actually the statement meant radically different things for these clients within the wider cognitive maps they discovered during their therapy that allowed them to understand and reflect on their psychological experience differently. In other words, answers to the items of these psychometrics were highly contextualised – a phenomenon also observed recently by Truijens et al. (2019).

In that respect then the exact nature of the psychometric measure was less important. However, on the other hand, the use of other idiographic measures, such as those reviewed by Green (2016) and Lloyd et al. (2019) in which the client specifies their own items for measurement, may have yielded useful data in the form of the resultant discussion on change across those items, as well as of course in the objective measure itself.

From a scientific perspective it may be regarded as problematic that I as the therapist was the one that administered the PHQ-9 and GAD-7 measures, and remain in the room whilst these forms were completed, rather than these measures being collected extra-therapeutically, for example by another person in the charity e.g. perhaps an electronic facility could have been set up so that the client may have returned their measures online without fear of disappointing or offending their therapist by returning scores that were unchanged or perhaps even reflected a deterioration in their wellbeing. In my own practice experience I believe these fears to be over-played. Often, if not usually, clients are not able to recall the answers they provided when the measures were first collected, and indeed have myriad ways of communicating to the therapist both implicitly and explicitly if they feel they are getting worse or that the therapy is not helping. My belief as a practitioner is that more helpful than a clean and clinical approach in which the measures are collected extra-therapeutically are the opportunities for dialogue between therapist and client made possible as they reflect upon the scores and responses to

individual items together. Indeed I have often found it useful – as I did working with the participant clients whose cases are reported in this thesis – to provide the clients with their original, pre-therapy responses once they have completed the measure later in the therapy to compare these out-loud: were there any answers that were surprising? Rather than being a scientific exercise the collection of the measure therefore becomes part of the therapeutic process itself.

2.2.5 Case reports and member checking

At the end of a participant client's therapy I gathered together all the data and notes I had about the therapeutic work with them and produced a case report. I tried to write these reports in a style that would be intelligible for the client themselves to understand. If I used technical words I took care to explain them in the report. These reports reflected my research interest in that most of the analysis in them was around the questions of what change had looked like and how it had been facilitated. I ended each case report with a series of questions, some generic and intended to encourage clients' commentary, and some more particular questions that had emerged for me as I produced the reports that I wanted to check out with the client. The generic questions included:

What's it been like to read through this report?

Was there anything that was surprising to read?

Is there anything I've got wrong or that you disagree with?

Was there anything that was uncomfortable to read?

Is there anything in this report that you would change?

Etc.

Some examples of particular questions that I asked were:

You reported that I gave you the confidence to do things that you might not have otherwise done – could this sometimes have caused problems for you, e.g. that in hindsight it'd have been better to have followed your own instincts? (Asked to Lou)

How did you feel on the evening that we had to cancel the counselling because of the snow? (Asked to Michael)

I remember at times our work feeling a bit breathless, maybe I was uncertain at times as to how I could help you and so it felt easier to fill the space with questions and talking – I wonder if you experienced that and if so what it was like for you? (Asked to Myrtle)

Generally I sought through the consultations on case reports to give my clients the 'permission' to identify any negative qualities of their experience, which meant me:

- a) Framing these consultations around the concept of 'improvement' – explaining to my clients that their responses could help me improve what it is that I do, and
- b) Actively anticipating where there might have been more to say.

Clients received these case reports either through the post or – in the case of *Michael* – collected from the charity building and had at least two weeks to read through them. After which time each client had the opportunity of a free session to explore their feelings as activated by reading the reports, to clarify any uncertainties they had, to challenge any points they didn't agree with, and for me to ask some further questions based on my own developing thoughts. *Michael* and *Lou* took up the opportunity of meeting to discuss the report and these sessions were recorded to add further data to the project. *Jennifer* and *Myrtle* opted to provide written responses – through email and post respectively.

Learnings from the case report were developed through dialogue with the clients themselves, my clinical and research supervisors, reflective diaring and through reference back to the existing theoretical literature. Three months following the end of each participant's therapy, I made a follow-up enquiry as to their continued progress or whether they'd experienced any retrenchment etc. *Michael*, *Jennifer*, and *Lou* took phone calls from me which lasted approximately ten minutes each, and these phone calls were also recorded. *Myrtle* opted to provide a written response to the questions I had at three-months, which she returned via email.

From those initial analyses of the case reports, formal cycles of analysis were phased and related to crucial milestones during my PhD project:

- 1) I first presented interim findings from my study at a specially organised event on Medically Unexplained Symptoms at the Department for Psychoanalysis and Clinical Consulting at Ghent University in February 2018. I discussed my work with Lou and Michael and framed the cases around the concept of migration of the person from one I-position to an alternative I-position (as described in chapter four).
- 2) During the period of data collection and the months following its closure, I produced a series of mini-studies which utilised existing research methods to draw out different patterns from the data. These have been reported on in a condensed and cleaned up form in chapters four to six.
- 3) Then in November 2018 I presented my research in its present synthesis to the School of Healthcare's PGR Conference at the University of Leeds. Here I presented brief analyses of data from all four pieces of client work and framed these around the longitudinal stage-based models of change that had become a core theoretical interest since the summer (as described in chapter five).
- 4) In May 2019 I presented my work to the BACP Research Conference in Belfast. Here I presented all four pieces of client work with a shifted emphasis towards cognitive maps (as described in chapter six).

In preparation for each of these milestones I returned to my data with fresh theoretical perspectives to perform new analyses and subsequently framed the cases differently in each cycle.

- 5) The final cycle of analysis was the writing of the PhD thesis itself which began intensively upon my return from the BACP Research Conference.

Echoing the dialogical framing of the knowledge value of case study research by theorists such as Stake, Kvale, Donmoyer, and McLeod (see previous section), I note how the development of my analysis was driven by the tangible opportunities to communicate my research to different audiences.

2.3 Mini-studies

In addition to structuring my analysis around the phased emergence of my map of change, I have provided in a condensed form three 'mini-studies' which are derived from existing analytic approaches to ask different questions of the data and thus draw out new meanings. By treating these analytic approaches as mini-studies rather than one of them, or a synthesis of them, becoming the organising principle of the research as a whole, I am placing my self as research instrument at the centre of the analytic process and decentralising the methods and methodology. In each successive phase of the analysis different tools became relevant to the emerging theoretical frame.

In the first mini-study I apply the *innovative moments coding system* as described by Miguel M. Gonçalves, Antonio Ribeiro and colleagues at the University of Minho (Gonçalves et al., 2009b; 2011) to data from the case of *Michael*. An innovative moment is an event in therapy – usually as represented in dialogue from a transcript – in which the client says or does something that would not be predicted by their dominant self-narrative, which in narrative-dialogical approaches is associated with their distress. An innovative moment is the first indication that an alternative, more adaptive self-narrative is emerging. The analytic process of the mini-study offers a conceptual bridge between the first template of my map of change – the migration of a client from one I-position to an alternative I-position – to the second template in which change is modelled according to longitudinal stages.

In the second mini-study I perform a *task analysis*, as originally envisaged by Rice and Greenberg (1984), to data from the case of *Lou*. A task analysis tracks sequences of client performances and therapist responses or interventions that appear to support a significant change episode – in the case of Lou where she was able to consciously reposition herself within relational entanglements. In the task analysis multiple change episodes that appear to be similar in form are compared to discern whether the sequences of therapeutic events can be observed to recur. The analytic process of the task analysis offers a conceptual bridge between the second template of my map of change – longitudinal stages of change – and the third template in which the client generates cognitive maps and thus discovers a degree of subjective competence in situations they did not have before.

In the third and final mini-study I perform a *qualitative (hermeneutic) analysis of change and effectiveness claims*, as envisaged by Elliott (2002) and Bohart et al. (2011) to data from the cases of *Jennifer* and *Myrtle*. These protocols exist for qualitatively appraising psychotherapy case studies for the trustworthiness of claims that the client experienced change, and that the therapy was instrumental in reported changes. The appraisal considers dynamics such as expectancy and placebo effects, whether outcomes were idiosyncratic to the client, and whether change might have been attributed to extra-therapeutic events. Different evidence is then weighed up in a process analogous to a court of law in which the prosecution and defence make their presentations. The process of producing the qualitative (hermeneutic) analysis offers a conceptual bridge between the third template of my map of change – the client generating cognitive maps – and the fourth and final template which is concerned with dialogism in the therapeutic relationship e.g. how clients used their therapy.

2.4 Ethical Considerations

In appendix 2, I have provided a full review of the ethical considerations of the research project which was originally accepted by the University of Leeds' School of Healthcare Research Ethics Committee (SHREC) on the 3rd October 2017. Following my father's death and the decision to introduce the autoethnographic methodology into the project, the amendments are also featured in red text in the review, and these were accepted on 11th November 2018.

However in this section I highlight some of the primary ethical considerations of the project, and therefore the policies I designed to recognise and contain these.

One concern that is often made about psychotherapy research is that a client invited by their therapist may feel pressured to participate in a study order to protect their fledgling relationship with their new therapist for example, or otherwise not to be seen in a negative light. Likewise a client may feel that if they do not participate in the research then they may receive less support than someone who did. Certain principles help to mitigate against these concerns. I decided that I would only recruit new clients rather than also seeking to recruit existing clients into the study. If I were to ask an existing client to participate in the study they may well have felt that they would lose

the relationship they had built up if they did not say yes. Along similar lines initial consent had to be established at the earliest opportunity, and so in my research I gave the client the participant information sheet in our first meeting. They then had a week to read the documentation and to clarify any queries with me during the second session before opting to give their consent or not. In explaining the research I stressed that the therapy they received would be exactly the same format whether or not they participated, however that there would be a few specified differences:

- That the confidentiality arrangement was different: the University of Leeds' position was that if a client admitted to serious crimes such as burglary, drug dealing or fraud that I would not be justified in protecting their confidentiality, even if I determined that others were not at immediate risk of harm.
- That a sound recorder would be present in the sessions
- That the client would receive a case report one month after the end of therapy and a 'follow up' phone call three months after the end of therapy.

On the understanding that it might have felt awkward for clients to question whether they wished to remain in the study following an initial granting of consent and the development of a therapy relationship, I checked with the client at frequent intervals whether they were happy to continue to participate in the study. Bringing this possibility regularly back into explicit consideration I believed allowed the client 'permission' to talk about any feelings or doubts they had about their continued participation, and mitigate against the fear that their withdrawal may cause a rupture in our relationship.

A system of obtaining continued consent also ensured that the client has every opportunity to withdraw from the study if they wished. My supervisors and I designed person-centred approach to continuous consent – the power was in the clients' hands to determine the frequency (a minimum of once every six weeks), and the mode (e.g. verbal, written, email etc.) through which continued consent was obtained. These options were set out in the Participant Consent Form and were thus agreed upon at the beginning of their participation in the research. The Participant Information Sheet was written in plain English: tested using a reading age analysis tool at www.thewriter.com it was found to have a reading age of 13-14 years old. This was provided to the client in the first session to read through over the week and then to return to the second session with any queries they had before opting to grant consent or not.

The client was informed that they could ask for the recorder to be stopped and/or for recordings to be deleted at any time. It was possible that in any one audio recording there was information that could reveal a client's identity. The digital sound recorder was therefore in my possession as I left the therapy situation and the sound file was transferred to my university hard drive at the earliest opportunity either at the PhD suite in the School of Healthcare or using the remote Citrix software which was approved by the University. That file was then encrypted using a password especially for the research project and the sound file on the recorder was deleted.

Each participant understood through the participant information sheet, and the process of originally granting consent, and then continuous reaffirmation of consent, that their opportunity to withdraw from the research expired upon the deadline of Friday, 30th November 2018 so that the thesis could be produced. No participant client took up the opportunity to withdraw any data or indeed to withdraw from the study before the specified deadline. However, as I return to in the following section on 'Honouring my Clients', and explore further in chapter three, the fifth participant signalled their wish to withdraw from the study entirely in the summer of 2019, following my production of the first draft of the thesis. Whilst according to the specified protocol the client had left their request too late, after consultation with my supervisors we were unanimous in our understanding that we must first do no harm and that to deny the client's request could have been potentially harmful for them. I therefore removed their data in entirety from the thesis and to delete all data I retained relating to them.

In terms of protecting my clients' data and anonymity, it was important that these were stored securely, that only necessary data were retained and that data transfers were kept to a minimum. The signed participant consent forms were stored in locked filing cabinet in the charity building, and all other data collected – essentially the audio recordings and my written notes – were stored in my university hard drive, behind password protection for access to my files, and a second layer of password protection for the individual data files. It was not necessary for me to print out transcripts or other data. The case reports were printed for the purposes of receipt of the client, whilst my three supervisors received their copies electronically by communication from my University of Leeds email account to their University of Leeds email accounts i.e. they always remained on the Leeds server. Printed case reports were sent to *Jennifer*, *Myrtle*, *Lou*, and the fifth participant using Royal Mail Special Deliver Guarantee – a

secure and signed-for courier delivery. *Michael* opted to collect his case report directly from the charity building.

A further ethical principle that was designed into my research was the importance of providing the client with a voice in the research to offer their own perspectives and theories. I had been putting together a qualitative synthesis of published case studies of psychotherapies (Hills et al., 2020) with embodied distress presentations and was surprised to discover that the vast majority of case studies offered the client no opportunity at all to pass comment on their therapeutic experience. This was despite strong arguments made for the client's own descriptions of change and their attribution of the factors they believe to have been facilitative made by Elliott (2002) and Bohart et al. (2011) in validating claims about change and effectiveness in psychotherapy case studies. Thus the production of the case reports and the clients' subsequent opportunities to comment explicitly on them, was intended to give the clients a greater experience of ownership over the subsequent research products. Likewise at the end of each client's therapy I asked them to choose a name through which they would be referred to in the anonymised process of reporting on their therapy. This too helped to foster a sense of ownership in the process with clients volunteering stories for why they'd chosen those names.

The production and consultation of those case reports required sensitivity. I understood whilst designing to project that receiving case reports can sometimes be distressing for participant clients as previous research had found – the client could feel they have been presented in an unfair and negative way, they may feel distressed that the relationship they thought they had with their therapist was experienced completely differently by the therapist, or they may even be disappointed that the therapist overlooked something that they believed to have been important. In the design of the project I took steps to mitigate against these. The most important of these was that approximately every six weeks, the client had a review session and this was the case whether or not they participated in the research. In a review session, the client was invited to take a step back and comment on how they thought the therapy was going, whether they believed there were any changes in their symptoms or wider experience, and what they believed might have caused the change. Giving the client this opportunity I believe not only helped them to flag up which aspects of the therapy they found helpful and which not – improving therapy going forward – but also to emphasise aspects most important

to them, and any new areas they wanted to 'work on'. I treated any appraisals by the client of the therapy or their own change process as primary data and as such intended that when they received the case report that the ideas contained within it should not have been experienced as coming 'out of the blue' but in fact should be experienced as ideas co-produced by the therapist and themselves. As discussed in the following section on 'Honouring my Clients' I believe that the receipt of the case reports was a positive experience for those participants that remained in the study – with evidence to suggest this in work with Jennifer and Lou. In designing the study I regarded the probability of a case report causing significant distress as low given the safeguards that were built in. Nonetheless at the point of receiving the case report, participant clients were provided the opportunity of a free therapeutic session to clarify anything about the case report, or indeed to challenge points made in the reports, as they were explicitly invited to do. However in hindsight I also recognise the potential negative impacts the report may have had on the fifth participant and offer some thoughts on how this process could have been improved in future, equivalent member checking procedures.

When I made the decision in 2018 to introduce the autoethnographic methodology – described here as 'the thesis beneath the thesis' - some additional ethical challenges came with that decision. These centred upon a) the impact upon participating clients of reading research reports that disclosed the therapist's personal material i.e. material from the therapist's personal experience, and b) protecting the interests of loved ones and family members who were also implicated in some of the relevant experiences documented in the autoethnographic strand. In addressing the first of these ethical challenges I worked on the principle that the relevance of autoethnographic data was not in how it was mapped on to the client's experience, but rather my development and 'performance' as a therapist. So for example if my work with my client involved their difficult relationship with a family member, I would not be seeking to map directly on to that work either that I was experiencing something equivalent or that my own experience had been different. The reasoning here was that it was important that the client felt that their experience and their story was appreciated as being intrinsically valuable, in and of itself, rather than that I was in some way projecting my own experience onto theirs or not actually 'with them' during the experience. Instead I made a parallel account of my personal experience and development as therapist and researcher at the level of the cross-case analysis. Where personal material was directly

relevant to particular client work e.g. personal feelings of anxiety, these were owned in the case reports received by the clients at the member checking stage but made sense of in the context of the process between us, as is the case in normal therapy, rather than in reference to any autobiographical events. The case reports provided an important opportunity for the participant clients to express any feelings of disappointment that their therapy had not been represented in the way that they had experienced it, or that important details had been missed. As well as providing a passive opportunity for the clients to respond to the material in the case reports I also anticipated particular concerns or issues that the client may have experienced and asked them directly about these, stressing the principle of developing and improving practice through research. Whilst this procedure was mostly successful, what I will recognise in the coming section on 'honouring my clients' were potential shortcomings in how the case reports were produced with thoughts on how the process might be improved upon in future equivalent member checking procedures.

As to the second challenge around the interests of my loved ones and family members who may be implicated in certain autobiographical events, I worked on the basis of the SHREC's own guidance on autoethnographic methods which is to write about and take ownership of my own personal experience – which is always subjective – as directly relevant to my development and performance as a therapist and therefore as directly relevant to the research, rather than in any way writing about my loved ones or family members per se including any judgements about their own actions or experiences. To use a generic example: if an autoethnographer felt she was neglected by her father in childhood, rather than say 'my father was neglectful' she would write about her experience of feeling neglected and the implications of that for her. When I had written the passages of this thesis where I have written about losing my Dad, and about my relationship with my Dad, I consulted with my grandmother (my Dad's Mum) and my brother, as Dad's two other closest surviving relatives, to ensure that they were happy and not disturbed by any of the material in those passages. If they objected to certain material being included I was prepared to remove it, or at least to negotiate an acceptable substitution. Ultimately there was only one such instance where my grandmother and brother requested a change and it was for the addition of some detail that helped to contextualise a point in one of the narratives. I also less formally discussed the autoethnographic strands with my wife throughout the production of this

thesis which helped me to clarify thoughts and ideas that might have been difficult to get hold of otherwise.

2.4.1 Honouring my clients

One of the important theoretical principles underpinning my approach as a therapist going into work with clients with embodied distress presentations was the importance of not foisting upon them a psychosomatic interpretation when they may not have agreed with that, may have felt it stigmatised them, and otherwise have had their own clearly developed ideas about what is going on with them. Luca (2012) observed through interviews with both cognitive behavioural and psychodynamic therapists working with clients with medically unexplained symptoms, that a good therapeutic relationship was founded upon openness to the client's own ideas about their condition, rather than setting up an opposition. Once a trusting, open dialogue had been established clients were then typically observed to naturally consider psychosocial factors relating to their symptom experience. Johnstone and Watson (2017) emphasised the importance of mutual formulation with our clients, that they described as a process of 'ongoing, collaborative sense-making' – a sharp contrast to making psychiatric diagnoses from an expert position. The importance of the client and therapist arriving at a 'common, acceptable illness theory' is one of the foundation stones of Luyten et al.'s (2012) mentalization-based approach for working with clients with functional disorders. I understood the importance of this mutuality right from the beginning of the opening of the data collection window, and indeed I found that *Lou, Michael, Jennifer and Myrtle* were quite comfortable to explore psychosocial factors influencing their symptom experience without me ever having to cut across their accounts of their embodied experience.

A further ethical consideration in the production of the case reports was the potential impact on the client of reading about the work retrospectively. In the present study, as is reflected in the pre-existing literature on the subject (e.g. Brenner, 2006) the impact of receiving case reports was typically that these were viewed as positive events by the clients, who described them as having a consolidating and crystallising effect seeing the accounts in black and white, reading back transcripts from sessions that may have taken

place months ago. *Jennifer* reported that when her husband read her case report to her, his first words to her were “I’m sorry” as he hadn’t realised how debilitated she had become as a consequence of her anxiety. *Lou* also observed that she found reading her report a moving and powerful experience, observing that it accurately reflected how she had felt during that period when we began our work together and thus demonstrated how far she’d moved from that point.

However a word of caution is necessary here in recognising the withdrawal of the fifth participant from the study. They were the only participant who opted not to provide any response to the case report when they received it. When I received their email request to withdraw from the study in the autumn of 2019 they did not provide any reasons for the withdrawal. Perhaps the participant simply had a change of heart about how comfortable they might have been to see rich descriptions of their therapy published, even with the extensive efforts gone to protect their anonymity. Alternatively it is possible that content in the case report had left them feeling misunderstood, blamed, or even let down by me as the author of the report. I had explained in the original participant information sheet that receipt of the case report may disappoint some clients, who might feel that they had been misrepresented or that important aspects of the therapy had been missed or minimised. Unfortunately the participant did not reply to my further invitations to meet to discuss the report and to try reach a degree of closure between us. I reflect on this episode with sadness about the way the relationship with my client ended. However I also recognise that the system I had in place to protect the interests of my participants worked: in having the power to withdraw my client retained a degree of agency. What I cannot gauge is the ongoing impact that the case report had on them. Perhaps as the case report appears to have crystallised therapeutic gains for the four participants clients who remained in the study, the case report may have crystallised an experience of therapeutic failure for my withdrawing client. If I were to conduct the study again one approach that may have been beneficial might have been to initiate a conversation with each of my clients in the later sessions to consider together what they believed should have gone into the case report before I began writing. This may have facilitated a greater sense of agency and influence over the arriving document, and of a conversation that had been opened up and might be continued; rather than the document being experienced as already a fait accompli. This approach would have more closely reflected the production of the

'goodbye letter' envisaged by Luyten et al. (2012) – the co-created document the client would take with them following the end of therapy.

2.5 Autoethnography as a methodological shadow-layer

The middle stages of my research project were the hardest and demanded the most soul-searching on a personal level. My father had died, in Amsterdam the Professor had mocked my research design; moreover I had failed to defend my work or give a positive account of it, and then from a very different theoretical perspective John made a series of penetrating critiques of the case reports I had produced which left me feeling my work was soulless or superficial. At the time of the closure of the data collection window, there was a memorial service for my Dad at the local church. A reading from the bible seemed to cut through and speak directly through me:

I tell you, unless a grain of wheat falls into the earth and dies, it remains just a single grain; but if it dies, it bears much fruit.

John 12:24

The seed referred to in the passage is at first reading referring to those who have already died, but I saw in it additional meaning. During that period I felt myself to be in the process of breaking down – not in terms of a mental breakdown – but rather that the maps that had provided me with a sense of meaning and purpose over the last few years felt to be breaking down. I felt undermined, as though I had lost control of my project, and I was questioning aspects of myself I'd always taken for granted. The message that a seed needed to break in order to bear its fruit was one that I needed to hear at that time. Given the Professor's refutation of my position and John's damning critiques of the case reports that I'd produced so far, by the end of 2018 I knew that the concept for my research as presented in my Transfer Viva the previous year, which was essentially a piece of Change Process Research (Elliott, 2010) would need to be radically overhauled. I had understood since my Dad died that I could not avoid the autoethnographic quality of the work – as a therapist doing a research project on my clinical practice, the death of my father was hardly something that I could avoid writing

about. I spent much of my research supervision meetings during this period thinking out loud about how I could frame my research. In one such session I mused on the symbol of Ouroboros – the Serpent eating its own tail – which originated in Ancient Egyptian iconography. I suggested to Jane and John that in superimposing an autoethnographic ‘layer’ onto my work that my project was in one respect consuming itself. I remember John didn’t really see the point of the Ouroboros reference but its appropriateness took hold for me.

Ouroboros is observed in various analyses to represent completeness, continuity and eternal homecoming (Chevalier and Gheerbrant, 1996). However in the act of consuming its own tail, Ouroboros is also observed to symbolise the possibility of transcendence onto a different plane of being – with its ordinarily linear course of development being transformed into a circle. For me the raw material of my project – the data collected from the case work, and from what was now understood as the autoethnographic strand – remained, but the constructions that had joined them together were being dissolved. In the act of consumption and digestion a whole new form was to emerge from those same raw materials. An analogy from nature also articulated my emergent



Figure 7: Ouroboros from German physician Michael Maier's Atlanta Fugiens Emblem (17th century)

understanding. When a caterpillar enters into the chrysalis, as I

understood it, the body and the tissues of the caterpillar completely dissolve – I imagine a soup of raw, organic materials within the chrysalis – and it is from this soup that the new form of the butterfly is constructed. My project had to break down in order to be reconstructed.

As I write these words I think of Moustakas' (1992) account of immersion within Heuristic Research. In heuristic research the 'self of the researcher is present

throughout the process [...] the researcher also experiences growing self-awareness and self-knowledge' (Moustakas, 1992, p.9). The researcher 'lives the question', and 'everything in his or her life becomes crystallised around the question' (Moustakas, 1992, p.28). Producing my master's dissertation – which John also supervised – I had had a dream in which the pages of my diary were being torn out and scattered across a huge table where people sat to weigh up the evidence and pass their judgement on me. It seemed like an appropriate analogy for the process of producing an autoethnography and I felt as though again, at these latter stages of my PhD I was experiencing another period of exposure.

As qualitative research, autoethnography offers a gateway into lived meanings and experience which may not be accessible through more conventional methods such as interviewing and surveying (Råbu et al., 2019). Though presently under-represented in psychology and psychotherapy research autoethnography therefore has the potential to yield extra-ordinary data and evidence to support emergent theory in conjunction with other research methodologies. Bager-Charleson and Kanap (2017) reflect upon the usefulness of imagery and metaphor in communicating subtle changes of experience or meaning that haven't yet broken through into full awareness. The 'thesis beneath a thesis' described here is delivered in the terms of narrative symbols – of orientation, navigation and journeying – as this was the appropriate language with which to demonstrate the subconscious origins of the emergent theory. The thesis that is then applied directly to the multi-case study is as such the literal translation from those symbolic origins.

2.5.1 The methods of autoethnography

As a methodological shadow-layer, the autoethnographic process required its own shadow research methods which were deployed in parallel to the methods described earlier in this chapter. First and foremost, throughout the period of data collection, and well beyond it as I cycled through periods of data analysis, writing and theory building, I used reflecting diaring – mostly in the form of freely reflecting on my thoughts as they came into mind. This gave my thoughts a greater tangibility and offered up data that I could later triangulate against the clinical work and phased constructions of theory. Because the diary entries, like the case work, were recorded chronologically, it was

possible to observe the way that my personal processes occurred in parallel with clinical events and developments in the research project, as a series of interweaving timelines. Additionally I got into the habit of making my first act of every day writing down my dreams into a notepad on my mobile phone to be typed up and reflected upon later. As a consequence of this activity dream material is used to illustrate emergent themes in this thesis.

Anderson (2006) laid out five features which demarcated an analytic autoethnography from an evocative autoethnography. Whilst my hope and intent is that the autoethnographic content advanced in this thesis is evocative, nonetheless the autoethnographic strand is incorporated into the research to support theory development, to demonstrate the organisations of my subjectivity as the researcher developing theory and thus that my synthesis of change in respect to my client work originates within what I've described here as a thesis beneath a thesis. Anderson's five features are:

- 1) 'Complete member researcher status' which I have achieved through the interweaving of my personal processes throughout the thesis as reported here.
- 2) 'Analytic reflexivity' which comes into play particularly in chapters three to seven when I repeatedly check in on my internal experiences as a therapist and as a subjective theorist of the cases being analysed in building up a more sophisticated clinical picture.
- 3) 'Narrative visibility of the researcher's self' – I have included throughout the thesis what I've described as 'narrative windows' into my lived experience as the therapist and researcher
- 4) 'Dialogue with informants beyond the self' – the development of this thesis has been driven by my dialogues with my clients, my research supervisors and my clinical supervisor as observed here.
- 5) And 'commitment to theoretical analysis' – ultimately the autoethnographic strand supports the development of an emergent and tangible thesis, as delivered in chapter eight.

(Anderson 2006, p.378)

In addition to the generation of extra-ordinary data, autoethnography may serve the additional purpose of making visible the typically implicit processes of knowledge construction at work in qualitative research, a possibility recognised by Råbu et al.

(2019). Likewise in this study, what I attempt to represent through the autoethnographic strand is not simply the implicit personal processes that I brought into the therapeutic situation, but moreover to take a meta-position in appreciating how my theories of change originated and evolved throughout the twelve months of counselling practice and the subsequent cycles of data processing, analysis and writing. Whilst I have rooted each phase in the evolution of my map in the existing literature, in reference to data collected in the project, and in responding to feedback from my participant clients, the construction of knowledge in this thesis is also a deeply personal process.

Muncey (2010) offered a stage-based model for the process of writing an autoethnography, which as well as mirroring my interest in stage-based models of psychotherapeutic change during this study, also appeared to map quite well onto my experience as a researcher over the last three years or so. The first stage, according to Muncey, is the *cognitive* stage in which we are full of confidence and enthusiasm about our ideas. I immediately recalled how I felt about my project at the time of doing my *transfer viva* at the end of the year one (July 2017). After the viva Jane remarked that I wore my theory like a skin. Then comes the second *scribbling* stage, which for Muncey is a messy phase where the ideas stop flowing, or have otherwise become so plentiful as to become unmanageable. I certainly identify with an experience of drift in the months following my Dad's death; of questioning the meaning and value of what I was undertaking. In the third phase we become *serious* which Muncey describes as 'the point of no return' – we are, I imagine, locked in at this point. I perhaps only reached this stage at the beginning of my third year (October 2018) when the data collection window was almost closed. Interestingly Muncey describes a tendency towards procrastination during this phase and it was about this time that I was doing a lot of teaching work and taking my *HEA Associate Fellowship* qualification. My project had gravity by that point but was held to some degree in suspended animation whilst I somewhat anxiously sought employment before my scholarship ran out. The fourth stage I believe I'm presently in as I write these words (October, 2019). In the *polishing* stage enthusiasm gives way to a feeling that one just wants it out! I have remarked to my wife how I imagine the feeling is comparable to being nine months pregnant. In this stage we read and reread our work and see many different ways the research could have been done; we feel proud of some of the aspects of the work but 'ashamed' of others. I'll return to some of these latter themes in the eighth and ninth chapters.

Finally, according to Muncey, the autoethnographer will enter the *relishing* phase in which at the same time as basking in the pride of a job well done, one might also be clearer about how the project could have been undertaken differently or indeed how the research could be developed further. I imagine myself landing at this stage by the time of my *viva voce* examination.

2.6 Structuring the thesis

A final comment is required here about the way that the thesis is structured. The production of a multi-case study, which is at every stage 'shadowed' by autoethnographic data required a careful consideration of how to represent the project in its completeness. What I was acutely aware of when preparing to write my thesis is of not wanting to compartmentalise the different aspects of the project. By the beginnings of 2019 – the year in which the thesis was written – I had a clear sense for the more significant contributions of the thesis. What I set out to achieve was to represent what I described as the 'interweaving timeline': not just how my model of change evolved before, during and after the therapeutic work with the participant clients, but also the underlying subjective processes including life events, use of supervision, dreams and personal therapy that appeared to evolve in tandem with this more explicit model of change. The result is a multi-layered narrative of the evolution of my model of change: with the formal model emerging from the actual client work, but that the forms described also appear to be being mirrored or shadowed in my more personal, and often subconscious experience.

This approach does represent a trade-off however. In a more conventional multi-case study the individual cases, including the subsequent analyses of individual case work, may have been presented in their fullness. Whilst I endeavour here to provide the reader with a rich glimpse into work with each of the participant clients – when they are introduced in chapter three – nonetheless the reader may find through chapters four to seven that the cases are presented in a fragmented approach, with analysis moving back and forth between different cases. The reader may feel that they haven't sufficiently got to 'know' my clients in the way that the thesis is presented. One way to think of this trade-off is that it represents a potential conflict between the analysis of a case and the

cross-case analysis, or to return to the language invoked by Stake (2006) that the emphasis is here placed upon the *quintain*, at the expense of the individual case. Nonetheless the present thesis may be seen to reflect what Stake described as the '*case-quintain dialectic*' (see section 2.1.1) with a regular oscillation between these two different levels of analysis.

2.7 Conclusion

This chapter then has established the theoretical rationale for the research design has been and the concept of mini-studies has been introduced. Chapters four to six are each supplemented by mini-studies that experimentally apply research methods to formally ask questions of the data that were pertinent at that chronological phase of the analysis. This chapter also delivered a 'nuts and bolts' description of how the research was conducted week by week. Thus our attention in the following chapter turns towards a narrative introduction to each of the participant clients, including descriptions of how we worked together and a recognition of the relative triumphs and failures of the work, as recorded during the data collection window.

2.8 The Salmon swimming upstream

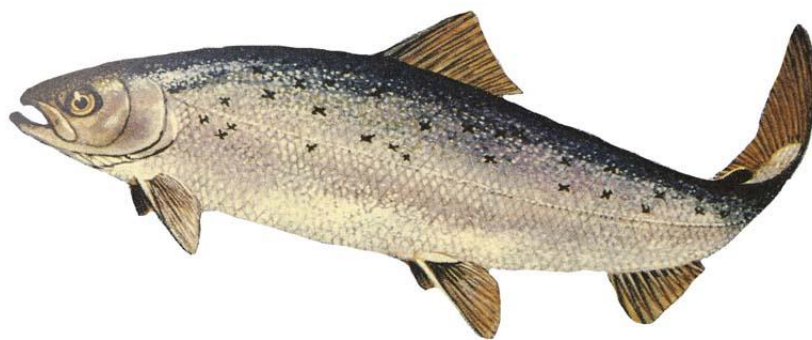


Figure 8: Atlantic salmon by U.S. National Oceanic and Atmospheric Administration. NOAA photos are in the public domain and cannot be copyrighted

Atlantic and Pacific salmon take part in some of the greatest migrations in nature. After spending two to three years maturing in their home rivers in Northern Europe, North

America and Russia they will migrate thousands of miles from their freshwater homes out into the saltwater oceans. They remain in the oceans feeding and building up body mass for one to three years before returning to their home rivers, where they themselves were spawned, to reproduce. They navigate their return according to the magnetic field of the Earth and as they get closer, by picking up on olfactory cues. Returning to fresh water, the salmon stop eating and live off their body mass, migrating back up river – sometimes as far as two hundred miles - to the spawning grounds. Navigating upriver the fish will have to negotiate rapids and waterfalls, sometimes leaping up to 12 feet to get to the next level, and need to avoid predators such as otters and bears along the way. Only the fittest fish will make it. When they arrive what energy they have left is devoted to reproduction and their eggs are laid in gravel beds. This final stage of the lifecycle lasts for up to two weeks, with the fish becoming increasingly exhausted with each day, until finally they die. It is thought that the decaying bodies of the adult salmon fertilise the river promoting the proliferation of insects which the hatching fry will feed on.

What impresses me about these great migrations in nature is that they happen collectively. Hundreds of millions of salmon are believed to return from the oceans to their breeding rivers every year. We human beings, like the salmon, may be born at different times but at each stage of our own life cycle we flow alongside millions of others. The idea of taking part in a human migration from birth to death is humbling for me – it challenges my self-centeredness; my perception of my self as something exceptional; rather I am a fellow traveller. Whilst no-one would follow the exact same course as I do, we journey *together*. Not everyone will make it: only about 5% of the salmon that begin the journey upstream make it to the spawning grounds. Fortunately for humans our odds are a little better, but the question of what it means to ‘make it’ is much harder to answer for people. Does it mean having and raising children, making a contribution to knowledge or society, living to a ripe old age, or perhaps in some other way transcending the circumstances we found ourselves in? I am mindful of the concept of directionality as advanced by Cooper (2019a), perhaps we humans ‘make it’ to the extent that we live a life congruent with our highest directions. I consider these matters further in chapters eight and nine.

As a constant humming in the background to my explicit development of this thesis were processes that were barely conscious, that had been taking place for many years

before I began this project, and broke through occasionally in dreams. The general theme of these dreams is travel, and perhaps more particularly navigation: in each of these dreams I am either travelling by road, by river, or by air. As long as I can remember I've had recurring dreams that I could fly. Just like Superman, but without the costume. I have always understood that the dreams of flight are dreams about transcendence. My brother and I grew up with our Mum in a working class town in the North and I was determined that I was going to do greater and exciting things with my life. My Mum once told me when I was about fifteen: "you think you're too good for this world" and in more than one respect she was right. The dreams reflected my own ambivalent feelings about my fantasy of transcending my present circumstances – on the one hand it was positive and creative, motivating me to do something with my life; but on the other it was a selfish, at times delusional, or even a narcissistic project.

The dreams are best understood in conjunction with other recurring dreams – of navigating in a boat down a river, or of driving a car down a road. In all these dreams I am travelling somewhere, journeying; in most of them my feelings are ambivalent and I encounter frustrations and difficulties along the way. I understand that my difficulties in navigation were difficulties in being human; in seeing through the different stages of my lifecycle. As a therapist I am mindful that I meet each of my clients at a certain point of their 'journey' when perhaps they too lack the skills they need to navigate this next stretch, or indeed the map that will help them orientate and know where they need to be headed. I will swim with them for often just a very small stretch of their whole journey, but will in that brief time get to know something of their unique origins and destination. As a researcher I am one fish swimming out into the oceans with thousands of my contemporaries, but I need to navigate according to my own course within this great migration. To extend the metaphor a little further, our research ideas are born within very particular spawning grounds, we head out to feed in the great oceans of collective knowledge and debate, and then we come home.



Chapter Three: An introduction to the participant clients

In this chapter I introduce each of the four participant clients *Lou, Michael, Jennifer, and Myrtle*. I provide an account of their presenting problems and descriptions of the therapy work. Also in each of these narrative accounts are glimpses of me as the therapist sitting opposite them; indications of my own presence as the therapist. In this chapter I provide some initial reflections on the outcomes of work with each of the four participants – including and especially recognising what we were able to achieve together, and also potentially layers to the client’s experience that we were not able to ‘touch’.

As observed in section 2.2.4, the routine psychometrics recorded by the charity were the Patient Health Questionnaire-9 (PHQ9) (Kroenke and Spitzer, 2002) and Generalised Anxiety Disorder-7 (GAD7) (Spitzer et al., 2006) measures, typically recorded at pre-therapy, mid-stage and end of the client’s therapy. The PHQ9 is understood to be a generalised measure of depression and the GAD7 a generalised measure of anxiety, and these figures are invoked here, and particularly in the mini-study at the end of chapter six, to support more general accounts of change given the evidence taken together.

In the penultimate section to this chapter I consider the presence and the subsequent loss of my fifth research participant. In recognising the difficulties of writing about a person without revealing any personal characteristics, I nonetheless provide some insights into their impact on the research project.

3.1 Lou (f, early 30s)



Entangled by Cathy Hillegas (used with permission of the artist)

30 ordinary sessions (●)

| 2017 | | 2018 | | | | | | | | |
|------|-----|------|-----|-----|-----|------|-----|-------|-----|------|
| Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep |
| ● | ●●● | ●●●● | ● | ● | ●●● | ●●●● | ●● | ●●●●● | ●● | ●●●● |

Plus one face-to-face case review session, and a three-month follow-up on the phone

| | Pre therapy | Post-therapy |
|--------------|--------------------|---------------------|
| PHQ-9 | 23 (Severe) | 6 (Mild) |
| GAD-7 | 21 (Severe) | 4 (Normal) |

As I went down to the reception area to pick her up, Lou and I would always greet one another warmly. However I imagine that as she arrived at the front door of the building she'd feel nervous; I imagine particularly butterflies in her stomach, and that she'd take a deep breath before she pressed the buzzer. One physical feature I often noticed about her was that her skin seemed to glow. I remember a particular session when the sun was flooding into our room and the noise of the traffic from the busy street outside could still be faintly heard. We sat together comfortably and Lou always spoke fluently. In this session Lou was sharing with me something of a revelation from the previous week. She had recently met with an old family friend, we'll call her June, who still lived near Lou's Mum and Dad. June was also a mum and when Lou was a little girl she was always welcome there. Over a drink Lou shared with June that she had been struggling with confidence issues and was having some counselling. This prompted June to share the following memory which spoke directly to the core themes of our own work (words spoken by Lou in our session):

I've known you for a lot of years and I know what kind of person you are [...] you grew up round a family of conflict and I can remember you coming into my house and saying "can I have a drink of juice" and I'd get you a drink and all the kids would be playing upstairs and you would just want to sit of my sofa with your drink as if to say - oh that peace and quiet, there's no arguing, it's peaceful here [...] you just used to breathe a sigh of relief.

This revelation from June triggered a series of memories of blazing rows between Mum and Dad including them throwing scalding drinks at one another. She described to me sitting at the top of the stairs whilst arguments raged downstairs – she just wanted to

escape from them. Following one such argument when Lou’s grandmother was present, her grandmother went into the kitchen and took a knife from the drawer saying that she would stab her (Lou’s) father upon his return. As a child of about eight or nine Lou understood this literally – her Dad was going to die. Lou remembered her Mum would come home every day “sobbing” because her older sister would not come back with her – she had gone to live with their grandmother. Her sister had said that she would kill their Dad and Lou often felt she had defuse these conflicts because her sister was just so difficult. We would often refer back to that image of Lou as a little girl just seeking some peace and quiet when considering what Lou described as her *Peacemaker* role in adulthood, and what it meant to protect herself.

When I first met Lou in November 2017 she had been deeply disturbed by panic attacks that she’d been having. Earlier that month, in a watershed moment, she was having a row with her husband

because he was making her feel guilty about going to an exercise class when there were chores to be done at home. She had screamed at him “you don’t care about me” before being overcome

by a panic attack she couldn’t get control over – including

hyperventilation, shaking and vomiting. There are many causes of vomiting – including extreme emotional distress – but it is always mediated through a particular region of the Medulla Oblongata in the brainstem. When stimulation of the vomiting centre through neurotransmitters such as cortisol and adrenalin reaches a critical point, an emetic reflex is triggered. The lower oesophageal sphincter relaxes at the same time as the diaphragm and abdominal muscles contract forcing the contents of the stomach upwards. It is thought that shedding the contents of ones stomach in this way was an

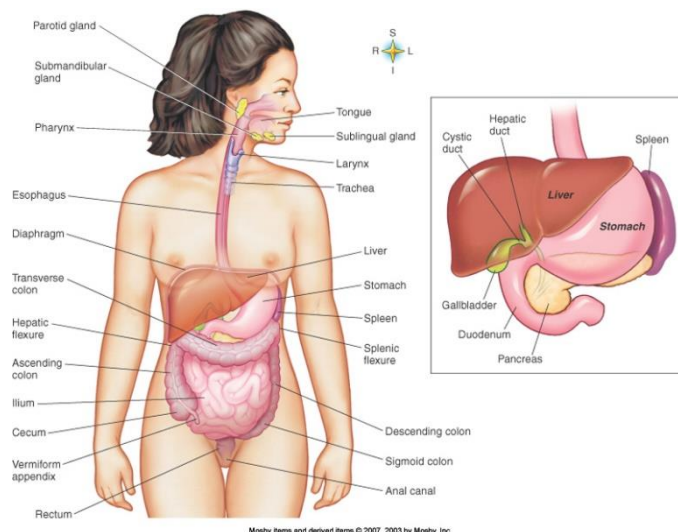


Figure 9: Illustration on the Digestive System. [No year]. [Illustration] At <https://socratic.org/questions/in-what-organ-in-the-waste-from-the-digestion-process-collects-for-eventual-disp> [shared under a Creative Commons License 4.0]

evolutionary protective mechanism in moments of danger, to allow the diversion of resources away from digestive work and to permit a faster getaway.

Following the row, a GP appointment swiftly followed and Lou was referred for therapy at our charity. In the first session she reported struggling with guilt about her and her husband improving their quality of life whilst her parents and sister were still struggling, and also a pervasive sense that she was wrong about everything. Given the somatic quality of the panic attacks – particularly the vomiting – I invited her to take part in the study. That distress should be expressed through her digestive system had additional significance given Lou's lifelong difficulties controlling her weight – she was struggling with a high BMI, which had become a focal point for her marital difficulties, with her husband becoming controlling over what she could eat and drink, and told Lou explicitly on occasion that if she didn't lose weight then it would be the end of their marriage. However Lou was also experiencing overwhelming waves of fatigue that would mean she would often have to go back to bed during the days. She had in the weeks leading up to the row with her husband been signed off work with depression.

In Lou's assessment she identified the following therapeutic goals:

- 1) *[Lou] would like alleviate anxiety*
- 2) *To be ok, to feel ok*

The assessor collecting these goals attempted to reflect as faithfully as they could what Lou herself had tried to convey. The wording of the second 'to be ok, to feel ok' I understood to be verbatim quotes from Lou's assessment. Lou did not identify tackling somatic symptoms as a separate therapeutic goal as from the beginning of our work she understood these to be bound up in her anxiety.

Lou was my first participant client, and it was very soon apparent that at the core of our work would be Lou's experiences of being entangled within various relationships which at that time were activating a lot of distress for her – most notably her relationship with her husband but also within her family dynamic which was still characterised by frequent conflict into which Lou, her sister and their Mum would become embroiled. In keeping with my narrative-dialogical approach I thus wanted to help Lou generate a biography and a characterisation of *who* she was within these relational dramas. I believed that if Lou could come to identify with an I-position she occupied within these dramas then she would be able to look past them; to discover glimpses of alternative

ways of being. In the third session Lou began to generate such a characterisation, giving her the name *the Peacemaker*, and this became shorthand for us for the sets of cognitions and behaviours that we observed as we explored Lou's participation in these dramas.

In our fourth session, just before Christmas 2017, Lou and I reviewed her goals and she did clarify them a little as evolutions from the original goals identified in her assessment. These were reframed as:

- 1) *Building self-confidence*, which we understood as the positive alternative to anxiety
- 2) *To be ok, to feel ok, to establish new dressmaking business*, the meaning therefore might otherwise be understood as Lou wanting to get back to feeling ok so that she was in a position to be able to get her business started.

In this review session, Lou also added a third goal:

- 3) *To feel less guilty about the things I want.*

The slight evolution of these goals represented some of the early work we were doing on the Peacemaker motif, which was associated with guilt for her about doing anything to further her own interests.

I experienced our work together over thirty sessions to fall into three phases, which might be conceived of as cycles of change, as explored in the coming analyses. In the first of these phases, our primary focus was on Lou's relationship with her husband in which she experienced a power struggle. She observed how she had traditionally performed as the Peacemaker in their relationship so as not to upset the applecart but that recently she had begun to rebel against that. However because she had not learned how to assert herself these instances of her taking a stand came out in a highly distressed and chaotic form. Having been off work for several months with depression, it was her husband that urged her to resign from her job, which she did, though she wasn't sure whether it was what she'd wanted to do. She experienced herself as financially dependent on her husband which was uncomfortable. At the end of the first phase – which had culminated in a temporary separation from her husband - Lou successfully established new terms with him which improved their marriage and held for the remainder of our time together. In the second phase Lou and I worked in a more behavioural fashion on self-consciousness – particularly in social situations in which Lou

perceived of herself as an awkward person. This phase culminated in a succession of successful exposures in which Lou became more relaxed about how other people perceived her – she was able to let herself go dancing at a concert or doing open-water swimming and getting changed with the other swimmers at the lakeside. During this period Lou first identified a template for experiencing herself in a way that was reminiscent of the peace she briefly connected with in the home of the family friend. She loves to swim and when she is swimming it as though she is in her own protective bubble that nobody else can enter, in this state everything comes naturally to her. We referred back to it as an experiential template she could apply beyond swimming, especially when finding herself becoming embroiled in conflict. In the final phase of our work our focus was most intensely on her relationship within what manifest as a drama triangle involving her Mum and her sister which Lou learned to successfully withdraw from. It was during this phase that Lou made the associations between the waves of fatigue that she had been experiencing and the family dramas she had been becoming embroiled in.

At the end of our work together Lou's day to day mental health – as reflected in her PHQ-9 and GAD-7 scores – had improved substantially and she was able to return to work. She was no longer having panic attacks, vomiting, nor was she being overcome by waves of fatigue. She was also able to relate differently to her body – where before she had been fixated on being “fat” and needing to lose weight, she shifted her emphasis towards health. I understand that during our time together Lou became increasingly competent in managing conflict and being able to “protect myself”. Having learned to protect herself Lou no longer experienced the same surges of anxiety, but also in learning how not to become entangled within family related conflict she was no longer being exhausted within those conflicts.

Lou had no previous experience of counselling or psychotherapy. However what was notable from the beginning of our work was Lou's readiness to share. This perhaps was informed by representations of therapy in popular culture which emphasise the sharing of one's personal secrets – I explore the extent to which Lou used therapy like a Catholic confessional in chapter seven. Lou may also have been motivated to share out of a fear of the social awkwardness of silence, something she explicitly identified during our work together. However Lou very rarely became ‘chatty’ in our sessions, sharing tangential or superficial information, that might be seen as creating a defensive wall against being

seen. Realistically I am aware of parts of Lou's experience that our relationship 'touched' and parts of experience that our work together did not reach. As explored in chapter seven, I believe Lou experienced me as a mediator and a kind of sanctuary she could retreat to when conflict surged. I was in other respects a coach, always on her side, and perhaps also sometimes as a Winnicottian parent 'hovering' in the background (Winnicott, 1965). Lou left therapy significantly more competent in managing conflict and redressing power imbalances than when she arrived. Lou also was able to challenge beliefs about herself that she'd carried all of her adult life through the process of my witnessing her experiences. However Lou recognised that early sexual experiences also left a lasting imprint on her capacity to enjoy sex, meaning that when her and her husband were physically intimate it was only for his enjoyment. This disconnect was something that didn't change during our time together, and Lou might benefit in the future by working with a specialist who could help her reconnect with sexual enjoyment. Likewise she continues to live with the relational trauma of her childhood environment, for example the murderousness suggested quite explicitly within those family dramas. She shared with me a recurring dream she would have about her father walking past her bedroom in the middle of the night and down the stairs, but in this dream her father was a skeleton. She gave some context to this dream in that her father used to lock her in her bedroom at nights so that she wouldn't climb into their bed – she would want to get to her Mum. Lou would wake up from these dreams feeling very angry. This dream remained something of a spectre for us – we never fully connected with its meaning, although it was vaguely understood. It is possible with more time that Lou and I could have retraced the same ground but to have worked more lucidly within these childhood scenes. However we ended together knowing that we'd done a successful piece of work, the results of which Lou continued to celebrate at the point of our three-month follow up.

3.1.1 Attainment of therapeutic goals

What was interesting about work with Lou, perhaps in part due to the longer term nature of the work, was that the goal-setting did have the effect for Lou of experiencing something like therapeutic failure. That the areas we had identified as being those we sought to tackle were not sufficiently evidenced in the review sessions and that our

mutual disappointment sometimes got in the way of us recognising the real progress we were making on a somewhat subtler level.

Indeed this feeling of doubt in the therapeutic process was aggravated in each review session. In the sixth session which Lou and I had in the New Year of 2018, we observe progress she appears to have been making in her PGQ-9 and GAD-7 scores, and yet the dialogue betrays a degree of disbelief on Lou's part about how trustworthy these signs of progress were:

J: So you've noticed a shift to the 2s, to the left, what do you read into that?

L: Well I remember looking at that [during assessment]... and bursting into tears... at the time... but now I just think... well, it's not great but it's better and that can only be a good thing.

J: So it feels like there's been a bit of movement for you? ((unsure))

L: Well I think so, well there must be, there must have been, even though you don't feel it [note spoken in third person] when you're actually asked to do that... it's different

J: Yeah I know for some people it kind of leaves them with a sense of 'hmmm maybe I was in a different mood when I wrote the answers last time' and never quite sure how much they can believe it kind of thing. It's one of the ways we look for change.

L: No I'm thinking, some of the things have gone from being a 3 to a zero [...] So 'moving or speaking slowly' I put a two and that's gone to a zero, 'poor appetite or overeating' has gone from a three to a zero, and the other two were a two and a one and they've gone to a zero now

What Lou is communicating here, in a constructive way, is that she 'must' be doing a bit better because that's what the scores are saying, but that she doesn't really feel any different. If we note her second identified goal to 'feel ok' – she is not there at this stage.

In the following review session, which we had at the end of January 2018, Lou is still speaking about hopefulness that therapy can make a difference, but doesn't yet feel it has done, as evidenced here:

I don't feel ready to give up yet... I just enjoy coming and it's my time to reel off. And some weeks when I come and I don't have anything going on in my life, and all this

comes out – it makes me think there’s something there, there is some reason why I feel like I feel

By May of 2018, in our 19th session, we were able to reflect on genuine gains made: that Lou’s marriage with her husband had been positively effected by her capacity to push back against her husband’s controlling behaviour – as they mutually recognised it – and self-confidence in social situations. Lou may have been said to have made gains in the first of her stated goals. However in this review session she expressed frustration with unpredictability of her emotions, energy levels and sleep patterns. She observed:

I feel like I’m a bit messed up from head to toe ((despairing laughing)) with various stuff, but I can’t see how I’m going to get better: how I’m going to get more self-confidence, how I’m going to stop feeling guilty, for example. How am I ever gonna do that?

In hindsight I learned that as a therapist I needed to have been more proactive in helping Lou to see the many tangible gains that she had been able to make – not least in terms of her growing confidence in asserting herself and creating space for herself – processes which were embedded within her realisation of her three stated goals. At that time the goals became monolithic: could Lou truly say that she ‘felt ok’ and that she wasn’t struggling with guilty feelings? Lou’s experience was that not being able to say she’d met these goals after 19 sessions felt like a failure. However as we will go on to observe in chapters five and six, the most substantial therapeutic events took place between sessions 20 and 25 in which Lou came to clarity about her energy levels, and with increasing competence within a drama triangle involving her Mum and sister, did at last start to celebrate gains made, as she did here in our penultimate session:

L: Yeah I do feel like I’m getting better, from standing my own ground.

J: Yes that feels like what’s needed to happen during this time together [...] I’ve seen my role as giving you the confidence to take some of these stands. You’ve had my moral support as it were [...]

L: Yeah it’s different when you’re on the outside. And for you to say to me: yeah it’s ok for you to do that, I were like: ‘it’s ok to do this’ ((smiling while talking)) ((both laugh)) I think because it was so out of the ordinary for me to do it, it was hard. But I think like now I’ve done it a few times I’m like ‘yeah I can do this’

In our thirtieth and final session, in which we looked over our work together, Lou commented more directly on the ambivalence she had felt in those earlier stages of the work:

L: But yeah I definitely feel like I've made good progress certainly over the past few months has been like the best I thought it was slow at the beginning but it just took time

J: Yeah I remember you saying in one of the early reviews... you never said it as direct as "I don't know if we're getting anywhere" but you kind of said "I'm enjoying it, and for that reason I'm staying on" You were enjoying having the space as you say. And then as you recognise in the last few months you've made a lot more tangible progress.

L: But I think that all that time at the beginning it's like building up I think the more you delve into it, the more progress you make.

By the end of our time together the original three stated goals that Lou identified had somewhat fallen into the background as we were able to conceive of a more integrated image of change, as reflected in motifs which we will go on to explore in the coming chapters such as Lou's discovery of "fire in my belly" and of the importance of "protecting myself". Within these motifs Lou would endorse growing confidence and a behavioural blueprint to manage feelings of guilt invoked within the family system, if not to be relieved of these feelings as she originally intended. As was evidenced in the case report session in November of 2018 and the three-month follow-up session of January 2019, Lou's energy levels returned to consistency and she was able to return to work. Her dressmaking business was going to strength to strength and she took pride in that, therefore achievement of the second stated goal was strongly evidenced.

When we met in November 2018 for the session in which Lou was invited to comment on the case report and for us to explore questions raised together, she made explicit comment about our review sessions and the regular check-in on her goals that those session entailed:

I think, for me, they [reviews] could have been less frequent because my counselling wasn't over a period of three months, it was like a year. And I think as time went on, the different points [goals], they were different, like they got different. And I think although it really looked negative on some of the points, on other points it were really positive but I guess you kind of focus on the negative don't you? But I feel like some of the points that were originally raised, as the sessions came through, they weren't as important as other

things. So even though I've not progressed with it it didn't really matter because we progressed so much in other areas, and different points were added to that. I think for somebody who's coming in for a shorter period of time that is beneficial, but for someone like me not so much.

There are a couple of interesting ideas embedded in this passage: firstly that according to Lou at least explicit goal setting may have been more useful for shorter-term work. Of course it could be argued that each review session could have been an opportunity to draw up new goals, and perhaps what I learned as a therapist is that goals should not be monolithic but should be broken up into more subtle and achievable steps that can be achieved in those review sessions. The second idea which I am acutely aware of is that as the therapy progresses, the meaning of the individual stated goals becomes increasingly embedded (or contextualised) within an emergent cognitive map – the system of meaning which is at the heart of this thesis – and that as goals are reviewed that the therapist should aim to triangulate these within that emergent system of meaning, rather than these retaining an intrinsic – relatively decontextualized – value which might set client and therapist up for the experience of therapeutic failure as we 'grew' in other directions.

3.1.2 Lou's feedback

In Lou's case report session she was able to feed back on several important themes in relation to her participation in the research project. When she received her case report through the post she was nervous and hesitant to even read it:

I knew it was going to be hard. I opened the page [...] then I put it down and told [husband] I'm not reading it. Anyway he came back home on Sunday and I was sat reading it, beefing, and he was like: "you said you weren't reading it yet" and I was like I couldn't stop thinking about it, thinking that it was there and I wanted to read it.

Note that the reference to beefing here I understood not as Lou feeling anger but rather that just that she was animated. The case report clearly meant a great deal to her – with an intensity of feeling attached to it. Lou was frightened to read it but ultimately curiosity about it nagged at her. Significantly for Lou, the case report evidently served

as a powerful memoir of Lou's time – with records of words we exchanged and work we did together which she wouldn't have remembered if not for the written record:

I feel like we'd covered so much stuff in our year, and I'd said them in here and then they'd gone straight over my head [i.e. been forgotten as soon as session was over] so it was almost like raking stuff up but not in a bad way. It wasn't in a bad way. It was like: 'God I felt terrible then' [...] I guess I was sad for myself really that I felt like that, and you don't realise. Like I'd come here for fifty minutes, said what I needed to say, sometimes beefed on the way home and then the next day I'd be ok, you know and I'd almost forget it [...] It was good to look back on and think: I don't feel like that now, I've made like so much progress, and I think that's just why it was so emotional.

Reading back on the case report had a therapeutic purpose in helping Lou to remember what she had felt like during the time we worked together and thus reaffirming that she felt very differently at the point of reviewing the case report. Lou went on to explain that when she had originally been invited to join the study, it was her husband who had been sceptical and suspicious about what participation would entail:

I remember telling [husband] at the time and he were like "that doesn't sound right" and I were like "well what do you mean it's like... I think it's helping studying and things like that" and I think he was more conscious about my identity and who would see it but as I explained to him like you explained to me it was all fine, and it's all... secret and all that stuff, he was like yeah.

What the passage also indicates is that Lou felt that her identity would be sufficiently protected given the safeguards explained in the participant information sheet – that she didn't herself have doubts on that score. In each of the case report sessions I tried to check out with my client explicitly for any signs of research participation affecting their responses. In this passage Lou explicitly rejects the idea that the presence of the audio recorder had an effect on her:

I wouldn't have told you the things I'd told you if I was conscious of that. Like I say you're the only person that knows the full ins and outs of my life, and so does that recorder. But it didn't stop me from saying anything – I didn't even know it was there. I didn't even give it a thought. The only time I did was when you said "do you still want to be involved" and I'm like "yeah" ((both laughing)) but other than that I didn't give it a thought.

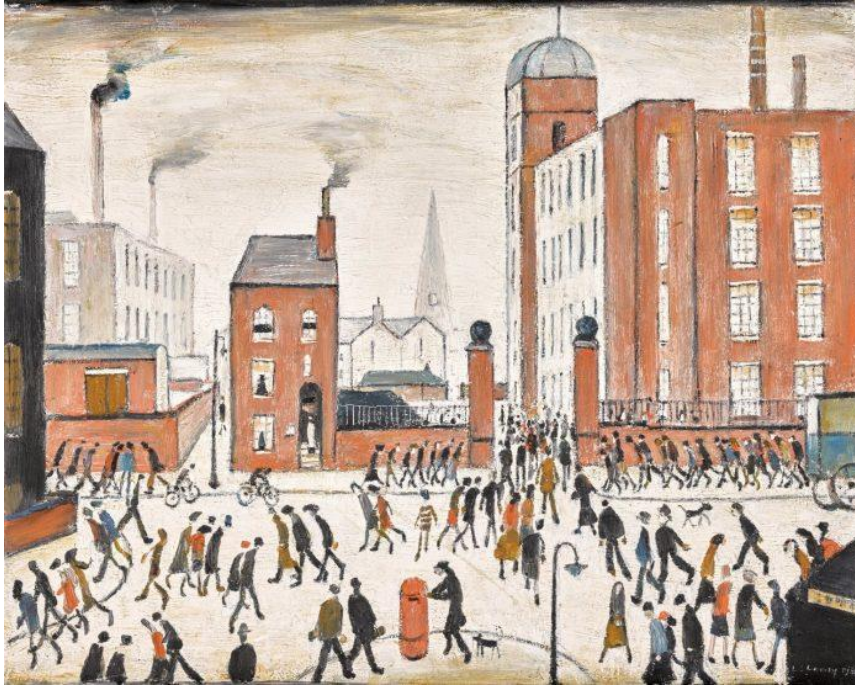
If we considered the potential detrimental effect on research participation on the capacity of the client to fully disclose their experience and their feelings, as her therapist I did not have the sense that Lou held anything back for fear of what was being recorded. This seems also to be reaffirmed in Lou's attitude towards the prospect of her husband reading the report: in the case report session she spoke about not fearing him reading the case report because she knew "everything" would be in there. I explore the idea that Lou in some ways used therapy like a 'confessional' in chapter seven, section 7.3.

Finally Lou fed back that my sudden disappearance due to my bereavement had been very difficult for her, and that this might have been compounded by a somewhat vague communication by the charity through which we had our sessions:

It's really hard that because I don't want to sound harsh. I didn't know why you were off work until I read that. I think the timing was just bad but you can't help that. But that session [the one immediately preceding my bereavement] I just like... poured it all out to you. And I felt a bit angry, because I didn't know the reason. I thought 'am I ever going to be able to go back and talk about this further' because I didn't know. [...] It was that session. I thought 'oh no, what have I done?'. 'Has John been told off, have I made him, like, do something'. You know what I'm like.

The final statement about 'have I made [John] do something' I understood as Lou feeling like she'd done something wrong in opening up to me, and perhaps may have even got me into trouble. I hadn't realised that the charity had withheld the reason for my sudden absence – I suspect they were trying to preserve the conditions of the client not knowing personal details of their therapist – but as a consequence Lou arrived at a more distressful idea, and on balance it would have been preferable for her to know very generally the reason.

3.2 Michael (m, mid 40s)



The Rush Hour by LS Lowry

10 ordinary sessions (●)

| 2017 | 2018 | | |
|-------|---------|-----|-----|
| Dec | Jan | Feb | Mar |
| ● ● ● | ● ● ● ● | ● ● | ● |

Plus one face-to-face case review session, and a three-month follow-up on the phone

| | Pre therapy | Post-therapy |
|--------------|---------------------|---------------------|
| PHQ-9 | 1 (None-minimal) | 0 (None-minimal) |
| GAD-7 | 1 (Normal) | 0 (Normal) |

When I first met Michael I noticed was a bit taller than me, with a slim frame. I made a point of shaking his hand but I only squeezed very gently. When we sat down together I offered him a glass of water and made eye contact to communicate to him my awareness of what it would mean for him to take a glass. He declined. He spoke with a deep, robust-sounding voice. An engineer by trade he described his own experience in very direct and practical terms, and if he struggled to find the right words he would trail off mid-sentence, often deferring back to me: that I understood what he was trying to say and could often volunteer words that fit. This wasn't the first time Michael had been for therapy. Approximately two years before we met he had had some cognitive behavioural therapy through the local Increasing Access to Psychological Therapies (IAPT) service which he had not found helpful, as he explains here:

[T]heir techniques were more physical - as you initially started with the breathing and the relaxation.. in the end they gave me a CD with kind of whale noises or whatever. That wasn't my thing... If I listen to that I just think: what is that rubbish ((laughs)) it's like yoga - I just don't get it.

As Michael shared with me his experience of CBT I remember thinking that I would be able to offer him something a bit more substantial than a CD with whale noises on it, but I understood from our early exchanges that he was seeking a more 'no-nonsense' type approach. Michael's primary complaint was of symptoms of spasming and tightness in his arm and upper body associated with cerebral palsy, due to complications during birth. Michael's physical symptoms thus at first glance could hardly be posited to fall within the very broad umbrella of psychosomatic or strictly medically unexplained physical symptoms. However he came because of a change in his experience which was getting worse as he got older. He was becoming increasingly self-conscious about the

visibility of his spasms and tremors and in a vicious cycle type effect, the more anxious he was becoming about whether or how other people were noticing these disordered movements, and the more he fought to hide them, the more frequent and exaggerated they were becoming.

In spastic cerebral palsy damage to the brain's motor cortex, for example caused by oxygen starvation during birth, means that the person is less able to inhibit flexions of certain muscle groups meaning as a consequence rigidity and spasticity. These meant Michael experienced not just difficulties in coordination and finer motor skills using his arms but also pain due to constant tension. He once helped me to appreciate what it felt like by asking me to imagine holding my arm out straight for ten minutes: it would eventually feel like a dead weight.

Michael could experience some relief from these symptoms by occasionally stepping away from his work to stretch out his muscles again. In his physical experience he seemed to be describing a winding up of tension, fed by growing frustration with himself – he would lose his composure and natural rhythm and become overwhelmed.

He also identified another 'presenting problem' mostly in a matter of fact way – that for the previous five years sexual relations with his wife had broken down and he had started using pornography, something he was keeping a secret from her. He owned feeling guilty about keeping this secret from his wife. My original theory was that feelings of shame relating to this were fuelling his anxieties about having his disability seen however as I got to know more about his life history this explanation didn't fit. His problems with self-consciousness emerged much earlier than intimacy issues with his

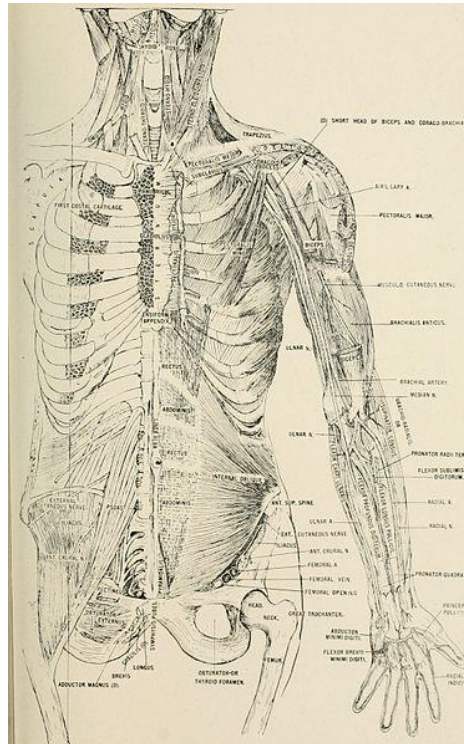


Figure 10: Ross Laughlin, W. 1905. Anatomy in a nutshell - a treatise on human anatomy in its relation to osteopathy. [Illustration]. At <https://www.biodiversitylibrary.org/subject/Human%20anatomy#/titles>

wife, the latter of which he mainly put down to the difficulties in maintaining intimacy in a household with young children.

In our early sessions I offered Michael a narrative-dialogical frame of reference. I tried to encourage him to describe not just what he was feeling during those times when he felt his tension winding up, but the relational situations he was in, what he imagined other people were thinking at the time and perhaps more mysteriously *who* Michael experienced himself as during those times. However very early in our sessions I realised that a purist approach was not going to cut through for Michael. Here was an engineer who was seeking an engineer's solution – he wanted me to teach him strategies for managing his anxiety in that situation. I had recently read several case studies of cognitive behavioural therapy for clients with somatic presentations and some of the techniques described in those studies I felt could provide that engineer's solution that Michael was after. As such I offered Michael a kind of hybrid of narrative-dialogical approaches on the one hand and cognitive behavioural approaches on the other; which was in one respect a compromise between our two positions. As I explore further in chapters four and seven Michael was originally ambivalent about our work. He was torn between two conflicting strategies: either he needed to learn how to conceal his disability and control his spasms more effectively, or the strategy I was advocating which was that he could learn to deliberately let his disability be seen or even to draw attention to it – a form of exposure – and thus bypass the anxiety of being exposed by others. Michael characterised these two strategies as “keeping my head down” on the one hand, or “standing tall” on the other.

Michael had identified two therapeutic goals in his assessment: he wanted to control his anxiety, and to learn to assert himself. However when we had our review during his third session – just before we broke up for Christmas – he was able to elaborate on those original objective considerably, and we agreed on the following words:

Relaxation in certain scenarios – being able to stand back and see the bigger picture

'Standing tall' in company of people you don't know

Confrontation – assertiveness. Being able to when necessary

Each of these therapeutic goals was relational in nature, indicating perhaps the subtle formulation work that Michael and I were doing in understanding the dynamics underpinning his self-consciousness about his disability. The social nature of the goals

reflected his anxiety that he might be perceived as “less than” other people if they were to see his disability.

When Michael came round to embracing the ‘Standing tall’ strategy he quickly made therapeutic gains that he was then able to reflect upon and learn from. We had designed together a ‘hierarchy of exposure’ (Ross and Proctor, 1973) – a device commonly deployed in cognitive behavioural therapy for phobias. Michael identified a number of situations in which his fear of his disability being seen were particularly triggered and then he ranked them in order of how difficult they would be. Over the course of a few weeks Michael set out to deliberately undertake these activities, working through the hierarchy from the least difficult, and thus derive a degree of agency in them. These included tasks that most of us wouldn’t have to think twice about: taking a cup of tea from a customer, or handwriting an invoice in front of them, but these were behaviours that Michael avoided for fear of exposing his disability. As the cognitive behavioural work took hold, Michael picked up on my narrative-dialogical conceptualisation of the work. He himself introduced multiple voices, beginning with the “inner demon” that drove him into a winding up of tension in those situations, and towards the end of our time together the development of what he called his “inner being” which was a more compassionate, almost paternal voice that allowed him to slow his actions back down, restore a manageable rhythm and thus release the build-up of tension in his upper body. As I’ll go onto observe in the coming chapters, Michael came to emphasise the value of openness (as opposed to concealment) not just as an idea picked up by doing the exposures but learned through the experience of having therapy, indeed of being open with me.

In the week immediately before my Dad died, Michael had already made significant gains and our focus was turning towards a consolidation of those. When I returned from my bereavement Michael reported that he had continued to apply the ideas that we’d generated together during that period. When I asked him in the case report session what it had been like for me to have suddenly disappeared Michael described his attitude as:

[R]ight, deal with it. Get on with it now, just see how you go, then you know, come back and reflect on it as to whether it's been successful what you've done or whether you've totally melt down. And it seemed to be... alright.

In this passage I note that Michael is describing his own form of reflective practice, as modelled during our brief run of therapy.

Given that progress, in that session, which was our tenth session, he had felt ready to end. As with work with Lou, I was aware that Michael ended therapy having made gains on one level – he had transformed his attitude about having his disability seen and had moreover embraced the idea of “openness” as he described it. As I listened back to our sessions I was mindful of how what would be such a mundane experience for most of us – such as going to the bar to collect a drink, or writing something down on a piece of paper – took on such a huge significance for Michael as a disabled person. When we met for his case report session he talked about feeling “emotional” watching comedian *Lost Voice Guy*, himself living with cerebral palsy, winning *Britain’s Got Talent*. Michael was so happy for him – Lost Voice Guy had not allowed his disability to stop him, so why should he?

Michael’s previous experience of cognitive behavioural therapy – as observed earlier – appears to have been centred upon relaxation training – the whale noises were incongruous with his way of thinking and thus he didn’t commit to that approach. In his case report review session Michael made some further comments on his previous experience of therapy:

[T]his [our work together] was more mental or mental awareness of the physical [...] they [the CBT therapist] never asked that kind of thing: when it was happening what was I feeling? It was: do this do that do that, see if that helps sort of thing. But I think with any situation if you have a greater understanding of it it doesn't matter you can deal with it.

This passage is helpful and revealing because it indicates that Michael had experienced therapy before that hadn’t offered him new ways of making sense his experience – the CBT was more focused on affect management, but was also ‘do this do that’. The CBT therapist appears to have deployed interventions in a way that Michael did not experience as collaborative or in any way tailored to his preferences. As I explore in chapter seven, what was notable about the way Michael and I worked together is that the work took the form of a ‘negotiation’ between our different ways of thinking, and the many motifs that Michael generated during our time together can be located within those two different worldviews we brought into the work. However I was also aware that other kinds of therapeutic work might have been beneficial for Michael. Whilst he

reported on several occasions, in a vague, non-specific way, that communication with his wife was improving, he was never confident enough to explore with me his feelings about the breakdown of physical intimacy between them, and his use of pornography, despite my invitations and connections I volunteered. To have done so would have been for us to 'drop down' a level. I imagine it could have been very powerful for Michael to have been able to share these feelings with me and for that to have been ok. As I'll go on to explore in chapter seven, I always experienced our work as 'in a box' in which Michael had drawn up implicit limits about what we would work on and what we wouldn't. When I asked Michael again about his relations with his wife during our final session he gave an engineer's reply – making progress with his somatic difficulties had unblocked something and as a knock-on effect had allowed him to make progress in "those other areas" too.

3.2.1 Attainment of therapeutic goals

Progress in the three goals that Michael and I formulated in the third session, as described earlier, were each evidenced. The specificity of the first goal means that the desired result is directly linked to mine and Michael's understanding of how he would achieve that result:

Relaxation in certain scenarios – being able to stand back and see the bigger picture

Michael had, from the very beginnings of our work taken up my suggestion to become an observer of others in those situations he felt intensely self-conscious. As he reports here in his tenth and final session:

That's what has helped me the last three months... I've just gone through life not thinking about it, now I've stepped back and started thinking through – how I sort of see it, and I can sort of describe it.

The specificity of the second goal of 'standing tall' no doubt helped to create that tangible link between what Michael was able to do in order to achieve his therapeutic goal, as indeed 'standing tall' became the behavioural blueprint that was definitive of our work, as we shall go on to see in the following chapters.

As for the third identified goal, Michael did on several occasions affirm that he had learned to be more assertive, particularly in relation to his wife. However these statements were made less emphatically. In chapter seven, section 7.4 I explore the extent to which my experience of our work being ‘in a box’ might have meant that success in this area was more superficial in these other identified areas of focus.

Ultimately achievement of all three goals was for Michael bound up in what he conceived of as a psychological solution. He had had various physical treatments before to manage his spasming, including Botox injections into muscles in his arm to induce a mild paralysis to relax them, but these had not been helpful. In this following passage, taken from Michael’s tenth and final session, he explained the significance for him of finding a psychological strategy to manage his distress:

I spoke to my doctor a few weeks ago, regarding... because they’d, they’d offered at the beginning of these sessions, they’d offered medications, and one of them was ... diazepam. And I thought: “No way, I’m not going down that road even”. [...] And I rang him up and said “Look, I’ve found a way with these sessions” – you know, because he’d referred me to this, redirection to... “that I’m actually dealing with it... from a mental point of view rather than from a medication and physical and that is actually better for me [...]”. All these things do, I think, is take the edge off you know [...] it might be different for other people, but for me that in my mind, that I know I’m dealing with and not reliant upon a medical substance to do it. And I feel happier that way.

3.2.2 Michael’s feedback

In his case review session Michael fed back that counselling was for him a significant line in the sand:

It [counselling] wakens you up, for the want of a better word, it's that things can't go on like this.

The reference to being woken up is particularly pertinent given the growing awarenesses that Michael reported through our sessions together and are evidenced through chapters four through six. It was Michael’s growing capacity to take a step back

from his experience that opened up new possibilities for him, e.g. including as to which I-position he would perform (as we will explore in the coming chapter four). Also in the session Michael went on to confirm my own sense of how we would need to work together, as represented in the case report:

It's my engineer's brain probably where I see things as structured - if you can sort that out then that'll [follow]

The reference to 'engineer's brain' is something I don't remember us talking about in our sessions but is language that perhaps Michael developed from reading the case report. In that respect then the perspectives he offers are co-created by us, much as is all meaning in the therapeutic relationship, but what is interesting is the way Michael takes up these ideas. In that passage he is referring more particularly to the way that by standing taller and practising more openness this had had knock-on beneficial effects, even though we didn't do any work directly on his relationship with his wife. In this following passage he directly addresses my observations in the report that he avoided direct discussion on his relationship with his wife:

I know I didn't enter into that as much as probably you'd have liked, but it was just something that I felt I could deal with - I've been able to... that side of things is a lot, lot better... we're back together as a sort of unit. And I sort of knew in my own mind that that I'd probably be able to do, if I could sort this out

By 'this' Michael means the anxiety and associated somatic effects of having his disability seen. However this passage activated mixed feelings for me. The first was in the idea of him not saying things that I would have liked to have heard implies a vision of me as a researcher hungry for data. He is also confirming a conscious compartmentalization of our work together. I go on to fully explore my sense of our work being 'in a box' in chapter seven and that these do evidence research effects over the course and quality of the therapeutic work we did together. Note how this contrasts with the work with Lou for whom I do not see evidence that our therapeutic work was limited by her participation in the research project. But just as research affected work with Lou to the extent that the reading of the case report became part of her therapeutic experience, Michael also demonstrated a self-validating motivation for participation in the research. In the case review session he asked me whether his participation had been helpful for the study and I reassured him that it had. He went on

to joke “so I’m not a freak”. As observed earlier in this chapter, Michael drew meaning from his shared experience with other people with cerebral palsy and in the case report session appeared hopeful that findings would go on to benefit people in a similar position to himself.

Michael also commented on the impact of my bereavement and sudden absence, however for him sudden cessation of our sessions was a call to action:

Again it's throwing me in... right, deal with it. Get on with it now, just see how you go, then you know, come back and reflect on it as to whether it's been successful what you've done or whether you've totally melt down. And it seemed to be... alright.

Michael and I had already begun to recognise the therapeutic gains he had made and was learning to consolidate and so when the unexpected therapeutic vacation arrived perhaps he felt more ready than other clients to continue applying these gains without ongoing support.

3.3 Jennifer (f, mid 60s)



An example of Rubin's Vase by John Smithson

6 ordinary sessions (●)

| 2018 | | |
|------|-------|-----|
| Apr | May | Jun |
| ● ● | ● ● ● | ● |

Plus one written response to the case report, and a three-month follow-up on the phone

| | Pre therapy | Post-therapy |
|--------------|---------------------------|---------------------|
| PHQ-9 | 18 (Moderately severe) | 3 (None-minimal) |
| GAD-7 | 10 (Moderate) | 0 (Normal) |

When I met Jennifer for the first time I noticed her physicality – she had a slim, almost birdlike figure, and her voice, like her physical presence, was neat and clipped. She later told me about the first time she came. The building we were practising from was a tall, grey and impersonal office block that from the outside might have been an appropriate scene from an apocalyptic movie. She pressed the buzzer and stood outside of the building, nobody answered, and she seriously considered just walking away.

The following little passage from the beginning of Jennifer’s second session was pertinent not just because it was a relatable description of social awkwardness but because it captured in an indexical form what Jennifer brought to therapy across multiple scenarios.

(Je = Jennifer; Jo = John)

Je: I have managed to drive the car further this week... My friend said “well I’ll come with you” but I said “I’d rather go on my own” ((said in a tired, dejected voice)). If I have someone in the car with me I feel like I need to talk to them and that, if it’s just sort of inane conversation, it can be quite tiring, it’s not good for driving really, so I was much better on my own.

Jo: So that sounded like energy and effort, because making small talk is hard work ((laughing))

Je: Yes, because if I’m driving I’m theoretically in control. So I have to make sure everybody else is ok. So that makes me very anxious.

Jo: And why would it be a problem to go quiet, why would it be a problem for them or a problem for you?

Je: I'd think they were anxious. I'd be thinking 'are they thinking what shall we talk about next?' and I don't want them to feel anxious because they're my responsibility whilst they're in the car, so I want them to be happy in the car. But then my husband says to me: why do you think everything thinks like you Jennifer, they might be quite happy...

Jo: And they might be

Je: They might be, they might be, but I've got to make sure everyone's alright. It does bother me what other people think and I want them all to be happy.

As Jennifer observes here, she felt she had to take responsibility for, and be instrumental in, making sure that relational situations flowed smoothly. An incident of social awkwardness such as she feared here would not only be improper, but would be a personal failure. In the hard work involved in maintaining a situation Jennifer would tire herself out. She was living with chronic fatigue syndrome having had a diagnosis in her early fifties. For Jennifer, the chronic fatigue was associated with other physical symptoms which could include aching in her eyes, the loss of her voice, nausea, loss of appetite, and weight loss. This was not the reason why Jennifer had come for counselling however. During the previous November a close friend whom we'll call Alice, whom Jennifer had come to identify as a mother figure in her life, died. Jennifer's biological mother had died several decades ago when Jennifer was a young woman. In the weeks that followed and in the height of their grief, Alice's biological daughter launched a tirade against Jennifer: Jennifer described a scene in which the daughter was jabbing her finger into her face, telling her she had no right to refer to Alice as her mum, and disputing the cash legacy that Alice had left to Jennifer's daughters. Jennifer insisted that she was not coming for therapy for help with her grief, but that the tirade launched against her by Alice's daughter had opened up a Pandora's box: "does everything think this about me?" Anxiety had taken over Jennifer's life – she had withdrawn from all of her social commitments and had stopped going to church which was a central part of her identity. She had had cognitive behavioural therapy following her chronic fatigue diagnosis and had learned various relaxation techniques and

visualisations. She told me that she had found it very difficult to practise these visualisations in busy social situations. However what she had found useful in managing her chronic fatigue was to set herself little goals – even if these were just brushing her teeth, or walking to the end of the street. When Jennifer arrived for counselling she was already trying to push back against her anxiety – getting back in the car, popping in to some of the social activities she had been at the heart of before Alice had died. However these excursions were the source of intense anxiety for Jennifer and she would quickly have to withdraw again from them.

In her assessment Jennifer identified the following therapeutic goals:

- 1) *I want to get back to being me,*
- 2) *To be able to say 'you'll be alright [Jennifer]'*

As we will see later in this section, Jennifer's revision of these original goals was a significant therapeutic event for her.

In the second session she reported leaving an event with a church group after just thirty minutes and feeling sickness and complete exhaustion for the rest of the day. Nausea is a part of the emetic reflex which can be brought on by heightened emotional arousal or the perception of danger, as observed previously. Whilst a critical build-up of neurotransmitters has not been reached such that vomiting actually occurs, nausea is the experience of preparation for vomiting. Tachycardia, salivation, and peristalsis (churning in the stomach) are all physiological processes feeding into our subjective experience of nausea. Why the hyper-arousal Jennifer experienced at the church group led to the extreme physical exhaustion she subsequently experienced is less well understood. Muscle fatigue is thought to be a conservation mechanism ensuring that after an exertion that we rein back on further activity so as not to deplete reserves of energy. It is thought that in chronic fatigue this conservation mechanism becomes over-sensitive, kicking in at a far lower threshold. However it may also be the case that there is an immune response to surges of cortisol, associated with the anxiety Jennifer felt. It has been proposed that surges in cortisol prime the immune system to fight off infections that may be picked up following a wound incurred in a primordial struggle. One of the primary symptoms of a surge in immune functioning is physical and mental fatigue, facilitating our withdrawal whilst recovering from such an injury.

My early impression with Jennifer was that our work would need to be situational. If we could repeatedly deconstruct these situations in which her anxiety was surging – e.g. what she was thinking at the time, what she imagined other people were thinking – then we might be able to interrupt some of the automatic thought processes that were facilitating the surges in anxiety she was experiencing. Conflict with Alice’s daughter had been an unanticipated exposure – exposure to the idea that some people may harbour negative thoughts about oneself. I suggested that Jennifer could practise a mild exposure between the second and the third session. We derived a statement that she would make to her friends and acquaintances in her various social commitments that let them know that everything was not ok. This was important to Jennifer as she described having created a façade in which she would be this invulnerable, ever dependable person. When people asked her how she was she replied by saying “I’m ok but I’m getting some help”. By help she was referring to the counselling she was having but this simple communication helped Jennifer to cut through the façade she had created which left her terrified of letting others down. She started to be able to introduce limits to the commitments she would make. In the spirit of working within a narrative-dialogical approach Jennifer introduced the metaphor of *the Hand in the Bucket of Water* (see chapter six) which provided a template for her to redefine her social role and the expectations she perceived to be on her.

All these processes came into action from the second session and Jennifer reported sudden psychological gains. Application of these behavioural ideas helped Jennifer to rapidly stabilise her anxiety and she was able to return to social life. However she did so on her own terms – setting more clearly defined limits on what she would be able to commit to, and learning the skill of being able to withdraw when she felt her chronic fatigue symptoms flaring up. I had imagined that an important part of our work would be Jennifer learning to understand her own states of mind, and those of others, better. What she did learn to be able to do is stand apart from her thoughts – a process known in Acceptance and Commitment Therapy as *defusion* (Hayes and Lillis, 2012) – and in so doing not be swept along by them.

When Jennifer reflected back on her PHQ-9 and GAD-7 scores at the end of her work together she reflected that it was quite “frightening” to see what a state she had got herself in before she began counselling. Furthermore she believed that the row with Alice’s daughter, which had been the catalyst, had in that respect been a necessary

event as the way she had been living before would not have been sustainable in the years to come. Given the dramatic gains that Jennifer endorsed I did seriously consider that expectancy or so-called placebo effects might have been at work in her recovery which may challenge the sustainability of that recovery in the longer term. I address these considerations in the Mini-Study on the Qualitative (Hermeneutic) analysis of account of change in chapter six.

Like Michael, Jennifer's previous experience of therapy was of cognitive behavioural therapy which focused on goal setting (behavioural activation as a way of managing her chronic fatigue) and relaxation training. Whilst Jennifer had found the visualisations given to her by her previous therapist difficult to practice in the situations where she needed to relax, she had benefited from goal setting as a way of managing her chronic fatigue. As with Michael, what Jennifer appeared to have derived from our time together which was novel were new ways of making sense of her subjective experience – both in the constructivist sense of the 'hand in the bucket of water' motif as explored in chapter six, but also in terms of a psychologising of her raw experience. When I called up Jennifer for her three-month follow-up she was still very positive about her therapeutic experience and the gains she had derived from it, apparently stressing to others the value they might derive from talking therapy. When I listened back to the recording of this follow-up phone call I noticed that my tone of voice was parochial, like a vicar calling one of his flock. We were warm and familiar – she called me "love" a couple of times which she never had done before and I wondered whether this was something she was now doing with people. Had I temporarily performed a quasi-religious function for Jennifer in the transference; unwittingly facilitating her 'born again' moment through the power of suggestion? Working with Jennifer, something happened in those sessions that took on its own life, and wasn't anticipated or formulated by me in advance. What I do understand is that she took some of the core building blocks of counselling and psychotherapy as I modelled them in my own imperfect way – behavioural change, conscious application of metaphor, reflective function, thinking about thinking etc. - and she ran with them.

3.3.1 Attainment of therapeutic goals

In work with both Lou and Michael I observed that the meaning of the stated therapeutic goals necessarily became contextualised within emergent cognitive maps – the systems of meaning which are at the heart of the present thesis. In Jennifer’s experience the evolution of her therapeutic goals was a significant component of her therapeutic process. In her assessment Jennifer had identified amongst her stated goals: ‘I want to get back to being me’. When we reviewed these goals, it was clear that the meaning of them had changed. In the following excerpt Jennifer is referring to the mutually reinforcing relationship between her anxiety and her chronic fatigue:

‘I want to get back to being me’, I think... won’t happen, because ... the me has changed ... Or... by going through this process I realise that the old me wasn’t the sort of me that’s going to get me through to being an old lady ((chuckling)). So, I’ve just... It’s been a real wake up call this has. To say: “Well, actually [Jennifer] you couldn’t carry on... being like that... it’s too much to ask of you” [...] I would have worn my battery out.

Jennifer had come to understand that a fantasy of putting things back to how they were before would not be sustainable looking forward into her future. As such, Jennifer’s re-definition of her goals in session three was a therapeutic milestone in and of itself across the six sessions that we had together.

Whilst the second stated therapeutic goal – of being able to say: ‘you’ll be alright [Jennifer]’ - is evidenced in positive statements that Jennifer made and which are reported throughout this thesis, in this statement from the fourth of her six sessions, she offers a paraphrase, which may be linked more directly back to that original statement:

I can see what a difference this has made for me [...] just by talking to somebody, and voicing, and by being given these tools I can see that it’s going to be ok, and that in and of itself is just amazing.

The meaning she perceives is the same – she’s going to be ok.

3.3.2 Jennifer's feedback

For Jennifer, the arrival of the case report was a significant event for her husband, as well as for herself. In her written response, she explained that receipt of the report had facilitated a greater degree of understanding from her husband:

I finally had a proper talk with my husband John after he had read the report. The first thing he said was sorry, he just thought I was doing too much and getting very tired, he didn't take on board how anxious I had become.

Lou also made observations about her husband reading the report demonstrating the additional effects that receipt of case reports can have beyond the client's immediate experience. There is another parallel between the experiences of Jennifer and Lou which is the extent to which receipt of the case report appears to have had a consolidating or crystallising effect over the therapeutic work we did together. Jennifer wrote:

When I first read your report it was a real eye opener, when you see your issues written down it makes it so real. However, the good thing was to see how far I had come, this is very encouraging and something I can work on and use in the future.

Lou also gained some greater sense of the 'reality' of her experience during our time together by reading back the report. What Jennifer also appears to indicate here is the way that the case report as a written record would be something she would refer back to in continuing to consolidate her therapeutic gains beyond our sessions together.

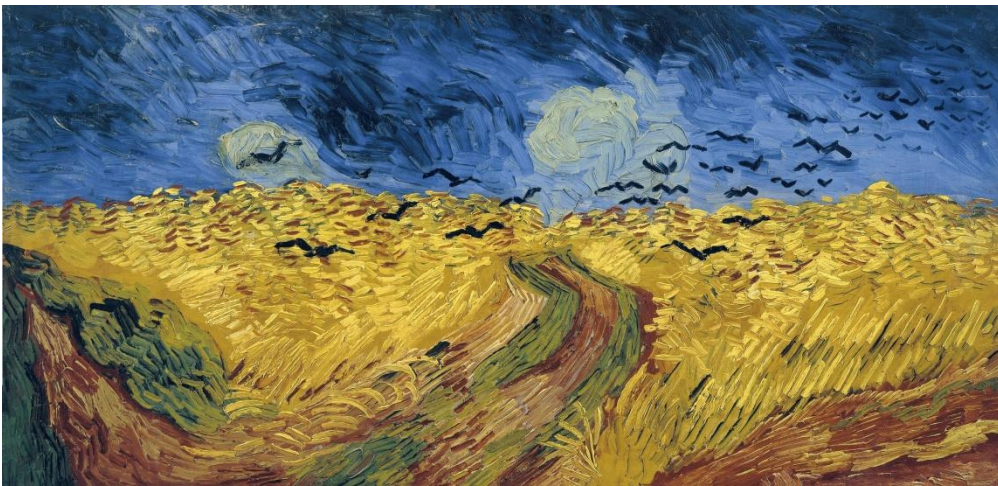
In concluding her written responses to the case report, Jennifer reinvoked the central theme of our work together – which is described fully in chapter six, as 'the hand in the bucket of water':

As time goes on I know I will be challenged and maybe my health will begin to suffer but I KNOW that it is something I can manage with the 'tools' I have collected and I will get over it. I must always try and remember and tell myself that my hand in the water is doing great!

One reflection I have about the case report process is that I could have done more not just to be faithful to my client's own use of language to present the case report in a form faithful to the core frame of reference within which we worked e.g. by telling the story

of our therapy and accounts of change from within that frame of reference rather than from a more neutral or objective standpoint.

3.4 Myrtle (f, mid 60s)



Wheatfield with Crows by Vincent van Gogh

5 ordinary sessions (●)

| 2018 | |
|------|---------|
| Jun | Jul |
| ● ● | ● ● ● ● |

Plus one written response to the case report, and a three-month follow-up communicated via e-mail

| | Pre therapy | Post-therapy |
|--------------|------------------|---------------------|
| PHQ-9 | 13 (Moderate) | 4 (None-minimal) |
| GAD-7 | 10 (Moderate) | 1.5 (Normal) |

When I first met Myrtle I remember heading across to her in the waiting area. She was sat on one of chairs propping herself upright with her walking stick. She had short cropped hair and looked back at me with what was almost a scrutinising look and smile as though she was getting the measure of me. I offered to carry her bag up the stairs; she declined. One of the things I noticed early on about the way that Myrtle communicated was that there was a subtle irreverence, which she described later as her “black humour” and which I struggle even now to find the right words to convey. She would laugh at moments in which laughter would seem inappropriate; when the content was otherwise compelling or potentially emotional. Which is not to say that I found the laughter offensive in any way, but it was almost self-deprecating, as though she was communicating through her laughter: *but don't think I'm taking myself too seriously*. Myrtle responded to my observations about her laughing in her written responses to the case report and argued that rather it just reflected her black humour, offering the following example:

When I fell downstairs and broke my ankle I emailed a relative with an account of this – and she said it was the funniest thing she'd ever read – and how could I joke at something so serious. But that's just me!

Myrtle's father had died approximately two years before we met. In the first session she explained that she was an only child and that after she was born her mother had fallen into a post-natal depression. As a consequence Myrtle lived with her aunt for much of the first two years of her life. Myrtle explained in that session how for all of her own life she had felt responsible for and blamed by her mother for everything that had gone wrong in Mum's own life. She remembered being a young girl – still primary school age – and worked up, anxious at the school gate; when somebody had asked her

what the matter was she had replied "I'm frightened my Mum won't come for me". Myrtle's mother, then in her nineties, was now living in a care home. Myrtle described her mother as playing a part, like on television. In company of others she'll say: "this is my lovely daughter" but in private Myrtle experienced her mother as giving every sign that she hated her. Myrtle described her mother as feigning or exaggerating vulnerability and illnesses to draw care and attention back onto her; she was characterised as a selfish and even narcissistic woman, with no self-awareness. In our sessions, she would mimic her Mum muttering foul obscenities under her breath, into her newspaper or drink, or indeed pulling faces at Myrtle when she thought nobody could see. I found these anecdotes amusing, and sometimes I felt that perhaps Myrtle being able to tell me, a stranger, these anecdotes, and see my own reaction, may have been somewhat cathartic in and of itself. It was as though Myrtle's Mum was playing a variant of Eric Berne's *If It Weren't for You* game (Berne, 1964) – anxiety had prevented her from living a personally meaningful life but she had derived some gratification from blaming Myrtle for these disappointments. Myrtle described her father as being like a "buffer" between her Mum and her, such that when he died, relations between mother and daughter became much worse. Myrtle's Mum did not go on to have any more children, and perhaps Myrtle being brought up with the implicit idea that her existence had ruined everything, then indeed she may well have felt she had no right to take herself seriously.

Myrtle had been diagnosed with fibromyalgia the previous August 2017 following consultations with a rheumatologist. However it was originally a different somatic presentation that had brought her to therapy. She had been experiencing waves of uncomfortable and unnerving ectopic heartbeats which could last up to two hours at a time. Given that several family members, including her Dad, died from heart failure, Myrtle wondered whether something was wrong with her own heart and went to see the GP. The GP believed that her ectopic heartbeats – what Myrtle called her "funny heartbeats" – were caused by adrenalin and anxiety and referred Myrtle to our service. When she arrived for her assessment she was wearing a 24 hour ECG monitor which helped to confirm the benign nature of her ectopics. As a consequence Myrtle began therapy always open to psychological interpretations of her embodied experience.

In her assessment, Myrtle identified the following therapeutic goals:

1. *To be able to relax more and reduce anxiety and stress.*
2. *To find your own 'self' again*
3. *Be able to face health issues*

Our first session was notable for a significant moment (described in chapter five) that was only indirectly related to her somatic experience. As Myrtle presented her lifetime experience as being a scapegoat for all of her mother's problems and woes, I picked up on the pervasive guilt Myrtle experienced in that position. I wondered whether Myrtle had experienced feeling guilty in other situations in her life. She considered the question carefully and landed on the example of her relationship with her mother in law who had passed away some years ago. When her mother in law withdrew from all her medication and subsequently died, Myrtle blamed herself: perhaps her mother in law had felt like a burden; perhaps Myrtle could have done more to reassure her? As she conveyed these thoughts she suddenly found herself in floods of tears. Myrtle had not had counselling before and had not expected to make contact with such powerful feelings. Her experience of that first session triggered a wave of clarity and behavioural change in her relationship with her own mother that may be described as a 'sudden gain'. I consider this sudden gain further in the mini-study on the qualitative (hermeneutic) analysis of change in chapter six.

The remaining four sessions we had together were defined by what had happened in the first. Myrtle used these sessions to demonstrate to me how she had come to new resolutions about her experiences of guilt in various key relationships in her life, and how she would no longer "play the game" with her mother – who despite now being a woman in her nineties continued to try to exert influence over Myrtle. In that context Myrtle's somatic experience became a somewhat parallel consideration. We explored Myrtle's physical experience in the second session – identifying the somatic sensations as Myrtle talked me through an ordinary visit to her Mum in the care home (see chapter five). It became apparent that whilst she saw a strong case for associating her ectopic heartbeats with her anxiety about her seeing her Mum; about feeling guilty and often hated by her Mum in those moments, she did not make any association between these experiences and her fibromyalgia flare-ups. Additionally when Myrtle and I did work on her fibromyalgia I had the uncomfortable feeling that

we'd ended up in a binary situation where we were either talking about her physical experience or her changing relationship to her Mum, and not locating much common ground between these two themes.

Ultimately Myrtle emphasised stoicism in the face of her physical conditions. For example when she had broken her ankle a couple of years back she purchased a mobility scooter so that she could continue to walk her dog – this story conveyed an eccentric image but also emphasised that she wasn't going to let anything keep her down. This attitude was somewhat antithetical to much of the prevailing wisdom of the time as I encountered it in the literature: of the danger of chronic pain sufferers 'pushing on through' and making their conditions worse; of the importance of listening and being responsive to our bodies. Furthermore Myrtle did directly contrast her own attitude to stoicism with the way her mother and maternal grandmother would take to bed at the first hint of unwellness. She described herself as being more like her Dad, who was tinkering with classic cars until two weeks before he died. As such Myrtle from the beginning of our work together actively rejected the "sick role" that Allen and Woolfolk (2006) argued would need to be renegotiated at the culmination of their therapeutic approach. I challenged her as to whether there was a danger to her own health of setting herself up as on an opposite pole to her Mum. However Myrtle doubled-down on her stoicism and I backed down – this image had become personally meaningful for her; it was a way of life that 'worked' for Myrtle, as I explored further in chapter six.

Myrtle and I only originally contracted for five sessions and when we reached the fifth session I suggested to Myrtle that she could take more sessions if she wanted them but Myrtle was clear that she felt "good to go". I felt some regret that we didn't continue beyond the fifth as it felt like we were only just starting to get under the skin of her experience of self in relation to her Mum and her Dad, and indeed how this was shaping her illness identity. The most significant moment, and the lasting impression for Myrtle, of our time together was that emotional outpouring in the first session that had taken her by surprise. It appears that that experience was a catalyst for attitudinal and behavioural change. Myrtle also did appear to have experienced an uplift in her mood, as reflected in the PHQ-9 and GAD-7 scores. She also reported a notable change in her ectopic heartbeats. Where before our sessions began these flare-ups could last for up to two hours at a time, by our fifth session Myrtle described only having about one flutter per week.

It may be significant that Myrtle had had no previous experience of counselling and psychotherapy before we met. As we will explore in chapter five and six, sections 5.5.2 and 6.7.3 respectively, Myrtle experienced what I will go on to describe as a 'crystallisation of discontent' in session one which set the agenda for all the meaningful work that we would do together (Baumeister, 1994; Hayes et al., 2007). As I will go on to explain in these sections, having me as a uninvolved witness to her experience, and indeed the novelty of the counselling situation - its confidentiality and its unconditional positive regard - may have been experienced by Myrtle as a line in the sand. Myrtle's experience for the first time of the core principles of the therapeutic environment per se may have been the active ingredient which allowed her to make contact with such profound grief in that first session. That being the case Myrtle may well have had a very similar epiphany if she had sought out counselling decades previously. When I consulted her about the case report she offered some thoughts on this experience, some of which I have included later in this chapter, section 3.4.2.

One September evening about a couple of months following the end of our work together, I received a text message. I remember it was quite late as I'd just finished my client work for the day. It read:

Hi John. Sorry but I don't think I will be able to meet you to discuss your notes. Unfortunately things have gone a bit pear shaped for me. I have been diagnosed with breast cancer.. which rather makes my worries about fibromyalgia a bit insignificant. Not sure yet how things will go as I need more test but definitely need an op. However I had made notes for when I saw you, I am happy to send them if it would help. Sorry to throw a spanner in the works.

Myrtle and I had had a very brief run of sessions together and her subsequent treatment for cancer occupied the next nine months, by which time she finally finished her chemotherapy having had a mastectomy along the way. As she anticipated, our brief stint together was placed in a very different context given the journey she was about to undertake. In our subsequent communications I was more keenly aware that therapy – especially such a brief run as we had – may only touch a person at a certain level; that subtle intervention may leave its own signature but that our clients' lives go on and on.

When she first got the diagnosis I offered her to return for counselling 'no research, just to give you a space to talk through your feelings'. Beyond it being an obvious point of care for my client, I wanted to have been able to support her during that coming chapter of her life. However she declined saying that she had various operations and procedures and then would be beginning the chemotherapy. I know from previous experience working with a cancer charity that when people are undergoing treatment they can be extra-protective. Myrtle had an experience of therapy that was in some respects exposing and energy-intensive and in that context perhaps understood that the kind of work we had done wouldn't have been helpful for her during that period. Alternatively, perhaps I had not provided a good enough container for the vulnerability that Myrtle had brought to the first session which made her doubly wary of being similarly exposed again.

Myrtle grappled with cancer with much the same stoicism I'd encountered during the time I worked with her. A couple of weeks after her original diagnosis she texted me again to provide me with an update and wrote:

It's odd. I feel mostly strangely calm and detached. As if it's out of my hands and I can only go with it. And I'm afraid the black humour still keeps kicking in though. And I'm beyond worrying if it may shock people. Lol. Fortunately my daughters share the same gene 😊

3.4.1 Attainment of therapeutic goals

Myrtle's three stated goals were those that were probably the most ambiguously evidenced. In her assessment, she set out:

1. To be able to relax more and reduce anxiety and stress.
2. To find your own 'self' again
3. Be able to face health issues

As we shall see in chapter five, section 5.5.2 and in chapter six, section 6.5, Myrtle's capacity to relax more and manage her anxiety was heavily bound up for her in her relationship with her mother – she went on to have a breakthrough about this in her first session with me and the subsequent meaning making which transformed her understanding her anxiety. Perhaps the most direct evidence that Myrtle was experiencing less anxiety was in the significant reduction of her ectopic heartbeats. However the moment we broke through into an awareness of how important her relationship with her Mum was, questions about anxiety and stress became more abstract and thus faded into the background. What I also find interesting are the parallels between what Myrtle and Jennifer set out to achieve and the divergence in where they ended up. Like Jennifer, Myrtle intended to find her own self again. Whilst Jennifer realised that it was important she didn't try to return to exactly the way before, Myrtle may well have had her own self reaffirmed by my witnessing of her funny stories, perhaps also by her reaffirmation of her black humour brought about by my questioning of her laughter in the case report that she read. I explore these issues further in chapter six, section 6.7.5.

Likewise, whilst both Jennifer and Myrtle both intended to manage their physical conditions better – chronic fatigue in Jennifer's case and fibromyalgia in Myrtle's case – they came to radically different positions about what it meant to listen to their bodies, as explored in chapter six. Whilst Jennifer learned to be more positive about resting, Myrtle actively rejected some of the established wisdom around listening to her body. And our attempts to facilitate Myrtle 'facing up' to health issues were successful only to the extent of Myrtle consolidating attitudes she already had about health and unwellness, rather than discovering a new approach. Perhaps it was implicit in the way the goal is phrased: 'facing up' which suggests Myrtle accepting the chronic reality of her fibromyalgia rather than hoping for any qualitative change in her experience of it.

3.4.2 Myrtle's feedback

In Myrtle's own written feedback to her case report she commented on the mixed successes of my advocacy of the 'bank account' method for preserving energy levels and avoiding pain flare-ups in fibromyalgia, she observed that:

It was good to clarify my thoughts and good to have someone playing Devil's Advocate. It helped me think – and to see that there was another way to come at this – especially my fibromyalgia. I know you feel we didn't fully sort this out. However I feel really we are flogging a dead horse. I will never accept that it's going to affect me and I will do my damndest to cope with it in my own way. I probably won't give in to it unless I have to – partly as a knee-jerk reaction to "I will not be like my mother" – I'm sure her "illnesses" have been just as real to her – but if she had made some effort she'd have had a better life – and partly because I am too stubborn!

This passage demonstrates how illness identities – even ones that might be considered adaptive – don't always fit with classic model of acceptance, going with energy levels, not pushing on through etc. Central to Myrtle's sense of self is her determination to keep going – here defined in contrast to her Mum's style of coping - even if sometimes this has the effect of aggravating her somatic symptoms. Myrtle's original stated goal of finding her own self again is indicated in this passage. It is almost as though the 'failure' of my advocacy of the bank account method is affirming to her. Where she comments 'I know you feel we didn't fully sort this out', this sounds somewhat apologetic on the part of the client to the therapist, or indeed the research participant to the researcher. However the comments might also be understood more collaboratively – an understanding between us about the 'pooling' of our ideas and sensibilities and thus of the therapeutic work as being co-created between us. There is I believe an indication of Myrtle's experience of equality between us in that statement.

Elsewhere, Myrtle took up my suggestion in the case report that she might have felt she needed to give me something more concrete to demonstrate the value of the therapy she had – a scripted or expected account of therapy, to please me as therapist and researcher:

Not so. The thing is that for probably last 30 years I have coped, looked after everyone, always had a firm belief that problems could be solved, that I was strong, never down, carried on regardless etc. etc. To find myself suddenly in floods of tears, pouring out my angst to someone I had actually just met was a bit of an eye opener to me. It made me think that actually – this isn't how I am.

Myrtle appears to emphasise that rather than feeling in any way that she needed to perform for me as her therapist and as a researcher, that rather my witnessing of her

torment over her guilt in that first session was a genuine line in the sand for her. I explore the significance of my witnessing of Myrtle's experience, and thus of evidence for or against expectancy effects, in some detail in the mini-study at the end of chapter six.

3.5 The Fifth



As observed in the Introduction, writing about a participant who was in the study and then withdrew, without revealing any personal qualities in the writing, presents a challenge. My selection of the above image reflects my impression that their influence over the project is somewhat like a gust of wind, invisible in and of itself, passing through the project, but nonetheless leaving an imprint. What I can say about my work with the fifth participant was that it reflected something of an outlier, perhaps even a 'disconfirmatory case' (Benoot et al., 2016) within the selection of five. Whilst each of the four cases which remained in the study might be described of in general terms as good outcome cases, the work with the fifth participant may be fairly described as a poor outcome case. I say this because the challenges the client arrived with at the beginning of our time together – including in their somatic experience – remained essentially unchanged at the end of our time together, notwithstanding some chinks of light we experienced along the way.

I recall Jane's description of the ghostly presence of the fifth participant within the thesis and the following reverie comes to mind: My four remaining participants, and I,

my professional self, clutching my explicit thesis, are stood on a stage, taking a bow to an appreciative audience. However behind the stage curtain stands another figure, whose image we can't make out. They are there as a messenger; they bring information from beyond the curtain – from beyond the limits of this thesis, and the beautiful theories that emerge from it. They implicitly stand for what didn't work and perhaps even the contexts in which the theories lose their explanatory power. They represent lingering doubt behind certainty, the fraying of the fabric, the pregnant pause that follows the spirited conversation.

As previously observed my work with the fifth participant was the most relationally intensive. In my writings on our work together I considered the layers of subtext that appeared to be communicated between us. We were for the most part stuck: the therapeutic work did not flow, and from that place of stuckness the therapeutic relationship became the primary source of 'material' that we might have used to become unstuck. It feels appropriate to share my feelings. I feel in a sense doubly disappointed: disappointed that we weren't able to break through clinically, and then disappointed that my client felt they needed to withdraw. That they didn't want to share any reasons for the withdrawal indicates to me that from their perspective our relationship had broken down – I was no longer a therapeutic ally. I believe the client experienced me as on their side during our time together, and so the loss of that 'understanding' leaves me feeling sadness. I also felt frustrated that after having done so much work in data processing, analysing and writing about the case - then re-analysing, rewriting etc. - that all that work needed to be removed. However as already observed, that work remains implicitly embedded within the thesis, perhaps as its own anti-thesis. This is an issue I'll return to in chapter eight.

3.6 Conclusion

In this chapter I have provided narrative introductions and some key pieces of information for the work done with each of the four participant clients, including some initial indications as to where I believe the substance of therapeutic change might be observed in the work we did together. In the four chapters that follow data as recorded

during the data collection window are analysed in an iterative, cyclical approach. I identify a succession of theoretical 'templates' which are applied in analysis of the data. Each template is a working theory about the nature of change in therapy for the participant clients and these emerged chronologically during and beyond the period of data collection itself.

3.7 A patchwork quilt

In my diary a few days before my Dad died I observed that my creative approach to building up theory during my PhD - dipping into the literature and collecting up little flashes of insight like silver pieces - made me somewhat like a magpie who was popularly thought to be drawn to collect up all things shiny in order to make their nests. I understood this as a strength at the time, but also that it was a bolt-on type approach, bolting on pieces of theory without allegiance to any one overriding theoretical frame.

Following my Dad's death the map I found to navigate through those first few weeks was to take responsibility for the organisation of his funeral. One of my primary responsibilities was to create and deliver his eulogy. I

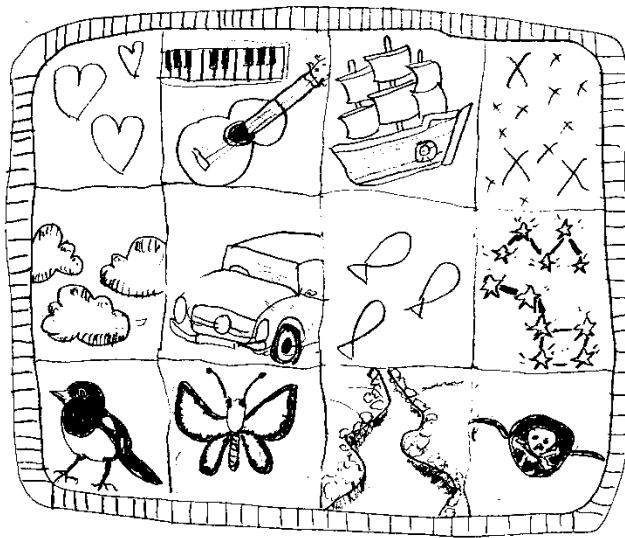


Figure 11: My sketch of a patchwork quilt

understood that I had known my Dad a certain way and at a certain part of his life, but my brother, and Dad's brother and sisters, his mother, his friends etc. would all remember him in their own different ways. As such I asked to meet with everyone that had known him well and just asked them to share with me their memories. I remember my laptop broke down so I was scribbling all these memories down on scrap pieces of paper. And what impressed me most of all were the different ways in which my Dad had touched them – they each knew different versions of him. He was in one story a teenager who made cine-films with his brother and sisters in their costumes; through other eyes he drove around on a chopper motorbike and once got in trouble with a policeman. Elsewhere he idolised Bruce Lee getting fit by running laps around the fields, or performing on stage as David Bowie in full make-up. Or taking his little boys out to the theme park in his red pick-up truck. No one witness account offered a complete account of how we all knew Dad. As I collected up these memories I remembered what I'd written about myself as the magpie and I

found myself knitting together all these different glimpses into a kind of patchwork quilt of a narrative. There was no overriding 'hook' or if it was it was very subtle, but it worked as a vehicle of his remembrance in the church.

Likewise the reader of this thesis may encounter something of this patchwork approach to theory, which is similarly my attempt to manage and contain an almost infinitely complex web of meanings. Whether by stitching together, as in the early stages, or an overlaying of theory as the thesis developed, different theories have been added to the fabric of the thesis, and its overall coherence was understood latterly, as an emergent property, and the addition of one element might have the potential to change the shape or feel of the composition again.

Analysis of the cases through the phased emergence of a map of change

In the following chapters I track the chronological development of my evolving map of change across four distinct phases during and beyond the period of data collection, and demonstrate how each new development draws out different analyses of the cases. Each new phase is marked by the conception of a template – an individual form of change – that entered my awareness during that period. Each new template may be considered to be layered upon the existing map, in building up a more complex and coherent account of change. The templates emerged chronologically as follows:

November 2017 (i.e. the beginning of data collection)

1. **Migration between dominant and alternative I-positions:** primarily influenced by Ribeiro and Gonçalves' (2010) account of narrative-dialogical change.

August 2018

2. **Mapping a longitudinal model of change onto the migration between I-positions:** primarily influenced by Prochaska and Norcross' (2001) application of their transtheoretical model to psychotherapeutic change.
And the **Introduction of novel stages relating to identification:** primarily influenced by stage-based concepts not covered in the original model, for example in immediacy in person-centred thinking (Rogers, 1961) and social learning (Luyten et al., 2017).

November 2018

3. **The generation of cognitive maps:** primarily influenced by the concept of subjective incompetence (as described in Figueiredo and Frank, 1982; Figueiredo and Griffith, 2016) and the functional contextualist basis of Acceptance and Commitment Therapy (Hayes, 2004)

April 2019

4. **Dialogism in the therapeutic relationship:** primarily influenced by recent studies such as Luyten et al. (2017) and Stuthridge (2017) in which the therapeutic relationship is directly conceived of as a vehicle for modelling change.

With each new phase, significant events and data from the cases are considered and re-considered in the light of the emerging template. Crucially in the terms of this research project, this emergent map of change guided my work as a practitioner in working with my participants and my other clients, and as a researcher in making sense of the data collected from the audio recordings. Directly put, the model of change informing my practice was also my framework for analysis.

I noticed early on in my data collection - as I was coding my audio recordings primarily for passages where my clients spoke from different I-positions - that much of the data remained uncoded. I understood even in those early stages that those uncoded data were being treated somewhat like 'white noise' e.g. the crackle behind and between the theoretically interesting material. In reality I understood that embedded within that white noise would be meanings as yet undiscovered and unexplored. I recalled a mathematical method that I first learned about in my late teens known as Fourier Analysis. In Fourier Analysis complex sounds, crystal structures, or radio signals that have their own unique pattern, may be treated using known formulas for different wave forms to reveal hidden regular patterns underlying the 'noise'. In the first-phase, searching for my clients speaking with different I-positions, I was looking for one form of regularity and extracting those from the totality of the data. What I found interesting during this process was that with each new template applied to the cases I found I was observing new meanings in data that had previously been treated as white noise. It would seem reasonable to suggest that beyond the four templates applied to the cases in this present report, yet more templates could and would emerge that lent new meaning and significance to the data beyond those recognised here.

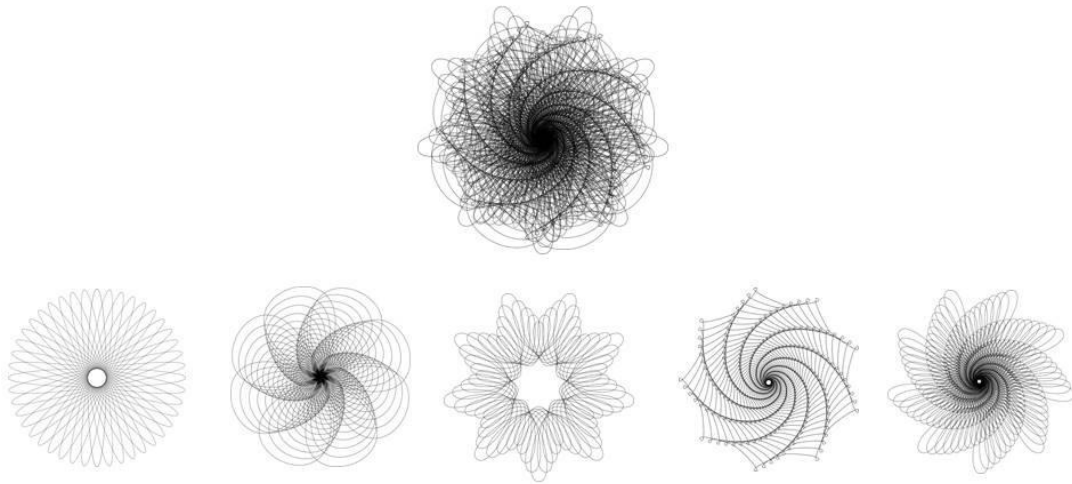


Figure 12: A visual analogy of the purer, simpler patterns that may be extracted from the entirety of the data

As these patterns are extracted from the 'noise' of the data, I imagine them as being layered onto one another again to create a more sophisticated, accurate and useful model, or map, of therapeutic change. As a visual analogy I imagined the way in which a map begins to take form as knowledge develops through the process of *map overlay*:

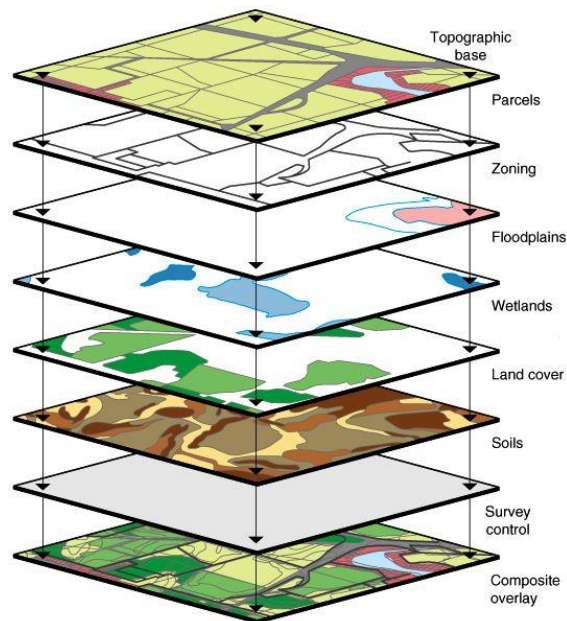


Figure 13: Map overlay process. [No year]. [Diagram]. At 'GIS Overlay Chart', on the City of Forney website, <https://www.forneytx.gov/821/What-is-GIS> [available as a public domain image]

Falling not flying

Sunday, 15th October 2017

A dream. It's the day of the presentation (to the School of Healthcare PGR conference in November), I haven't collected my poster yet, but I'm still having to write the information sheet. I'm working in some sky scraper building on a floor a long way up. The room I'm in doesn't have a floor and so I'm literally clinging on for dear life whilst I try to type the information sheet. If I lose my grip I'll fall hundreds of meters to my death. I don't question the fairness of this – the thought that I have is that this is how life is and most people get on with it, survive it, and take it for granted and I must too. When I get there I realise that I've been put in charge of lights and sound and so have to quickly learn how to do these on PowerPoint. Greg (one of my tutors during my training) speaks and he says that there are sixth form students coming through who are so much brighter and more talented than my generation. I recognise this as truthful but think I've still got enough in me to compete. Then I see the running order and I am on just before Jon Stone, who is an international expert on the neurology of Functional Disorders. I fear that during his own presentation he will pick apart some of the things I've just presented in mine and it will destroy my image in front of my colleagues and contemporaries.

Here was a classic anxiety dream. However the skyscraper was a motif that recurred in my dreams during this period, as was the danger of falling to my death. For most of my adult life I'd had recurring dreams about flying, however somehow during this period I was losing the ability to fly – and was falling instead. The skyscraper possibly represented the vertical structure provided by the University – a structure that led not just to me getting my doctorate but also an allusion to the subtle social hierarchies in the University. The fact that there is no floor indicates for me that this “game” – the term used by the School of Healthcare's director of research in a recent meeting – was one that I was not guaranteed to win: one false move and I could fall right back down again. This in turn evokes for me the migration of salmon back up their home rivers – not all of them will make it back to the breeding grounds, some will fall foul along the way, and I could be one of them.



All the world's a stage,

And all the men and women merely players:

They have their exits and their entrances;

And one man in his time plays many parts.

Shakespeare, *As You Like It*

Chapter Four, 1st template: The migration between dominant and alternative I-positions

In chapter one I provided an account of the development of my understanding of psychotherapy for embodied distress presentations during this period, and thus the genesis of my model for change as the migration between dominant and alternative I-positions within a narrative-dialogical approach to psychotherapy. In the first round of analysis that follows then, I consider the evidence within the cases of my clients occupying certain I-positions - especially in relation to their illness experience and its wider associations with sense of self and identity – and evidence of my clients making contact with, or speaking from, alternative I-positions during the course of their therapy.

4.1 Lou: The Peacemaker vs “Fire in my belly”

Lou identified very early on that her role within the family, including with her husband, and originally in her childhood family – particularly in relation to her mother and sister – was as a peacemaker. Lou shared with me memories of violent family arguments involving both her parents and her grandparents at times, and one image stuck in my mind: of her cowering at the top of the stairs whilst arguments raged downstairs, and people threw things at one another. Lou as a girl learned she had to be the peacemaker. In adult life this meant intervening between warring family members and herself getting caught in the crossfire; it also meant her bending to accommodate the demands of others, including her husband. Lou began therapy shortly after an intense panic attack that she’d had during a row with her husband. She had taken a stand against him after he had given her a hard time about going to an evening class. This was understood by Lou and her husband to be out of character and following a GP appointment she was referred for counselling.

Lou came for our second session of counselling following an intensely upsetting argument with Mum, which in many ways bore some of the same qualities as the original row with her husband. We often referred back to this in later sessions, and it provided an early glimpse for me of Lou’s relationship with her Mum. The following passage also demonstrates how a change process typified by the breaking down of old pattern of relating – Lou keeping the peace - already seems to be taking place, indicating that the change process began before Lou arrived for therapy:

(L = Lou; J = John)

L: I just go into a rage, and it’s not me [...] when that happens I just want to push everyone away. It was the same with [husband] that first time – I pushed him out, I just want to be on my own. So I ended up driving the car with the door open because she wouldn’t shut the door because she didn’t want me to leave because I was upset. But obviously like, I set off and she slammed the door. But then I was really upset and started having a panic attack. So I pulled over and sorted myself out for ten or fifteen minutes and then carry on.

(Later)

L: The thing that I was most upset about after was that I'd upset my Mum [...] I felt guilty that I'd upset her and upset my sister because they've never seen me like that before.

J: So this is completely new in terms of what your sister's seeing – your Mum too?

L: Oh yeah my Mum's never seen me like that and [husband] has but only recently.

(Later)

L: I was angry at myself for upsetting my Mum even though it stemmed from something she had said.

J: Are you allowed to have a grievance or has it all become about your Mum and your Mum's grievance?

L: Well that's it, and I was frantically texting her saying I was sorry. And I was texting [husband] saying 'Can you ring my Mum and tell her I'm sorry' and started panicking because she'd not responded to me.

((Lou breaks down, crying))

After the argument Lou's Mum had gone out shopping with Lou's grandmother and sister which Lou took as sign that the argument hadn't affected Mum as much as herself.

(Later)

L: Last night I just had the most weird dream, it's about people dying, you know like my family dying, and when I wake up I can't, you know when you wake up and you get rid of it, and you go back to sleep and it just continues, you know like I can't ever get out of it.

Although Lou's dream was shared with me later in the session I attach it to this passage because it felt to be relevant to what I understood at the time to be a new I-position breaking through. Lou was terrified after the argument of the effect it would have had on her mother; desperately seeking to repair the situation through the text messages. That night she dreamt about her family members dying, and I experienced it at the time as though if she broke out of her usual peacemaker role this would 'kill' the people around her. I would go on to learn in a later session how when Lou was a girl and heard her family arguing she feared that someone was going to be killed.

By session four I recorded in my notes a feeling of our sessions starting to have their own momentum. In that session Lou was also starting to report the first few signs of being able to take alternative behavioural positions with respect to her husband who she experienced as putting pressure on her to have more sex:

L: [Said to husband] You know what you're being unreasonable, because you want something I can't give you right now and you're going to have to accept that. So I think... I was quite proud of myself after I've done that because I was like "yeah well you need to tell him" ((as though coaching herself))

(later)

But then when he walked off to the train I looked at him and he looked miserable, I felt guilty then and I got home and I was texting him 'I'm sorry, I'm sorry'. So even though I was strong and I did tell him afterwards it was like with my Mum, although it wasn't as frantic [...] but, I don't know that I did need to say sorry. I said sorry to try and keep the peace. Cos when he got home I didn't want any conflict I just wanted it to be right.

(later)

L: In the midst of everything I am starting to think: this isn't right, or I don't have to do this, or I'm doing this for your benefit.

I highlight in these passages an ambivalence in Lou's attitude – on the one hand she believes that things have to be different and is starting to take a different position with significant others, but on the other feels panic when she takes these positions. Lou recognised she was starting to do something different; something not typical of the peacemaker. When I asked her if she could describe it, she described it as "Fire in my belly" – and this became the label that stuck as we referred to the alternative position.

It was in Lou's friendships that she first started to confidently cast aside the Peacemaker role and stand up when she believed something was wrong. In the following passage Lou is reflecting on how she experienced a close friend disclosing to her an extra-marital affair. Lou felt disillusioned that even close friends could behave selfishly or deviously:

L: She expected me to say: oh that's rubbish, but whatever. But I said: "I don't agree with that at all, it's not fair on [friend's husband] it's really selfish" and she was a bit like "oh ((as if shocked)) why are you saying that to me?" But I can't hold back how I feel all

the time because I feel like it's so wrong. I can't just sit there and say it's not when I know it is.

In this passage Lou describes her management of a conflict involving her husband and a mutual friend applying the work we'd done in therapy, taking control and experiencing positive affect:

L: If I go to [class] it'll be like nothing's happened and I'm not prepared to do that because she sent me this long message on Sunday and put on the end 'shall we move on from this'. And I'm like, well, no actually no, I'm not prepared to do that.

J: That would be what the peacemaker would have done.

L: Yeah, yeah I do feel like that, and she's like.. so after I texted her saying 'No thank you I'm going away. I'm not interested in coming to [class] this week, I'll see how I feel when I get back' is what I said

(later)

L: But after it all died down and it was peaceful again I just sat on the sofa and I just went ((breathes sigh of relief)) God I feel better now. That I've told her that I'm not happy. I need to do it more, when I'm annoyed with something, just say it ((smiling as talking)). I feel like, like today when she was messaging me, I thought no I'm going to be in control. I want to be in control of this. And I was just like no I don't want to come this week. Because normally I'd be like, ok I'll see you at 7 o'clock, carry on as though nothing had happened. Today I just thought, no, why should I?

Note how in this passage I am modelling for Lou a contrast between a present I-position and an older, dominant one, when highlighting what “the peacemaker would have done”. It was about this period of therapy that Lou started to practise the alternative I-position “Fire in my belly” with more confidence and without the anxious ambivalence that originally had followed those e.g. as she rowed back from the stance she'd taken with her husband as reported in session four. As we will observe in chapter six, Lou became more skilled in asserting herself – having “fire in my belly” – in the core family dynamic that was at the heart of her distress, but which she had recognised was a greater challenge for her than standing up to her friends.

Lou's increasing competence in performing the “fire in my belly” position can be tracked longitudinally. Pre-therapy it perhaps could be conceived of as ‘beginning’ with a

mysterious rebellion against her diet in early 2017 (as we will return to in the mini study in chapter five). Later in 2017 she had no means of channelling or conveying the anger that she felt towards her husband constructively and so it came out as rage, and she literally vomited it out. In the early stages of our work Lou began to assert her own needs but felt intensely anxious and ambivalent after the event and tried to make it right with those who she felt she'd injured. However in the latter stages of therapy Lou was able to assert her own needs calmly and to feel proud of herself afterwards.

Thus the "Peacemaker" intervenes to reduce the temperature when those around her are in conflict – but as a mediator she would often then herself get caught in the crossfire. The Peacemaker could never assert her own needs as that would be dangerous – the atmosphere was already flammable and to assert her own needs would be extremely dangerous. For the Peacemaker, where there were conflicts and disagreements, the safest strategy was the sweep everything under the carpet and move on as soon as possible. As we shall observe in chapter six, being the Peacemaker was an exhausting position to occupy, such that when Lou began therapy she was not able to work.

Lou with "Fire in my belly" on the other hand was not, as it might seem on first glances, necessarily aggressive or selfish, though Lou struggled with the idea that to assert her needs felt selfish. Rather Lou with "Fire in my belly" stood up for what she believed to be right, as when she stood up to her friend in her extra-marital affair. Lou with "Fire in my belly" learned that people did not die when she asserted herself and that rather it was liberating for her, and redressed power imbalances between her and her significant others. Lou in this mode learned that "I don't have to do this" – that she had a choice. As Lou learned to practice "Fire in my belly" skilfully she was no longer overcome by waves of physical exhaustion.

4.2 Michael: "Keeping my head down" vs "Standing taller"

Early on in my work with Michael we were able to identify what amounted to a phobia – Michael was afraid of his disability being seen by others. In being faithful to Michael's own language, the description that appeared to index most closely back to his dominant

I-position was that of “keeping my head down”. When Michael first introduced this idea I immediately thought of an LS Lowry painting with the workers with their bent backs, hurriedly getting to where they needed to be – each body much the same as the next, almost characterless silhouettes. In the Lowry painting the people are all moving en masse – as though to the chimes of a factory clock – and yet there’s no interaction between them. They each face down, in their private thoughts, which seem impoverished and narrow because they are only internally generated. When Michael talked of keeping his head down I imagined an aspiration to be yet another of those silhouette people, blending in, flowing along. In the following passage from session two he is disturbed by the possibility that others might have seen through his efforts to disguise his disability without him realising:

(M = Michael; J = John)

J: I get the impression that one of the potential thoughts that went along with that before you start to talk about it [Michael’s disability] is that sense of... are they noticing it ((M: yeah yeah)) are they aware of it, kind of thing, yeah?

M: That’s it. How long have they noticed it and have they just decided to say something now or have they just... you know

J: I see, so even when you start talking about it there’s also that sense of how long have they been aware of it?

M: Yeah yeah have they just been polite and not said anything or, you know... obviously you don’t know without asking ((said with a stifled laugh))

J: No that makes sense, that makes sense, absolutely

M: So then you know you think in your head: ‘God has it really been that... pronounced for the last, I don’t know... six months that I’ve been working for them or whatever... they’ve known me or whatever or is it just... the odd time that they’ve noticed it’. That’s it ((said as though concluding))

J: And you don’t know

M: No

J: And it’s the unknown that ((inaudible as overlap with Michael))

M: Yeah yeah I think so... it's that... yeah sort of the unknown ((quieter as though trailing off))

I suggested to Michael that he wished to “pass as normal” and he agreed with this. The horror for him was as being seen as different, and somewhat ironically, that desire to conceal his difference heightened his feelings of alienation. By the fifth session (out of 10) Michael was already envisaging an alternative to “keeping my head down” as identified in the following passage:

J: I can hear it in you somehow, I can hear that you're sounding pro-active, you're going for this, your attitude has... has shifted into a proactive role here

M: Yeah. Like I said I do feel more positive and comfortable, going forward now... and trying to get out of that rut, that's been the... the comfort blanket, keeping my head down, sort of thing. Sort of just... standing up a bit more. And like you said: standing a bit... taller, just, when things are... sort of, starting to get to that point, just sort of taking a deep breath and looking around... seeing what else is going on in the world, instead of my world.

I note here the way that I was implicitly modelling my map of change such as it was at this time, when I talk about Michael “shifting” into a different “role” I am conveying the image of moving between I-positions. At the time I didn't pick up on the literal significance of Michael “standing a bit taller” suggesting at an embodied I-position distinct from that of “keeping my head down” by virtue of posture. Retrospectively I think about the observed psychological value of correcting posture, for example the association of ‘power poses’ which typically involve a straight back, head up, chest out etc. with increased testosterone, reduced cortisol, and greater capacity for risk taking (Kim, 2018). By the seventh session Michael was revelling in successful ‘exposure’ techniques that we'd designed together where he would deliberately draw others' attention to his own disability. What is also notable from that passage is where Michael draws a distinction between “the world” and “my world”. In our first session Michael had complained of intense social anxiety in situations where he felt everyone was looking at him. I taught him a basic affect management technique where he would actively choose to watch others in these situations – to people watch – and thus shift

the attention away from himself. This simple exercise triggered a lot of clarity for Michael about his self-consciousness that appears again in a more digested form here.

Thus for Michael when he was “keeping my head down”, passing as normal was the objective and the way that he got on with the rest of the human race. “Keeping my head down” meant Michael avoiding having his disability exposed at all costs – what is private is private. Michael “Standing taller” by contrast was more assertive. This assertiveness manifested directly in Michael actively deciding to draw others’ attention to his disability but also more generally as he increasingly reported being able to take different points of view to the people around him and thus being less afraid of conflict. Standing taller, Michael was less self-conscious and more interested in “the world”; more specifically the lives of his friends and their families. Finally “standing taller”, Michael emphasised the importance of being more open, which he believed was one of the most important ideas he’d acquired in therapy.

At the same time as these examples from the work with Lou and Michael thus demonstrate, I was able to identify data from all four cases which might be associated with different I-positions my clients appeared to be occupying, and that – as anticipated by Ribeiro and Gonçalves (2010) – the power imbalance between dominant and alternative I-positions shifted during the course of the work, either gradually as with Lou and Michael, or more suddenly as with Jennifer and Myrtle. In the following section – the first mini-study - I provide a window into the systematic way that I coded data from each of the four cases, according to *innovative moments*, associated with the emergence of alternative I-positions, as theorised by Ribeiro, Gonçalves and colleagues.

4.3 Mini-study: Identification of innovative moments in the case of Michael

As observed in chapter one, the *Innovative Moments Coding System* was developed by Miguel M. Gonçalves, Antonio Ribeiro and colleagues at the University of Minho as a means of systematically tracking longitudinal change in clients’ self- narratives (Gonçalves et al., 2009b; 2011) through the emergence of novelties. For Ribeiro and Gonçalves (2010) clients making contact with and developing an alternative self-narrative is a primary vehicle of change. To track the emergence and evolution of the

alternative self-narrative the Innovative Moments Coding System is designed to identify novelties within the transcripts of the therapy sessions. A novelty is an utterance by the client that would not be predicted by their dominant self-narrative (Gonçalves et al., 2009a). Passages from transcripts from every session of a client's therapy are coded according to the researchers' understanding of the client's dominant self-narrative: a client utterance that appears to deviate from it and the subsequent therapeutic exchange are coded as innovative moments. However the researcher also codes for *ambivalence markers*: passages which indicate a client's retreat back to the dominant narrative, for example as an anxious reaction to the unfamiliarity of the alternative narrative (Gonçalves and Ribeiro, 2017). In good outcome cases ambivalence markers are observed to decline in frequency as therapy progresses. Innovative Moments are coded on three different levels. As explained in chapter one, Level 1 innovative moments were the first indices of novelty in a client's self-narrative, as expressed through action, reflection or protest. Level 2 innovative moments were those innovations in self-narrative that feature either contrast with how things were before, or an observation about a change process that appears to be underway. Finally, Level 3 innovative moments were those innovations which featured both contrast with how things were before and an observation about the process responsible for those changes – originally the domain of the reconceptualisation and performing change innovations (Gonçalves and Ribeiro, 2017; Nasim et al., 2018).

4.3.1 Lines of enquiry as informed by the Innovative Moments literature

Given the gains Michael reported and demonstrated I understood this to have been a good outcome case. In recent literature on innovative moments as informed by the developments around the concept, it is observed in both Nasim et al. (2008) and Fernández-Navarro et al. (2019) that in good outcome therapy Level One innovative moments are observed from the beginning of therapy and remain constant or fall into decline as therapy progresses, and Level 2 and 3 innovative moments emerge later. Furthermore in good outcome cases Level Three innovative moments are observed to emerge from the mid-stages of therapy (Fernández-Navarro et al., 2019). This observation I found interesting as it suggests that much of the break-through work of

therapy – moments of insight, experiences of behavioural change etc. begins to occur from the second quarter of therapy such that by the mid-point clients are already starting to reflect on these and generate an alternative self-narrative. My understanding was that the most significant gains of Michael's therapy occurred from the seventh session until the end e.g. in the final third of therapy and thus I set out to observe whether indeed the pattern as anticipated by Fernández-Navarro et al. was observed in the analysis of Michael's sessions.

Eugénia Ribeiro et al. (2018) in considering therapeutic change as the 'reconceptualisation of the self' conceived of therapists' interventions as falling into two general categories: therapists may either be supportive of what the client has said – e.g. by providing empathy or helping the client to elaborate, whether they have spoken from the dominant or alternative self-narrative – or the therapist may challenge what the client has said, for example challenging the coherence of the dominant narrative, or by inviting a comparison with an alternative narrative. Gonçalves and Ribeiro (2017) similarly highlighted the importance of therapists' responses to ambivalence markers. In poor outcome cases therapists were observed to be more likely to push their clients to work on their alternative self-narratives. This would be instead of for example, simply empathising with the client where they expressed ambivalence or indeed facilitating any form of negotiation between the different narratives. My understanding of this is that challenging a client at the point of expressing their ambivalence may push them beyond their therapeutic Zone of Proximal Development (the Vgotskian concept as applied to psychotherapy in Stiles et al., 2016) – such that the challenge is alienating for the client and may even increase their anxiety further. Therefore in systematically identifying the innovative moments and ambivalence markers within my work with Michael I wanted to understand better the nature of my own interventions – where had they been supportive and where challenging; in what contexts were these different orientations facilitating and where may they have been unhelpful or counter-productive?

I had been using the innovative moment coding system as a guide from the beginning of my data collection in November 2017, and at various times throughout the coming twelve months I attempted analyses of the data I was collecting, testing various theories that were present for me at the time. As already observed in chapter two, key dissemination events such as presenting my research as it stood at conferences, drove analytic cycles of the data, including analysis of innovative moments within my case

work. The mini-study presented here then might be regarded as a polished or idealised synthesis, or even a case study of my approach to analysis using the innovative moments coding system during this period. I have selected the case of Michael because his therapeutic process was most obviously trackable as something in development across the ten sessions in which his motivation grew, his narrative accounts emerged and evolved and when he ended at the tenth session it was clear that we'd done a discrete 'piece of work' together with well-evidenced good outcomes.

4.3.2 Performing the analysis – coding

My procedure was to listen through each of the nine audio recorded sessions of my work with Michael, and label passages from the recording as either Levels 1, 2, or 3 innovative moments, or ambivalence markers. I identified the time boundaries of each of the selected passages and was thus able to calculate what proportion of each session was occupied by therapeutic exchanges associated with the different markers. I transcribed these identified passages where they were helpful for elucidating meaning or where the transcriptions would have been useful for analytic work elsewhere in the thesis.

The following table provides examples from the coding of passages across the nine audio recorded sessions, as they break down into themes.

Table 1: Examples of innovative moments from Michael's therapy, as coded Level 1, 2 or 3

| Code | Examples |
|-------------|---|
| Level 1 IMs | <p>Motivated for change : "I've got to do it, it's not good saying I'm not doing it, that way I'm not confronting it"</p> <p>Imagining what a greater openness could be like: "If you could walk into a crowded room and say RIGHT EVERYBODY, I'VE GOT THIS PROBLEM WITH MY ARM, And then, that's it, done"</p> <p>Other people see Michael more positively than he fears they do, or perhaps don't even notice: "And it starts playing on my mind that</p> |

| | |
|-------------|--|
| | <p>maybe that's what's happening to me – they have a quick glance and then they move on to the next person..."</p> <p>Preparing to take a risk: "It's a protective mechanism that I've installed, and maybe I just need to step out of it sometimes and just take a risk"</p> <p>Successful exposure e.g. drawing attention to hand with customer "it's just a bit of nerve damage"</p> |
| Level 2 IMs | <p>Experiencing self in relation differently: "I've had a problem with how people see me; whether this is me or just a part of me" [contrast]</p> <p>Practising more openness: "I'm trying to stand a bit taller, take a deep breath and see what else is going on in the world rather than just <i>my</i> world." [process]</p> <p>Practising more assertiveness: "I think I've got a bit better with [assertiveness] – saying what I want rather than keeping my head down" [process]</p> <p>Enhanced awareness, capacity to reflect: "I try to now think back over the day [...] And sometimes I've gotta think back and say well actually I don't think there's been a [problem]... so I do that more, as a self-exercise really" [process]</p> <p>Improved experience in marriage: "I feel calmer. And I feel positive about where we're going in the future." [contrast]</p> |
| Level 3 IMs | <p>"It's more calming now" [contrast], Identification of inner, calming voice [process], which is linked to coming of age (maturity)</p> <p>Improved communication with wife: "We are better now [contrast] because of everything being out [process] It's more of a confidence thing"</p> |
| Ambivalence | Can't get past the idea that other people see disability |

| | |
|---------|---|
| markers | <p>It's very difficult to let go of something that is a defence mechanism: "I don't stand up and shout about it, it's very difficult to make that statement"</p> <p>Size of the task is outfacing</p> <p>Openness could be dangerous: "If I could just be a bit more blasé about it. But then, on the other side of the coin, does that put you in a dangerous position?"</p> |
|---------|---|

The passages across the nine sessions which I coded as innovative moments or of ambivalence markers are quantified in the following charts, according to the proportion of each therapy they covered e.g. (length of passages/total length of session)

Table 1: Proportions of Michael's therapy sessions 'covered' by innovative moments and ambivalence markers

| Session | Level 1 IM | Level 2 IM | Level 3 IM | Ambivalence |
|---------|------------|------------|------------|-------------|
| 2 | 19% | 0 | 0 | 0 |
| 3 | 34.50% | 0 | 0 | 3.50% |
| 4 | 9% | 0 | 0 | 16% |
| 5 | 3.50% | 11.50% | 14% | 0 |
| 6 | 13% | 3% | 0 | 5% |
| 7 | 7.00% | 33.50% | 0 | 0.50% |
| 8 | 0% | 28.50% | 6% | 0 |
| 9 | 0.00% | 13.50% | 9.50% | 0 |
| 10 | 0% | 0.00% | 25.50% | 0 |

These same numbers are then plotted onto the following chart which also reflects the discontinuities between sessions based on the Christmas break, a week we had to miss due to snow, and my bereavement towards the end of Michael's therapy (meaning a space of five weeks between sessions nine and ten).

In reality I found that in many of the instances in which Michael appeared to have demonstrated a Level 2 innovative moment; where Michael was making a contrast he was implicitly referring to process, and where he was commenting on process he was implicitly observing a contrast with how things were before. Nasim et al. (2018) had already grouped Level 2 and 3 IMs together, under the description of 'High Level IMs' (as opposed to Level 1 IMs which were described as 'Low Level'). Therefore I decided to combine level 2 and 3 passages to produce the following chart.

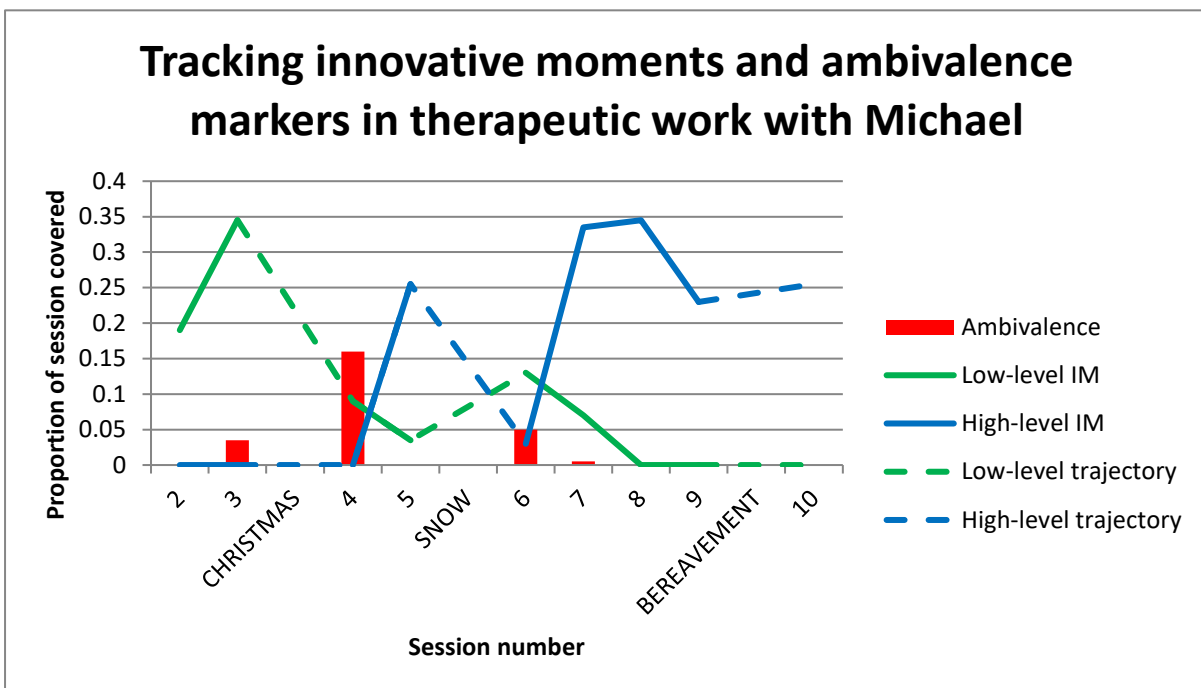


Figure 14: Proportion of Michael's sessions which were 'covered' by innovative moments and ambivalence markers

(Note that the trajectories span the periods of interruption in Michael's therapy, anticipating the changing rate of innovative moments as recorded in the next session)

In this first chart, we can see that Michael begins therapy motivated towards change, with a high frequency of low level innovative moments which were associated with statements about how things needed to change and already an understanding that there were alternatives to the narrative that prevailed in Michael's experience. Also as

Level 1 innovative moments decline, Level 2 and 3 innovative moments emerge and become more frequent. These trajectories are as were anticipated in Nasim et al. (2018) and Fernández-Navarro et al. (2019). What is also evident from the quantitative results is the frequency of ambivalence markers in the middle stages of Michael's therapy which disappear for the final three sessions as Michael by which time is making and consolidating gains as reflected by the rise in Level 2 and 3 innovative moments.

What this chart also appears to demonstrate is that Michael's early therapeutic momentum – as indicated by the high frequency of level one innovative moments – is interrupted by the Christmas break. The first session back after Christmas Michael is less motivated and more ambivalent about whether he would be able to make therapeutic progress. The pattern appears to be observed again in the session following the interruption because of snow: the innovative moments fall off and ambivalence reappears. However it is between the seventh and ninth sessions that Michael makes his most important therapeutic progress. As such at the point of the third interruption, due to my bereavement, I believe Michael had already picked up templates that were working for him and so was able to carry on doing the work during my absence. Indeed our next (and as it turned out) final session following the bereavement shows no sign of retrenchment, and Michael felt ready to end that day.

4.3.3 Performing the analysis – therapist responses

4.3.3.1 Responses to Michael's Innovative Moments

This first exert is from Michael's second session and was coded as a Level One innovative moment. Here Michael is considering his mother's perspective in which people see his positive attributes not the 'weirdness' of his disability. It is an early indication of the alternative self-narrative that is available for Michael:

Table 2: Transcript from Michael's session two demonstrating therapist's responses to an innovative moment

| Transcript | Commentary |
|---|---|
| <p><i>M: I spoke to my Mum today because obviously she's aware of it now and she said "it's just... it's only as you're... perceiving yourself. You know, everybody else sees you as a nice, likeable young man, honest, hardworking, just take that [...]" rather than she said "I know it's difficult for you with everything you've grown up with", obviously she's been there through it all, she said that it's difficult to see what other people see from the outside, you're just thinking about that negative rather than the positive – what people do actually see in me.</i></p> <p><i>J: Mmmm Mmmm yeah and I guess that was what was going on in my head in terms of what you think about yourself when you've done a job well done it's kind of, it might not be about the job 'Oh yeah [Michael's] a really nice guy' and sort of the anxieties are about 'are they perceiving spasms' or do they think I'm weird' to use that very negative word. And the positive flipside might be 'Oh [Michael's] a really nice guy' . So how did it make you feel when you're Mum said that?</i></p> <p><i>M: When it comes to your parents... I felt quite emotional about it. Not sadness but you know that feeling inside that actually yeah my Mum knows what it's like because obviously I've never felt threatened by my</i></p> | <p>I noticed Michael's Mum describing him as a "young man" here – he was 44 years old at this point. In session I thought about the inner child, and how there was an opportunity for Michael to make contact with a different way of seeing himself as he has a vague sense of in his positive/negative contrast.</p> <p>Here I am trying to help Michael develop his own positive/negative comparison but I was also trying to retain contact with that compassion that he had verbalised through his mother. Hence asking him what it had felt like.</p> <p>Although Michael doesn't speak with emotion here, my impression was that by recognising the emotional content we'd added a greater degree of significance to</p> |

| | |
|---|---|
| <p><i>Mum, because she knows but then like I said to you if I could walk into any room and say "I've got this problem" then that's it, but if I walk into my Mum's room, then she knows ((J: She knows)) so it's not an issue</i></p> <p><i>J: Yeah your Mum has been there from the beginning, and you must feel like she understands what it's like for you?</i></p> <p><i>M: I don't share a lot with her about it, I do sort of hide bits from her, I don't tell her... and this year I've talked about it openly for the first time. She's aware that I've been to the doctors over the years and I've told her what we've tried to achieve by calming things down physically but not the emotional, mental side, sort of thing. Again I've been dealing with it myself. Obviously now she knows, and it's "anything we can do to help" but it's difficult. Because there's not a lot they can do to help apart from being there and understanding.</i></p> <p>(Progresses to our first explicit recognition of the fear of being seen as different)</p> | <p>what his Mum had said.</p> <p>I.e. Perhaps we can access some self-compassion through your Mum's eyes</p> <p>However Michael emphasises the distance between him and his Mum – limitations in how much shared, limitations in how much she can help.</p> |
|---|---|

In this fashion I was sensitive to material Michael brought that indicated a departure, or the possibility of a departure, from his dominant self-narrative about needing to keep his head down; needing to conceal his disability for fear of what others would think. Catching these innovative moments my role as therapist was to encourage Michael to elaborate on them; as a template of an alternative means of experiencing himself in relation to others.

This exert is from Michael's eighth session by which point he was experiencing and reporting significant progress. In this passage Michael identifies for the first time an 'inner being' which personified his capacity to take the pressure off himself in situations which he also links to getting older:

Table 3: Transcript from Michael's session eight demonstrating therapist's responses to an innovative moment

| Transcript | Commentary |
|---|--|
| <p><i>M: There's been times [...] when I've been doing that wiring in the lights and struggling and that, not wanting to pace... there've been bits like that where I've just got to stop myself and 'calm down, take a minute, it doesn't have to be done in the next two minutes, you're only doing it for yourself' so the only pressure that I'm putting on is on myself</i></p> <p><i>J: Oh ok, so it sounds like you just deciding to be a bit kinder to yourself?</i></p> <p><i>M: Yeah yeah I'm one of these people that if I'm I'm going to do something I'll do it – just get on and do it. I don't sit down for a week and think about it [...] Just get it done and get it ticked off the list. I am a bit... OCD, I admit that myself and have a way of doing stuff in how I want it to turn out.</i></p> <p><i>J: And so when your... own <u>hands</u> don't obey that's...</i></p> <p><i>M: Yeah, frustration. Just take a step back and slow down. Because it's then getting to the</i></p> | <p>Michael talks about what he's 'got to do' but there was an 'epiphany' quality – that he was discovering ways to take the pressure of himself.</p> |

| | |
|---|---|
| <p><i>point, if I start pushing it and pushing it and pushing it I know in my own mind I'll end up making a mistake [...]</i></p> <p><i>J: It was reminding me of... something that you've mentioned in various contexts before that idea of feeling critical of other people and expecting that criticism in return [...] almost putting those same standards on yourself, there's someone watching over you, there's a pressure, and it sounds like you're describing something here about <u>rather</u> than feeling that criticism of you, there's a different kind of climate. As you say, you're giving yourself the time to do it... I wonder what it's like this different climate. If it's not criticism of you, how does it feel different?</i></p> <p><i>M: I think it's the two people on the shoulders. ((J: Aha yes ((enthusiastically)))) where one's saying 'come on come on'. It's a battle with them saying to each other. If I'm doing the 'Come on get it done get it done' and I'm getting more anxious, tightened up, and everything becomes difficult and I just need to step back and just listen to my 'inner being'.</i></p> <p><i>J: 'Inner being' ((said admiringly)) So... you've talked about a demon on your shoulder before, so there's this one demon that can be very sort of... critical I guess is one word for it 'come on get on with it, come on keep going' ((in a critical voice))... and this is you being able to listen to the <u>other</u> voice the 'inner being' you</i></p> | <p>By saying 'It was...' I was trying to bring our attention back to the essential difference Michael appeared to be reporting at the beginning of passage.</p> <p>My enthusiasm here demonstrates my client's implicit experience of my framework for practice. He introduces a dialectic between two voices and I enthusiastically endorse it. But note also the somatic qualities when Michael is led by the 'person' on one shoulder – physically tightening up.</p> <p>When I voice the critical demon, I give it its own voice which is intense and persecutory – I'm trying to model the contrast and help Michael to make contact with the experiential quality</p> |
|---|---|

| | |
|--|---|
| <p><i>mentioned. So what's the other... what kind of <u>tone</u> has the other voice, or what <u>attitude</u> does the other voice have?</i></p> <p><i>M: It's more calming now I think ((J: Mmm-hmm, mmm-hmm ((encouraging)))) "just... just calm down and don't be silly"... sort of thing... daft as it sounds, the way you might address a child who's very upset or whatever , "hang on, just calm down, just take a step back, it's not as bad as what it..." it's <u>more</u> like that now sort of... just calm myself down, just not rushing to get... I'm not, I'm not getting any younger ((both begin to laugh)) you know, you get wiser with age, so hopefully you know that's the thing, it's not just learning to deal with the practical but also the emotional as well.</i></p> | <p>of the idea he's introduced.</p> <p>In this last speech turn Michael starts to introduce a contrast with how things were before in statements like 'Its more calming now'. Note also the link back to Michael's inner child, which was also suggested when he invoked his Mum's voice in the second session.</p> <p>Perhaps by laughing along with Michael here there was a danger of minimising the association he was making between the inner being and his life going forward, which could have developed further.</p> |
|--|---|

As with the innovative moment picked up on in the second session, my primary role as therapist here was to catch the novelty, to direct attention towards it and to help the client elaborate upon it. There was a (co)creativity about Michael's description of the 'inner being' – he was not just telling me what he thought I wanted to hear. It resonated with my framework for practice such as it was at that time means I was particularly keen to add an experiential quality to it. The fact that Michael began to make contrasts with how things were before suggested that what began as a relatively passing comment about taking the pressure off himself became a more substantial, tangible form – it acquired the name 'inner being', and thus became something potentially useful for Michael as a template for future equivalent situations.

4.3.3.2 Responses to Michael's expressions of ambivalence

This passage is taken from session three by which point Michael and I have recognised his fear of having his disability seen, of this making him weird or abnormal, but Michael is ambivalent about whether the solution is to make contact with a new way of experiencing himself in relation to others (as I was encouraging him to explore) or simply to get better at concealment. Here he appears to be leaning back into the latter strategy as we explore why it was so uncomfortable for him to spill a drink on a social night out:

Table 4: Transcript from Michael's session three demonstrating therapist's responses to an ambivalence marker

| Transcript | Commentary |
|---|--|
| <p><i>M: It's drawn attention to my condition. I suppose from... what you're saying is people spill drinks all the time, whether they've got a condition, or whether it's just by accident or whatever. I can't get that, in that they might just see it as an accident, or that I stumbled, or my hand slipped or whatever, it's got nothing to do with me being slightly different.</i></p> <p><i>J: I mean this is fundamentally about your experience, it's fundamentally about how you experience it, and again playing Devil's Advocate, what if someone doesn't just witness you spilling a drink, but then they also thought 'Oh maybe he's got a condition' – what's bad about that?</i></p> | <p>I.e. People might spill drinks all the time but I can't get past my fear of what they may think when I spill a drink.</p> <p>I'm trying to explain to Michael that he's projecting his experience onto others. However rather than sticking with projection I go down a more cognitive path – would it be so bad if people did put it down to his disability?</p> |

| | |
|---|--|
| <p><i>M: I don't know, just seeing me as different. Initially if... some people if you've got an obvious sign it's not... an issue to them, not being horrible, it could be easier I don't know, than trying to hide. And that's what I think I probably do too much.</i></p> <p><i>J: Yes, you feel you need to [...] But <u>why</u> do you feel you need to hide it?</i></p> <p><i>M: Because I don't want to be seen as being different. I just want to be normal. It's just that side of my life that lets me down and everything else pretty much I can control. It's that thing that... I can't control that. I can't deal, or put right, or put to one side or whatever. I've always been a practical person. I've always solved things but that I can't fix.</i></p> <p>(I went on to try to encourage Michael to imagine what it would be like not to need to hide being different and he emphasises the habitual nature of his concealment)</p> | <p>This speaking turn is difficult to understand retrospectively but Michael is thinking about whether it would be easier if his disability was obvious – he gave the example elsewhere of being in a wheelchair.</p> <p>Here Michael doubles down on his dominant narrative – I don't want to be seen as different, I just want to be normal.</p> |
|---|--|

It is evident from this passage that I am challenging my client's ambivalence in a style Gonçalves and Ribeiro (2017) associated with poor outcome cases. Rather than empathising with Michael's discomfort with being seen as having a condition I'm questioning why he needs to hide it and Michael doubles down on his ambivalence.

In session four Michael and I designed a hierarchy of exposure together and indeed he had been enthusiastic about what he described as an "incremental" approach. However

by the sixth session, his ambivalence about whether exposure was indeed the right strategy returns as reflected in the following passage:

Table 5: Transcript from Michael's session six demonstrating therapist's responses to an ambivalence marker

| Transcript | Commentary |
|---|---|
| <p><i>M: That's the bit that I find difficult, that letting go, just relaxing, just letting it do what it wants to do. Because immediately I feel it...</i></p> <p><i>J: And at the moment you're 'just relax', is 'just relax but don't you <u>dare</u> show that disability off', 'just relax but you must not reveal it' rather than just relaxing and if they see your disability they see it. There's something about that migration in attitude. Because at the moment you're telling yourself to relax but there's a <u>desperate</u> worry about being exposed which obviously prevents you from being able to relax.</i></p> <p><i>M: Yeah yeah I can tell myself a hundred times but it's not a physical or mental shutdown on that side, it's always...</i></p> <p><i>J: It's almost us saying – you must not think of the colour red, you're gonna see the colour red. <u>But</u> it's almost like saying you <u>must</u> see the colour red. Fire away. It's almost us saying the opposite. Let it do what it wants to do even if that means you being seen.</i></p> | <p>Michael is referring to the problem as located in his arm, which he describes as 'it' as though it has a life of its own – indicating a return to the dominant narrative.</p> <p>I'm modelling a critical voice in this speaking turn – I'm trying to draw attention back away from Michael's arm as having a life of its own, to the underlying anxiety and fear.</p> <p>My use of the phrase 'migration in attitude' is too abstract and probably loses him.</p> <p>Here I'm attempting to remind Michael of the cognitive value of the hierarchy of exposure we designed. But we are evidently talking at cross-purposes, almost literally talking over</p> |

| | |
|---|---|
| <p><i>M: If I'm in bed and I've been reflecting on the day, I can think about my arm, my arm will actually do it in bed. I'm not bothered then because I'm in bed. It's pitch black, there's only [wife's name] beside me. I'll be conscious of it doing, and then it'll subside. I won't try as much then to hold it because I don't need to. Although it's.. it is always there it is more, if there were somebody else in that room then I'd be more conscious. If there were somebody stood at the bottom of the bed watching me and I knew [then it would be harder to control] Because I've spent so long hiding it, restraining it, that I don't know what the potential is if it <u>does go</u>.</i></p> <p>(We go on to explore particular scenarios and Michael's fear about his disability being seen in those situations)</p> | <p>one another.</p> <p>In this last speaking turn Michael is to some degree returning to the logic of exposure – however it is in terms of his ability to control the spasms in his arm, and only indirectly to the core fear of being seen.</p> <p>But Michael also verbalises here an anxiety about even a successful exposure to being seen. The 'potential' could be of what his arm might literally do, but the potential may also refer to the permanent loss of control over how he is seen by others.</p> |
|---|---|

As such in this later example of ambivalence I am again trying to challenge Michael's dominant self-narrative by asserting an alternative way of thinking. However in failing to 'go with' Michael's ambivalence e.g. by empathically helping him articulate it better, we end up almost literally talking over one another. When Michael alludes to the 'potential' danger of letting go I miss the subtlety in what he is saying. Here would have been a good opportunity to empathise with that fear of a Pandora's Box being opened; of losing control of how others perceive him.

4.3.4 Observations

As a therapist I was aware of the concept of ‘innovative moments’ whilst I was working with Michael. As such when he expressed an innovative moment in a session I would recognise this consciously as such and understand my role at the time as one of highlighting its novelty and helping Michael to elaborate upon it – an approach known in narrative therapy as ‘thickening’ (White, 2007). As the two examples in this mini-study demonstrate my responses to Michael’s expressions of innovative moments appears to have been facilitative of further developments in his emergent self-narrative. My therapeutic responses to innovative moments in my work with Michael were typified by a few core qualities:

- Observing the novelty of them e.g. ‘this is you thinking about the situation differently’
- Offering Michael a language to make sense of the innovation e.g. ‘it sounds like you’re being kinder to yourself’
- Framing the innovation as part of a change process
- Channelling attentional energy to these e.g. vocalising the different positions, asking Michael to describe their different tones

As a consequence of these forms of response, Michael appears to have been able to convert what would otherwise have been more general and passing comments on his contemporary experience into templates which he was able to apply to equivalent situations, including those still to come. This is indicated by themes underpinning the Level 3 innovative moments as identified in table one. The particular qualities of these templates, e.g. the language used to describe them, were co-created between us in our sessions.

4.4 Conclusion

As a researcher I found the innovative moments coding system had several conceptual difficulties which mean the ‘truth’ of particular data might be missed in a purist pursuit of the method. For example that some innovative moments that might have been correctly coded as Level 1, were in reality Level 2 or 3 because of implicit meanings

behind statements ‘understood’ by both therapist and client. Likewise statements that might have appeared explicitly as innovative moments may have more subtly been signs of ambivalence – the client giving a scripted account of what the therapeutic agenda is but giving signs through their pace, tone, or body language that they have lost some of the ‘belief’ in that agenda. These are substantial limitations of the method as I understand it. It is also important to observe that whilst the theory supporting the innovative moments literature fits relatively well with the therapeutic work with Michael, as it did analysing cycles of change from the case of Lou, the other two cases appeared to have different dynamics. Both Jennifer and Myrtle appeared to demonstrate sudden gains (Abel et al., 2016) in their therapy from very early in the process. The trajectory of their own innovative moments does not therefore fit very well with the gradualist conception of change as represented in the literature. I return to this issue of sudden gains in the mini-study in chapter six.

However what I did find useful was applying the method to systematically consider my responses as a therapist to my client’s innovations and expressions of ambivalence. Formalising my appraisals of the case work using this method helped me to realise both strengths and shortcomings in my therapeutic working with Michael. Innovative moments may appear to emerge spontaneously but their subsequent ‘management’ in the therapeutic process may determine whether they build into change that has momentum, or pass by as missed opportunities.

What is implicit within the conceptualisation of innovative moments as occurring on three levels is that a person’s migration between I-positions or self-narratives may be tracked *longitudinally*. What is logically inferred in existing theory and is observed in this analysis of my work with Michael is that the first innovative moments appear early in the work and that more developed self-narratives which include reflections on what has changed/is changing populate the latter stages of the therapy. This longitudinal quality of innovation was one of the theoretical drivers behind my interest in stage or state based concepts of change, as is developed in the coming chapter. However in my early analyses of the cases of *Lou*, *Michael* and *Jennifer*, I was beginning to notice longitudinal patterns which my existing model wasn’t articulating very well. For example in work with *Lou* there is very clearly a growing confidence – what I would later describe as *subjective competence* – about Lou’s ability to assert herself. This began with asserting herself amongst friends, then with her husband, and then, most difficult

of all, in a relational triad involving her Mum and her sister. *Lou* also evidenced diminishing effect during those moments of assertiveness: from panic and vomiting early on, to more manageable levels of discomfort and anxiety, towards an increase sense of mastery and peace in the application of new relational strategies (as we shall revisit in chapter six). In work with *Michael* there appeared to be a sequential stages or states that we were passing through – when Michael and I generated his hierarchy of exposure, this prepared the ground not just practically but also in terms of building confidence for the exposures that he would go on to perform. Michael needed to embrace the possibility of an alternative strategy to ‘keeping my head down’, before going on to perform those exposures. Likewise with *Jennifer* the generation of motifs in our sessions, such as the identification of ‘Generous Jenn’ (who we will meet in the coming chapter) and ‘the hand in the bucket of water’ (which will be explained fully in chapter six) appeared to prepare the ground for behavioural changes as reported following those sessions.

The following stage of analysis therefore captures a period during 2018 in which I became fascinated with stage and state-based concepts of therapeutic change. The second template is as such conceived of as a mapping of existing longitudinal models of therapeutic change onto the original vision of a migration between I-positions. As is indicated through the mini-study that was conducted in the chapter now concluded, the role of the therapist is important in facilitating a client’s movement through those hypothesised stages.

4.5 River of Time

Saturday, 12th November 2010

A dream. I am sat on the banks of the River Thames. There is a girl stood behind me reading a poem aloud. The message of the poem is that in every stage of life we give something up and receive something in return. I imagine that these stages were like vessels that we had to travel inside to pass to the next stage. The poem refers to a coffin as a boat (The previous day I had been reading about how the pagan Norse used to send their dead out to sea in a canoe). I think to myself that the next stage would be an urn but then also wondered whether there was a means of rebirth through that material vessel and the thought is exciting.

When I woke up I had understood that the River Thames represented the river of time – something I couldn't resist but just had to flow along. The River Thames also carried meaning because it was London's river – I had been living in London until two years previously and 'gave up' a significant part of my identity by retreating back to Yorkshire. However I was 28 years old, and with my thirties on the horizon, the promise that we gained something new for everything we gave up was exciting. The dream suggests at a continuous transcendent process, like shedding skin, that takes place throughout the lifespan. The symbols of the dream thus anticipate my interest in dialogical change as conceptualised through I-positions later in the decade, but also the qualitatively distinct stages we might pass through in that metamorphosis, an idea which entered my consciousness fully during my PhD study, as explored in chapter five.



Chapter Five, 2nd template: Mapping a longitudinal model of change onto the migration between I-positions

5.1 November 2017 - August 2018: where I was

When my position felt to have been demolished by the Professor at the SPR dinner in Amsterdam I had already for several months been battling with a feeling on some level that my research and my practice were meeting with challenges for which I did not have answers. My own version of the imposter syndrome was powerful during this period and when the Professor challenged me I was tongue-tied: I had no coherent reply – I felt sort of paralysed, like a jellyfish washed up on the beach. In the weeks and months following that incident, and debriefing with my research supervisors I was gutted on a personal level but was gradually able to place the experience in context. I would come to understand that the Professor's challenge to my research was an echo of much wider debates in psychotherapy research: of the relative scientific merits of clinical vs systematic case study research, and beyond to fundamental epistemological debates about constructivist vs positivist versions of knowledge. At the time, sat opposite the Professor at that dinner, I couldn't connect with any of this – this was about me and my incompetence.

In the fall-out from Amsterdam I experienced multiple, dread-full dreams in which I was falling. In one I am in the middle of a huge city like London or New York. Originally I see

a woman trying to move around the city by hanging off ledges over a river a hundred metres below: sort of recklessly like viral videos of young daredevils. Then the person hanging off the rafters is my Dad and this is how he died.

In another dream I am to jump out of an aeroplane into the sea but know that falling from such a height I'll die in collision with the surface of the water – like hitting concrete.

In another dream I am parking up the car. Backing into a space the car falls backwards at great speed, as though into the water, and I wake up in a panic.

During this period I was thinking a lot about my average-ness; that all the qualities I thought I had were being exposed. I lose my capacity to fly and instead I fall. In each of these dreams I – or my Dad – are falling into water. Jung considered water to represent the unconscious, but in these dreams water seems to represent death. In these dreams we're falling through the acts of living. What I understood on this symbolic level during that time was that I needed to locate a new foothold.

5.2 November 2017 - August 2018: where my theory was

From the beginning of data collection in November 2017, until August 2018 – I had understood that there was a longitudinal quality to change as I was conceiving of it. My concept for change emphasised gradual and incremental processes over individual moments of insight or experiential breakthroughs after which everything was different. This attitude is reflected in the description of *Lou* and *Michael's* migrations from a dominant into an alternative I-position, and in the mini-study in which innovative moments were observed to increase in frequency throughout Michael's therapy. However beyond appreciating a concept of Innovative Moments as indices of change operating on different levels, I had not developed a formal theoretical basis for analysing the longitudinal 'shape' of change.

In the summer of 2017 my supervisors and I produced a paper which I presented at the *International Symposium on Qualitative Research* in Salamanca, Spain and which was

published the following year (Hills et al., 2018a). The paper's primary purpose was to highlight the semiotic quality of indices of change, including Innovative Moments but also instances of Topic Change (Skjerve et al., 2016) and Significant Events in therapy (Elliott, 2010) e.g. that they were the first indicators of deeper and more continuous change processes that may not have yet been fully understood. However we also attempted to sketch a map in the paper of how different types of indices might emerge at different stages of a person's therapy e.g. at stages such as 'Client notices a shift in their internal experience' and 'Client names change orientation'. Thus the paper reflected a growing awareness of a longitudinal, staged concept of change, although at this stage this was a side issue rather than my primary interest. When I presented this paper at the Society for Psychotherapy Research's UK and European Conference in Oxford later in 2017 it attracted a lot of interest from other researchers who were interested in the changing phases of therapy, including gauging a client's readiness for change and how the therapist might respond to these changing conditions e.g. by opting for certain interventions. Even so I considered these ideas to be already embedded within my existing model.

However by January 2018, after two months of data collection, I began to become aware of the limitations of my own model of change. *Michael* had not initially responded to my narrative-dialogical framing of his fear of having his disability seen – it was an alien way of thinking for him and he preferred an engineer's solution. The hierarchy of exposure strategy was one Michael could relate to; it enabled him to take ownership of the process and to believe that it was possible for him to 'get there'. Likewise *Lou* during this time also appeared to be investing herself more fully in the process. On the 2nd January 2018 I wrote in my notes how I felt that through my existing approach I was able to 'contain' whatever Lou threw at me, and this gave her more confidence in the approach. I came to understand that what I was observing in my client work was a mutual and implicit sense of direction or even directionality within the therapeutic process (Bocknek, 1976; Cooper, 2019a). This might be conceptualised initially as the therapeutic work having a direction, but also reflected a mutual sense of a state of selfhood that the client was migrating into. When we felt to be going somewhere, this seemed to be motivating for the client. In a psychosomatic context there is evidence to suggest that being able to look beyond present circumstances may help to attenuate the experience of somatic symptoms, for example the distress associated with them. Crombez et al. (2012), for example, observed that where chronic

pain sufferers commit towards life goals then their sensitivity to pain reduces as the pain signals simply provide less relevant information in that context. It was this growing interest in how a sense of direction might be embedded within thoughts and actions, moment to moment, that drew me back theoretically into longitudinal models of change. Therefore over the spring and summer of 2018 I reviewed the literature on longitudinal models. Cashdan's (1973) model of longitudinal change from a psychoanalytic perspective placed a central emphasis on the transference cure, and that the client's symptoms dissipated as they brought their conflict into the room. This frame didn't fit well with the instances of change that were presently being witnessed and recorded in my present client work which appeared to be being performed 'out there' in the world. Stiles et al.'s (1991) *assimilation of problematic experiences* model was most compatible with narrative-dialogical approaches, having already being applied to case studies alongside multi-vocal theory (Tikkanen et al., 2013) and innovative moments coding (Ribeiro et al., 2016). However one difficulty I had with the assimilation model was that it was problem focused, whereas I understood that change occurred on a level beneath problems; in one's dialogical relationship with others and the world i.e. their sense of self. Also given the assimilation model is essentially mapped over eight stages, it appeared there was considerable overlap between the stages, such that their boundaries were not qualitatively distinct. Some of my client work amounted to just five or six sessions, and thus I found it difficult to imagine clients passing through multiple stages during the course of a single session, or between one session and the next. Notwithstanding those other issues, I have since come to appreciate the argument made by Krebs et al. (2018) that a realistic therapeutic goal may be to facilitate the client's progression just one stage along a sequential model which would have addressed my latter concern. Rogers' (1961) seven-stage model of change did incorporate a client's deconstruction of their self-constructs, however was not a true stage based model as Rogers proposed instead of a continuum of change, as such this model too did not appear very useful in drawing out patterns from the data. Over the summer the longitudinal model that seemed to fit most closely to my clinical work was Prochaska and Norcross' (2001) *Transtheoretical Model* of change as applied to psychotherapy. The Transtheoretical Model offered five phases – which they argued were qualitatively distinct - to the therapeutic work which could be mapped onto my case work more coherently than the other models. Whilst dialogical change was not implicit within the Transtheoretical Model it was adaptable to that theoretical

framework. What was also attractive about the Transtheoretical Model was that it included ideas about how a therapist might respond differently to clients at different stages. The five-stage model was thus:

1. **Precontemplative** – The client does not yet perceive the need or intention for change. The therapist is in the role of a ‘nurturing parent’.
2. **Contemplative** – The client recognises an awareness of the problem but lacks any commitment to take action towards change. In this stage the therapist in the role of ‘Socratic teacher’.
3. **Preparation** – The client makes a decision to change and the commitment to change. The therapist is in role of ‘experienced coach’.
4. **Action** – The client performs overt behaviours in the service of change. The therapist in role of ‘consultant’.
5. **Maintenance** – The continuation and consolidation of actions that support change. The therapist continues in a consultant role.

(Prochaska and Norcross, 2001)

I thus made an investment in this model, not just as a researcher looking for an analytical framework, but also as a practitioner – consciously theorising at what stage each of my clients were and thus shaping my interventions accordingly. I mapped onto the original model of change in which a client migrated between a dominant and an alternative I-position, five longitudinal stages by which that change came about. What that meant was that a client’s progression from a dominant I-position into the identification and the performance of a new, alternative I-position involved:

Contemplation – which I understood as the client being able to recognise a dominant self-narrative and describe who they are – what version of self they perform – within that narrative;

Preparation – that the client’s commitment to change was a commitment to doing things differently out there in the relational world, relating differently to others;

Action – where the client does do something differently out there in the relational world that they then have a glimpse of what an alternative self-narrative might look or sound like, and indeed how their sense of self might be different within it; And

Maintenance – that once a new, alternative I-position has been discovered, that the client continues to behave in ways congruent with this new, emergent version of self, such that it is habituated and becomes part of one’s repertoire.

I gave this version of my model a name: I called it the *Migration Model*.

The development of the migration model served as a kind of transitional object (Winnicott, 1953) in helping me find my feet again. When I first introduced the migration model to Steve, my clinical supervisor, he responded positively and I found this very validating. Steve and I had been discussing for months a quandary that I’d been battling with about how best to structure my therapeutic work and where

interventions fit into that structure. I imagine that when I brought this synthesis to Steve he was as such mindful of not wanting to strangle it at birth by focusing on its limitations, but to implicitly recognise it as something that I needed. He communicated the importance of consolidating the model and applying it to all my client work. However Steve also introduced a beautiful analogy that he drew from his own experience as a sculptor. Steve reflected that in creating a sculpture, for example of a horse, the sculptor begins with a wire armature – a frame around which the sculptor will build the clay. The armature will subsequently be removed before the clay sculpture is fired. Likewise my model of change gave me a structure around which to build the therapeutic work but it too would be removed once its usefulness had passed. If I applied the framework rigidly and unquestioningly I would be modelling for my clients an inflexibility and a closedness towards change.

In a dream following my meeting with Steve I had discovered how to fly longer distances and thus I was seeking to produce video evidence of my flight e.g. to verify my science. People generally accepted that I had this gift but they regarded me as a bit of a narcissist, like Elon Musk. The dream is significant a) because I’m flying again after months of falling, but b) because I realise I am trying to find a reconciliation with others

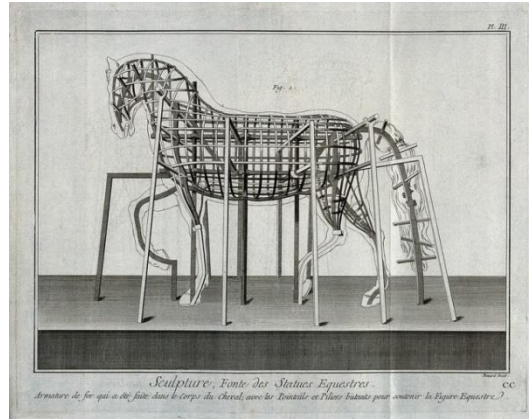


Figure 15: The preparatory iron armature for an equestrian statue, engraving by Robert Bernard (18th century)

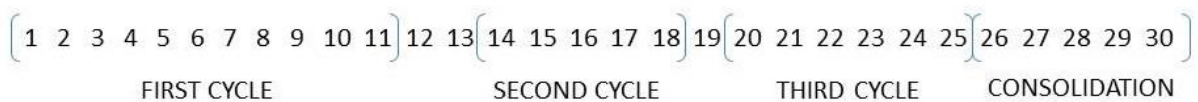
in justifying my flight. Clearly the discovery of a way to fly longer distances refers to my longitudinal model. Elon Musk was somebody else who dreamt of flight – during my PhD he was developing his re-usable space vehicles in a new space race in competition against other billionaires. I observed narcissism in Elon Musk and I had been thinking a lot about how one of the reasons I was so vulnerable at the dinner in Amsterdam was because it felt to be all about me – it was my incompetence, my shame, I was the imposter; I was not able to appreciate my place as a minnow within debates that raged long before I entered into them.

The migration model provided me with a theoretical foothold but in identifying with an existent framework it also provided me with a sense of roots – something I had lacked that evening in Amsterdam when on a much more primitive level it was all about me. From the beginning of August 2018 I began to map all my client work onto the transtheoretical model, which is to say that I would consider with each client – for example when writing my notes after a session – what stage of the model I thought we were presently in, and what therapeutic approaches I believed might enable us to move into the next stage. However I also found time during this period to look back over data collected so far in the window. I had just completed work with *Jennifer* who had just six sessions over the summer of 2018 and I was coming towards the end of my work with *Lou*, whom by this time had experienced significant and personally meaningful therapeutic gains. What I found was that it was possible to code qualitative data from within those cases according to each of the five stages of the transtheoretical model. What's more, the amount of data coded for each stage peaked at a different chronological point in the therapy in the sequence anticipated by the model, as I will now explain.

5.3 Lou

I understood my work with Lou to progress through cycles of change each of which culminated in significant events as performed out there in the world – what might be described as Action within the transtheoretical model – and subsequent learning and reflection upon those events, which might be described as part of the Maintenance process. By the time we had finished our work together I believed we had passed through three such cycles, the first of which I demarcated as taking place between

sessions one to eleven. This cycle was defined by a process of renegotiation of what Lou would go on to describe as a power imbalance within her marriage. Looking back I believe if Lou and I had ended at session eleven or twelve, she would have left counselling having realised change in her life that would have been meaningful and sustainable. As it was we went through two further cycles, each of which Lou derived further gains from. Sessions fourteen to eighteen mostly focused on Lou's experience of social anxiety and awkwardness with Lou successfully pushing back against excessive self-consciousness and being more relaxed, having more fun. And during sessions twenty to twenty-five we did our most intensive and successful work on Lou's experience within a dramatic triangle involving her Mum and her sister, and her developing capacity to disentangle from that drama. The sessions between those cycles lacked the same sense of direction – therapeutic themes were explored but it wasn't clear where we were going with them. The final five sessions focused on consolidating the key gains that we understood had been made in our work together.



In consideration then of those first eleven sessions – the first cycle of change – during this period I came to understand that the Transtheoretical Model could be mapped onto material from those sessions in a way that appeared to validate the model. Such an approach might immediately be considered to be unscientific – wasn't I just trying to make the data fit the theory? What I also hoping to discern were any disconfirmatory data e.g. indications that a client had 'skipped' a stage, whether there were any deviations in the prescribed sequence of stages, whether there were overlap between these stages which challenged their boundaries or definition, or whether any data could not easily be placed within one stage or another, perhaps requiring new explanatory concepts. To a large extent the first eleven sessions of Lou's counselling could be seen to fit with that model as is summarised here:

1

Pre-contemplative

As described in the account of Lou as Peacemaker, Lou arrived for the second session to tell me about an extremely distressing argument with her mother that at one point had seen her driving away from the house with the car doors open and then later frantic text messaging to try to make it

right with her Mum. Returning to the data with the Transtheoretical Model I understood this to be an example of Lou at a *pre-contemplative* stage of motivation. Lou knows something is happening, but her own behaviour is shocking to her, she can't understand why she behaved as she did. My interventions at this stage included giving voice to, and helping Lou to put into words, the intense emotions associated with experiences like those.

2

Contemplative

It was during the third session that Lou introduced the motif of the Peacemaker, explaining that this had been her traditional role in the family – she would bend to suit everyone else's demands so as to keep the peace.

In session six we started to think about the breakdown of Lou's diet in 2017 as a primitive rebellion against her Peacemaker role and the external pressure she felt to lose weight, especially from her husband. In those early sessions we were able to recognise that Lou felt to be in a power struggle with her husband; that she didn't feel in control of her own life from within the marriage, in matters of home-life, work, finance, even her own diet and health. Thus in demonstrating some understanding of how she was replicating this role in her marriage and in identifying with a pattern of relation I believe Lou demonstrated a *contemplative* stage of motivation. At this stage my primary intervention was to help Lou increasingly personify the Peacemaker I-position – what were the behaviours associated with those position, in situations was she activated etc. Lou came to understand that in her constant endeavour to keep the peace she relinquished her own needs within her marriage.

3

Preparation

From session four onward Lou was able to voice some of her own feelings and needs in session. I also began to observe the appearance of a different tone to Lou's presentation, subtly more defiant as though she was bringing a primitive rebellion against her peacemaker role into the sessions. This period I understood as a *preparation* stage of motivation – Lou preparing to perform a different version of herself outside of her therapy. Between sessions four and ten were several significant events which might have been described as 'proto-actions' – including communications with her husband, and a significant event where she took a stand against her in-laws

(explored in the task analysis mini-study later). I experienced my role at this stage as one of validating and thus providing some sense of moral support for Lou as she stepped into unknown territory. But she was also learning to be more competent in asserting her own needs and by exploring scenarios together I believed Lou became ‘primed’ for action – a theme I return to in the later task analysis.

4

Action

Retrospectively, the significant event which defined this first cycle of change was between the tenth and eleventh sessions where Lou left her husband for a week. This event is also explored in the later task analysis but it was an event that crystallised a new relational stance she was to take with her husband. Thus that decision to leave for a week was the culmination of Lou’s *action* within this cycle of change. Because the significant action – certainly in Lou’s case – took place outside of the therapy room, I had no direct role in facilitating this action.

5

Maintenance

From session eleven, Lou reported that she and her husband had created a set of resolutions about how their marriage needed to change for them to move forward. When I met with Lou for a follow-up appointment in April of 2019 – over a year later – she confirmed that these resolutions still held and had improved the quality of their marriage. Thus this period could be reasonably labelled the *maintenance* stage of the cycle of change. My role during this period was to help Lou explore the significance of this set of resolutions and how they created a platform that she could build on – we recognised they created some breathing space for her, and helped her to preserve her independence.

In proposing that five stages of change might be mapped across the first eleven sessions, the reality of the data collected from those sessions is that there was considerable overlap e.g. with passages that might be called Pre-contemplative or Contemplative appearing throughout the eleven sessions, and thus some difficulty in discerning which sessions marked the boundary between Lou being in different stages. Taking our lead from the mini-study on Innovative Moments, a quantitative analysis in which different passages were coded according to one of the five stages might be performed – the

dominant stage could thus be discerned for each session. However from a practitioner point of view the question of identifying at any one point in time at which stage a client is in is perhaps not the most important or useful application of the model. Rather the model's usefulness may be more about recognising within the different motifs clients bring to session which stage of change these motifs appear to come from. Thus a therapist might respond to material that was Pre-contemplative, Contemplative, and Preparatory at different times within a single session. It is important to observe that during these eleven sessions I as the therapist had not yet heard of the Transtheoretical Model, and as such there is no way that Lou was picking up on implicit cues that she ought to be performing in a certain way by a certain time. Nonetheless my interventions shifted according to my own sense of the changing therapeutic situation. I was also aware at the time that the good work that Lou had done in those first eleven sessions prepared the way for future work that we would do, particularly in consciously managing her relationships with her mother and her sister. Petrocelli (2002) described the Transtheoretical Model as a spiral with stage five giving way to a new stage one, operating on a higher level. My experience of working with Lou appears to fit with this description: each cycle of change gave way to the next.

5.4 Jennifer

Likewise I was able to locate data from Jennifer's sessions within the stages of the model. The therapeutic work with Jennifer ran over just six sessions, and only five of these were audio recorded (the first never being recorded).

1

In session two, Jennifer appeared to be still mystified by the emotional fallout from Alice's daughter's tirade against her, and described avoiding conflict at all costs:

Pre-contemplative

I avoid conflict... erm... I do, and I just get emotional... I just get upset and say I'm sorry and just back down, I don't, I don't like conflict at all.

She went on voice frustration with herself for needing to withdraw from social situations:

And then that tires me out, it's like a... a vicious circle then. Because I've come home from café and I was really upset and I was only there for half an hour and I came home and I just felt absolutely exhausted I was all tense and... you know I'd said "oh yeah I'm fine thanks" ((in a self-deprecating, mocking voice)).

In other words in these early exchanges Jennifer has no capacity to reflect on why she finds these situations so tiring and thus needs to withdraw.

2

Contemplative

However also in the second session, she described a façade of invulnerability that had been built up over many years that had been broken by the events following her bereavement:

I, I just think that I put on this façade, and this... façade has been broken.. One person has broken through this façade that I've always had that says: "it's [Jennifer], you can rely on [Jennifer]".

In this passage are the first glimpses that Jennifer recognises a pattern that has structured her relationships and some understanding of how the rupture within the family has exposed that style of relating. This might be considered to be the first index of a *Contemplative* stage of motivation. She identified a nick-name she had had, it was an alliteration that sounded like *Generous Jenn*, which indicated what others expected of her. In this session she was starting to recognise the limitations of being Generous Jenn.

3

Preparation

Also in the second session we designed the first of what would be a succession of exposures where Jennifer would go back into a social situation – such as her church community - and deliberately admit to her vulnerability, and thus do something not expected of Generous Jenn. I suggested to her that when she was asked how she was, rather than simply to say automatically "I'm fine" that perhaps she could reply with words to the effect of: "I'm having some problems with anxiety". Jennifer seemed to appreciate the simplicity of the change that she might be able to introduce. As we created this statement together she appeared to be motivated and saw the potential benefits of using it. She also appreciated the value of having a label for her difficulties – such as had been derived from her chronic fatigue diagnosis – and likewise that it could potentially be

liberating to admit to struggling with some anxiety. We agreed that she could attempt the exposure as a form of experiment to see how it worked in a real setting.

4

Action

In the third session Jennifer arrived reporting successful practising of the exposure. She had crafted it so that it was more authentic – and more subtle – in the social situation, such that the phrase deployed was "I'm ok but I'm getting some help". The subtlety appealed to her as it could be interpreted however a person chose to. Simply practising the exposure Jennifer considered to be a significant step forward: she was "very pleased with myself for doing that". The subtle shift in her openness to the people around her, she conceptualised as "the cards have been on the table". Throughout the rest of our time together Jennifer went on to report similar examples of how she'd related differently and thus been able to return to her social relationships on her own terms.

5

Maintenance

From as early as the third session, logically following the first successful exposure, there are also passages that could be associated with the maintenance stage:

This lady asked if I would like to come along and help. So I said "Yes but I'm only coming along to help"... and again I said to her "but I might not be able to help all of the time". So I'm pre-empting that. And hopefully soon I won't even have to do that.

Here Jennifer is talking about her commitments within her church community where she had had a tendency to make unboundaried commitments of her time, upholding her Generous Jenn stereotype and feeling completely exhausted. In this passage Jennifer is describing 'pre-empting' what she'll need in certain situations to avoid falling into an old trap which would enable her to maintain the behavioural foothold she had just began to establish with her exposures. When Jennifer observes that in time she won't even have to do that she is making the implicit assumption that here is a process to become habitual and thus automatic. As will be explored in chapter six when we consider the Third Template in which the clients generate 'cognitive maps' the motif of the *Hand in the Bucket of Water* provided a structure around which Jennifer was able to renegotiate

her social roles and it was this emerging narrative that helped Jennifer to rapidly progress through the stages of change as conceptualised here.

5.5 Extending the 2nd template: Introduction of novel stages relating to identification

I had therefore begun the month of August enthusiastically mapping the Transtheoretical Model of change onto my therapeutic work and also my analytic framework as a researcher. However through application of the model I began to become aware of its limitations. My clients would arrive with different levels of motivation and these levels could fluctuate throughout the course of therapy. I understood that what appeared to be driving change processes in my client work was not motivation per se, the driving force behind the transtheoretical model as envisaged by Prochaska and Norcross (2001), but what I described at the time as ‘identification’. My understanding of identification inside the therapy room was the reflective act of the client identifying with a certain problematic pattern of relation: ‘This is what I’m doing in these situations’. This is not to say that the behaviour of others in the client’s life is not also problematic but rather that by owning their own part they realise a degree of agency. It was this factor that seemed more reliably to correlate with change processes as observed in my client work. As an idea it had been in incubation for some time: when I presented the *Indices of Change* paper in Salamanca in 2017, one of my hypothesised stages of change I described as ‘moments of lucidity’ (Hills et al., 2018a).

There were also theoretical points of contact with what I was calling Identification within the existing literature. What I had originally found most attractive about Carl Rogers’ (1961) seven-stage model of change was that the client identified with what Rogers described as ‘self constructs’ and then subsequently went on to deconstruct them. In the Rogerian model the culmination of this process was what he described as *immediacy* in which the client learns to hold their personal constructs lightly and that these are continually being evaluated in the light of new experience. Rogers’ immediacy suggested a form of change in which the client does not so much pass from one I-position – with its own styles of cognition and points of reference – to another I-

position, equally determined; but rather that we learn that we are performing I-positions and as such that we are able to enact these more consciously as appropriate to the situation. This notion of holding personal constructs lightly in a person-centred perspective appears to anticipate the more recent development of the cognitive behavioural concept of *psychological flexibility*, most typically associated with Acceptance and Commitment Therapy (Hayes et al., 1999). Kashdan (2010) argued that the latter concept was fundamental to human health and functioning and defined it as:

‘...being aware of thoughts and feelings that unfold in the present moment without needless defense, and depending on what the situation affords, persisting or changing behavior to pursue central interests and goals.’ (Kashdan, 2010, p.868)

Investigating psychological flexibility I found a deal of evidence relating this concept to quality of life in chronic health conditions. Psychological flexibility was associated with a reduced pain intensity in chronic pain sufferers (McCracken and Velleman, 2010), less somatisation (Masuda and Tully, 2012), improved functioning whilst living with chronic pain (Scott et al., 2016) and improved quality of life in people living with chronic fatigue syndrome (Densham et al., 2016).

Factoring this concept of identification into my model of change did not revolutionise the analysis I was doing, nor my practice as guided by the emergent model of change. However what it did do is bring clarity to me about a fundamental, and perhaps necessary, stage or state for my clients in realising the purposefulness I’d perceived in the work where we felt we were going somewhere. In those early developments I saw the concept of identification with problematic patterns of relation within session as one necessary stage of change, and where clients were able to recognise these situations in the seven days between sessions I considered this to be another necessary stage. Both of these stages ‘primed’ my client for subsequent Action in the longitudinal model. There are examples of ‘priming’ in each of the cases. Once *Michael* identified with the pattern of relation of fear of being seen, and thus an objective of ‘keeping my head down’ he increasingly demonstrated a motivation to do something differently through statements made in the sessions, and his ownership of the hierarchy of exposure we designed together in our fourth session. Thus creating the hierarchy of exposure Michael was thus ‘primed’ to recognise relevant relational situations in the seven days

between sessions. Whilst examples of identification can be seen across the four cases, a couple of examples elucidate the point here:

5.5.1 Lou

My experience of working with Lou was that from a very early stage she took ownership of her participation within patterns of relation that were causing her distress. In this passage from the third session, Lou first identifies with the peacemaker role which subsequently became the label that we would use as a shorthand to refer to her own role within the family.

J: So when you feel you have to defend [husband] and take responsibility for it I guess, who does that make you in the family or what kind of role does that put you in?

L: I just feel like I'm trying to be a peacemaker a lot of the time and I'm like in the middle and everyone's around, and like I've felt like this before, that everyone's around and they're bickering, and I'm the one that's trying to be like: no he doesn't mean it like that or she doesn't mean it like that or she didn't say that or he didn't say that [...]

J: So if you find yourself in that role, often, of being the peacemaker, of being at the centre, trying to shoulder impossible burdens about trying to make everyone feel alright, what's it then like for you to do something for you – buy your own house, set up your own business?

L: Well it just makes me feel guilty – I should be this person that just keeps things together.

J: So you can't do something for you?

L: No never [...] And when I was doing that exam all the time I was thinking 'I should be studying' but at the same time I'm never going to do anything with this, I shouldn't be doing it [...] the blockage is myself.

Here I am modelling my I-positions theory, such as it was that time, by encouraging Lou to identify the kind of role it put her in. However what this passage also demonstrates is

that Lou has a good understanding of the limitations of occupying this I-position – the exam is symbolic of her advancing herself, following her own path, but there is a fatalism: ‘I’m never going to do anything with this’ and a feeling of guilt that it’s not what she ought to be doing – it is incongruent with her family role. The final statement: ‘the blockage is myself’ is the clearest indication that Lou appreciated her own agency in the problem. That early ownership of the problem I believe provided us with a basis on which we were then able to make progress across multiple phases of our work together.

5.5.2 Myrtle

It was in our first session where following a reflection on the guilt she felt in relation to her Mum I enquired as to whether Myrtle had felt guilty in other situations in her life, and she had wept and with intense emotion shared her doubts with me about whether she could have done more to support her mother in law before she died. I consider this to have been a therapeutic example of a ‘crystallisation of discontent’ (Baumeister, 1994; Hayes et al., 2007) in which individual instances of distress accumulate to the level that they can no longer be dismissed. It was the most profound moment of our five sessions together. Myrtle’s emotional reaction to having her guilt witnessed by me took her by surprise and was a threshold moment after which she had a new clarity, as she reflected back to me in the second session:

I’ve kind of had a sit and think since I spoke to you last, and I thought... do you know what... none of this is my fault. I can’t change anything that’s happened in the past with my mother and anything else. How she is is not my responsibility, she is a grown up... And I am not responsible for how she acts or how she treats me.

It was as though by coming into awareness of Myrtle’s own part in the passive-aggressive dynamic she’d become locked into with her mother, she was thus able to start to look past it. Myrtle had recognised in the first session that her anxiety levels were higher when she would visit her Mum in the care home. In the second session I encouraged her to explore her emotional and somatic experience when she went to visit her Mum. Myrtle explained that her Mum made her feel guilty: "I feel hurt - I'm trying

to do my best by you and all you're trying to do is make me feel bad", she described feeling agitated, tense, "gritting my teeth". I reflected back to Myrtle just how much depended on what mood she'd encounter her mother in:

(M = Myrtle; J = John)

J: So it's going into that... room essentially, going and visiting your Mum [...] your hackles are up, you're tensing

M: I'm tensing... yeah... I always have to look through the crack of the door to see what she looks like before I go in ((laughs)) She always has the door in I can see down the crack, I always stop outside and just ((laughs)) see as if she's happy enough or grumpy or whatever

J: You're bracing yourself?

M: Yeah yeah

J: Because you ((pondering)) If she's unhappy you're going to get attacked?

M: ((exhales)) It's... it's... Well it's not really a form of attack. It's more a form of piling on the guilt trip – she tries to make everyone feel guilty for how she feels – you know? She kind of... tries to pile it on the “look at me, I've not been well and you've been on your holidays, and look how I'll I've been and you've been away. I can't get out and I can't do this” ((Myrtle mimics her Mum in a kind of breathy, weary voice)).

Through this form of situational based work I was attempting to 'prime' Myrtle to come into consciousness of her own part in that drama with her mother. (This session took place in June 2018 and thus preceded my explicit development of the Identification concept). Indeed throughout each of the remaining situations Myrtle demonstrated how she was confidently and competently engaging with her mother and stepping outside of the passive-aggressive dynamic, though with some ambivalent feelings. In the third session she described a sense that she was “ganging up on an old lady” however in the same passage recognised that this was a process they needed to go through. In the following passage she compares how she had traditionally related to her Mum's expressions of distress with a new approach:

M: And then we'll be driving round now: “do you want to stop and have a coffee” “Oh I don't know, do you think I'll be alright if I get out”. So now I've started “do you want to

go out?” And she’ll say “Oh I don’t know” I say: “It’s your call but we’re only here for an hour so if you don’t decide in the next ten minutes... well, you’ve lost your opportunity” And then she gets cross, because we’re not doing the “Oh oh” ((mimicking fawning sympathetic voice))

J: Yes you’re not playing the game almost?

M: Yes we’re not playing it [...] And she said “do you think I’ll be well enough” ((pathetic voice)) And I said: “I don’t know, you know how you feel. If you don’t wanna go, let’s not go”. And I just sat back again in my chair.

That last line “And I just sat back in the chair” I understood at the time to be an index for the way Myrtle was becoming aware of the drama that she would otherwise be getting dragged into, and was consciously choosing to do something different. We thus conceptualised this new stance that Myrtle was taking towards her Mum as “not playing the game”.

5.5.3 Reflections on the use of this template

The work with Myrtle, in particular the ‘crystallisation of discontent’ observed in the first session, does not fit so neatly with the gradualist account of change implicit in the Transtheoretical Model. That particular passage from our first session together had a far greater therapeutic impact for Myrtle than any other work we did across the remaining four sessions.

The Transtheoretical Model, and other stage based concepts of therapeutic change, are not without their critiques in the existing literature. Bandura (1998) rejected the Transtheoretical Model because he argued genuine stage-based models involved stages that were 1) genuinely distinct from one another, such as the various stages in the lifecycle of a butterfly; 2) that followed an invariant sequence; and 3) that were irreversible. Bandura correctly observes that the Transtheoretical Model does not feature any of these qualities: there is potential overlap between the stages; certain stages might be bi-passed – for example that a patient or client might perform health promoting actions before preparing for these; and that patients or clients can regress and go backwards as well as forwards in their states of motivation. All of these critiques

can be and were verified with reference to data from the four cases in this present study. Of these I find the second of Bandura's critiques is the one that has the most power. Can it really be said that change in psychotherapy can be determined to always follow a certain sequence of discrete stages? My response as a practitioner in my awareness of the virtually unlimited causal factors that support and facilitate change, that it seems highly unlikely that a certain sequence of discrete stages might be observed to hold in any objective sense. However the Transtheoretical Model was useful to me in providing a frame of reference in which to appreciate therapeutic work with my clients as directional in nature, and indeed to think of the work as passing through stages that are qualitatively distinct from one another, each requiring different approaches.

West (2005) anticipated my own awareness of the shortcomings of the gradualist structure, observing that often change can occur suddenly and that these changes can be triggered by apparently small causes, that might have a tipping point quality to them. West instead proposed a conceptual shift away from stage-based concepts of change, towards state-based concepts. West's argument anticipates concepts of change originating from dynamic systems theory, stressing the importance of critical periods in therapy in which relatively small inputs can have very large outputs because the conditions are ripe for change (Bonn, 2009; Marks-Tarlow, 2011; Trop et al., 2013; Seligman, 2014). In developing my own appreciation of state-based change I wanted to see if I could drill down a bit further into some of the critical incidents that appeared to be important landmarks for my clients across the course of their therapy. Research studies that have attempted to apply dynamic systems theory to case studies tend to rely on quantitative rather than qualitative analysis. For example, in this recent case study on the nonlinear dynamics of change in play therapy (Halfon et al., 2019) a qualitative commentary was provided retrospectively on quantitative results rather than a qualitative analytic approach being applied directly to the data. Given there are not yet in existence qualitative frameworks for analysing nonlinear change process, I turned to *task analysis* which is a qualitative approach designed to draw out patterns in the client process and therapist responses that appear to underpin the change episodes under investigation. In the mini-study that follows I produce a task analysis of three significant events from Lou's therapy. The common feature of these significant events – which each occurred in the seven days between our sessions - was that in each case Lou became aware that 'now is one of those situations we've been talking about in therapy'.

5.6 Mini-study: A task analysis of Lou's conscious repositioning within relational entanglements

Rice and Greenberg (1984) first advanced the concept of task analysis as a method within the change process research tradition, as described in their seminal text *Patterns of Change: Intensive analysis of psychotherapy process*. They were interested in observing 'recurrent change episodes' across therapy cases in which client processes – known as client performances - and therapist interventions/responses could be modelled sequentially. In a task analysis actual client performances are compared against an idealised model of the change process, with the model continually being adjusted to 'fit' with each actual client performance in an iterative approach. What attracted me to task analysis as a research method is that it appears designed to address directly my own foundational questions in this project of what change looks like and how change is facilitated. But what I also found congruent about task analysis was that the analyst begins with a hypothesised model of change, and this model is continually being refined with reference to actual instances of psychotherapeutic change. This to me reflected in a formal setting what we practitioners are doing all the time implicitly: we keep our idealised models of change in our minds but these are constantly being tested by and refined in the context of actual clinical work.

Whilst task analysis as a research method is now over three decades old it is still used formally to model change processes. Recent published studies include: Meystre et al.'s (2015) task analysis of therapist interventions that facilitate the client's progress through the assimilation model of change (see Stiles et al., 1991), Murphy et al.'s (2017) task analysis of working with worry in emotion-focused therapy, and Benítez et al.'s (2019) task analysis of therapeutic working with families 'trapped' in parental-adolescent conflict.

Typically a task analysis is applied to data from multiple cases in which structural similarities have been observed across change episodes, which are referred to in task analysis as *events*. However here I analysed data from one case – that of my work with Lou – and in particular three events (change episodes) that have a structural similarity. In each case Lou identifies with a problematic pattern of relation during a therapy

session and goes on to successfully create space and perform an alternative stance in relation to significant others in the period following the therapy session.

A task analysis begins with the specification of the task (Greenberg, 2007). In this mini-study therefore I performed a task analysis to ask a formal question of the data:

What were the steps through which Lou was able to create space for herself within relational entanglements?

Given my interest during this period in longitudinal patterns of change, I aimed to discover whether there was any regular sequencing of Lou's processes and the interactions between us. Greenberg (2007) asserted that in task analysis we needed to select the 'purest examples' of the process of interest, using the analogy that if we want to model the molecular structure of gold we need a pure sample. As such I selected three significant events during Lou's therapy which were the purest examples of her successfully creating space within key relationships where problematic patterns of relation had been observed.

5.6.1 Hypothesising of a rational model to test against the data

I looked for indices within relevant passages from Lou's therapy that described the change events, which were composed of the following elements:

- A beginning marker, what Elliott (2012) describes as a signal that the client is in a state of readiness to work on the therapeutic task
- Client processes, as discernible steps through which the client progresses towards resolution
- Therapist interventions e.g. that take on meaning as responsive to client processes and are facilitative of the task

- An end marker, or what Elliott describes as ‘a task resolution, in the form of meaningful therapeutic change’ (Elliott, 2012, p.76)

Recognising my original theoretical awareness that extra-therapeutic conditions may provide the necessary environment in which the client can see through the task, Elliott’s conceptualisation of the beginning marker as a ‘state of readiness’ is helpful. The state of readiness may be considered to implicitly contain the coincidence of all facilitative factors, whether or not they are relating to the therapy or indeed to the client’s life outside of therapy.

Likewise given Elliott’s description of an end marker as an index of ‘task resolution’ what would a ‘task resolution’ look like? My decision was to identify individual behavioural examples of Lou being able to successfully create space within relational entanglements involving significant others as an end marker; of ‘task resolution’.

From September 2018 through the first half of 2019, I performed several such task analyses in relation to my data collected, particularly with reference to the work with Lou, who being my longest term client in this study I had the most data available for. Given the high density of data processing required to conduct a task analysis, much like in the previous chapter, the mini-study that is presented here can be understood as a smoothed out and simplified account of how the task analysis worked in practice, and delivered emergent theory. I present the process in four stages:

- 1) The original hypothesising of a ‘rational model’ (Greenberg, 2007) of task resolution
- 2) Narrative accounts of the three ‘recurrent change episodes’ identified from my work with Lou
- 3) Direct comparison of key features from these episodes and how they relate to the model of task resolution
- 4) And a presentation of the ‘rational-empirical’ (Greenberg, 2007) model of task resolution as a consequence of performing the analysis

It should therefore be noted that the task analysis described here is more properly defined as ‘discovery phase’ task analysis (Greenberg, 2007). Out of the discovery phase

ordinarily emerges a rational model which is then tested through empirical trial in what is known as the 'validation phase'. However the purpose of this research is to generate hypotheses rather than to verify them and so this second phase of task analysis is beyond the scope of the present study.

I began conducting the task analyses approximately two months after the third of the key change episodes described in this mini-study, which took place in July 2018. Based on my experience as a therapist working with Lou, I therefore hypothesised the following sequence of generalised steps through which I had understood Lou had been able to create space in a series of relational entanglements. This was the rational model that I 'took into' the task analyses I would go on to perform:

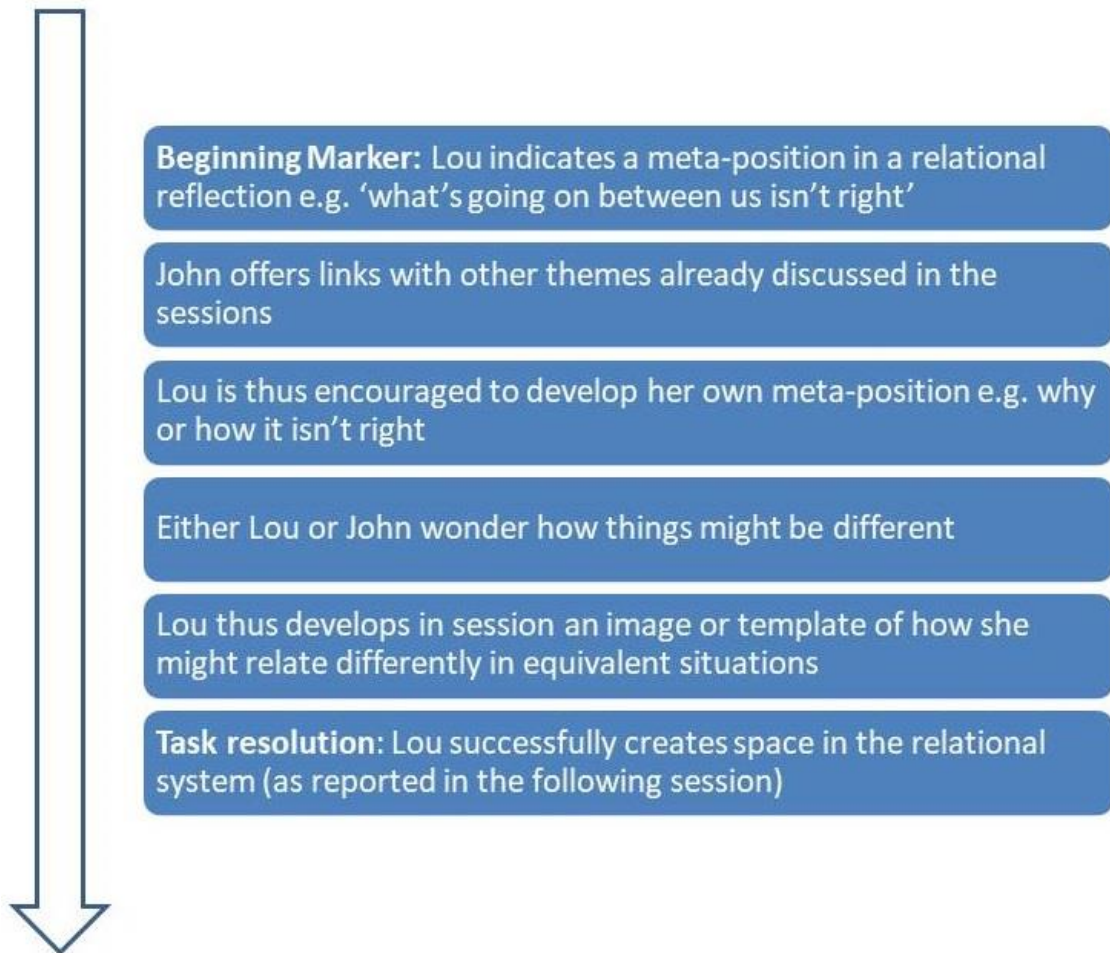


Figure 16: The rational model that formed the basis of the task analysis

The sequence of events thus envisaged is a more or less 'common sense' sketch based on my practice experience working with Lou as with other clients with comparable systemic challenges, before the model was thus compared with the data as in the common sections.

5.6.2 Selected therapeutic events from Lou's therapy

Each of the following three 'events' then documents comparable change episodes in the period of my therapeutic work with Lou. What they each have in common were that

they were moments in which Lou was able to create space with significant others including her parents-in-law, her husband, and finally, and most challengingly, with her mum and sister. Each of these events was reported by Lou in the following session, and in later reflections, as significant milestones in her own progress. I have described these events in a narrative form, however have broken up the paragraphs to better represent what appear to be the qualitatively distinct ‘steps’ in the event. I have also underlined the words that appear to describe the core action associated with that steps. The data that appear to represent the beginning marker and the task resolution respectively are also emboldened.

5.6.2.1 First event: Lou stays at home

Between sessions 6 and 7 Lou took a stance with respect to her husband and his parents that was very difficult for her but became a symbol for her renegotiation of her Peacemaker role. In session six Lou reflected on being out of work presently and wanting to get back into employment as “not working for me is not normal”. I linked this back to what she had told me in the previous session about her discomfort in being looked after financially by her husband. Lou explained that since our previous session she had shared some of those feelings with her husband and I encouraged her to reflect on how she experienced being able to communicate those feelings to him.

(Session six)

Beginning Marker (1): Lou reflected that it had helped her to realise that her husband was “a big factor in how I’m feeling”. Her husband had felt that he was being supportive by telling her that she didn’t need to worry about working, but was not appreciating that being unemployed and not bringing any money in was impacting upon her self-esteem. Lou went on to tell me that a friend who had gone to see a psychic had told her that her (Lou’s) husband was having an affair.

2. I reflect that there was something here about fate – how much control does Lou feel she has over how her marriage plays out; is her husband fated to cheat on her?

3. Lou reflected that she could use the experience of the psychic as an opportunity for her and her husband to talk about their feelings on their marriage.
4. I observed there was some potential for control there too – that by talking about it they have a chance to determine what kind of marriage they want to have.
5. Lou went on to share with me her experience of a diet designed for her by her husband and a mutual friend that she went on last year. Originally the diet had been a success and she lost a lot of weight, but increasingly she came to rebel against the diet, describing it as “spitting my dummy out”, and put much of the weight back on. Lou said it was mysterious ; she couldn’t understand why she’d done it.
6. I acknowledged the sense of mystery but also suggested that control was again a theme here, linking this back to Lou’s Peacemaker narrative. During the rest of the session we go on to talk about food, the meanings of food for Lou, rather than persisting with the control theme.

(Session seven)

7. When Lou arrived for reported on a significant relational stance she had taken. One day during the week her and her husband had planned to go out for a walk. However he took a call from his parents who, upon hearing they were going for a walk, invited themselves along. Lou had wanted him to say that he would prefer they didn’t as the two of them needed some time together, but he said it was ok.
8. During the time waiting for them to arrive, Lou reported: “I was sat there on the sofa and I was like: you know what I don’t have to do that. I don’t want to do it; I don’t have to do it ”.
9. Lou’s anxiety about taking a stand was evident, as she described: “all the time when I was waiting for them to come I was playing in my head what I would say to them”.
10. When her in-laws arrived she explained that she would not be going on the walk with them, and when they asked whether it was because they were there she confirmed that it was. So Lou remained home whilst her husband and in laws went on the walk.

11. In the session I suggest that this incident, like the rebellion against the diet last year, was in some respects a polar opposite position to that of the Peacemaker – in that Lou was asserting herself in a direct, rather than diplomatic way.

Task resolution (12): She reported ambivalent feelings: **“Afterwards I felt quite guilty that I’d said it but I felt quite proud of myself as well.”** I reflected that she had been able to say “I feel” and “I need” in a way that the Peacemaker is not able to do. Lou reflected that “I just feel stronger”.

Whilst the hypothesised rational model features six steps, I discerned twelve potential steps, as reflected in this narrative account. An initial beginning marker is proposed where Lou declares that her husband is a “big factor” in how she’s feeling. In other words the problem is not simply that of failing to be a provider per se, but moreover that it creates a greater sense of dependency on her husband. The following exchanges between Lou and I for the remainder of session six have been broken into five steps which may be more appropriately described as oscillation between us in which a core theme emerges – that of control; how much Lou feels in control within her marriage. My experience as the therapist was that as the therapeutic conversation moved on, and as the session ended and Lou went back out into the world, that the theme of control continued to be ‘incubated’ within her thoughts. One of the twelve ‘steps’ as the narrative is broken up here, which is also not anticipated in the original hypothesised model, is based upon a critical moment within the relational system; in this case Lou’s husband’s parents inviting themselves on the walk and her husband assenting. Also significantly in this therapeutic event, Lou has not made any comparison between the present pattern of relation and how things might play out differently. This hypothesised imagining of how things could be different I reference in the literature back to the Preparation stage of Prochaska and Norcross’ Transtheoretical Model as applied to psychotherapeutic change (2001) but it is not evident in this event. What was not anticipated in the original model was the preparatory work Lou would do in real time – repeatedly playing through what she would say in the moments before her in-laws were set to arrive. Perhaps what this demonstrates is that the preparatory work *could* have been done in the therapy session but in this instance was done outside of it and in a pressured situation rather than with Lou having the luxury of a space to reflect. Also significant is that my conceptualisation of the task resolution as that moment when Lou

successfully creates space was challenged by the significant reflective work following the behavioural breakthrough – Lou’s feelings of pride afterwards as a necessary part of the task resolution. I was mindful of the Gestalt cycle (see below) in which the Action stages and followed by experiences of Final Contact and Satisfaction.

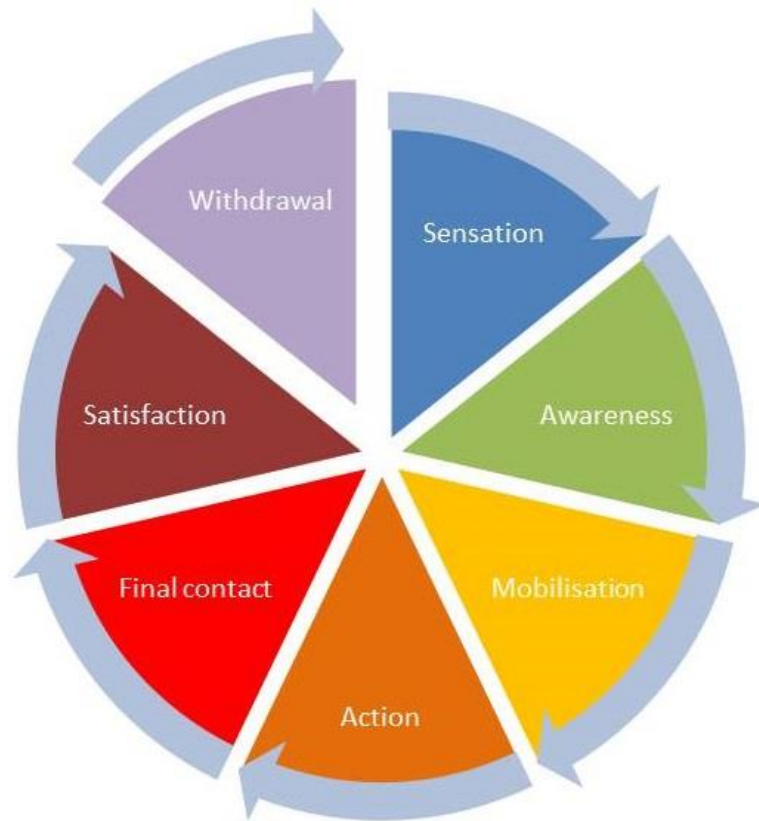


Figure 17: The Gestalt Cycle (Clarkson, 1989)

The successful completion of the task, certainly from a therapeutic point of view, included the reflective processes that followed.

5.6.2.2 Second event: Lou walks out

This second event marked probably the most significant of turning points in Lou’s marriage during our work together, with the resolutions made at this point still holding

when Lou and I met for her follow-up appointment in the next year, following her completion of therapy.

In the ninth session Lou and I had been managing the fallout from a significant disclosure she'd made to her husband about a sexual relationship she had had with a much older man when she was still in high school. Her husband was furious that she'd not told him about this period in her life before, which she had withheld because of the shame she felt around it. In the ninth session I'd emphasised that Lou was the vulnerable one during that situation, which had amounted to childhood sexual abuse.

(Session ten)

Beginning marker (1): In the following, tenth session **she reflected that after seeing me she'd felt validated and able to go back to her husband and frame what had happened differently.** She was able to hold her ground when before she'd felt intense guilt.

2. She went on to explain how her husband was essentially giving her the ultimatum that if she did not lose weight then he would leave her. However Lou reflected that she doubted he would go and I observed that this was the first time she'd said this e.g. as though the ground that she stood on had been stronger.
3. Lou reflected further that perhaps they could both benefit from some time apart, so that he might realise that there was more to their marriage than just weight.
4. I take up Lou's own theory that because her husband had lost his own excess weight, he has transferred his obsessiveness onto her and is frustrated that he doesn't have the same control over her that he did over himself. I mused over the question of who was in control, observing a power struggle not just over weight, but also over finance, of Lou's handing in of her notice (which her husband had argued strongly that she should do), what work she would do, and so on.

5. Lou related again her discomfort with having to use her husband's debit card to make purchases and wondered out loud whether he did derive some feeling of "oh I'm in control" from that.
6. I ask Lou if there was one thing she could do, even a small thing, that she could derive of feeling of independence from.
7. She identified raising enough money from a stall she was running that she'd be able to afford to pay to do her nails rather than her husband paying. I reflected back a mental image I had of a life buoy in an open sea – that she'd just identified a life buoy. She went on to reflect how converting her room in her house to set up her dress-making business would give her a greater sense of control in her life and the session ended on that hopeful note.

However Lou cancelled the following session, having left her husband for a week, to stay in a different part of the country with family.

(Session eleven)

8. When I saw her the next week she explained that one night her husband had returned drunk and went straight to playing on his video games as though she didn't exist.
9. She spent all that night battling with the question of whether she should go
10. At 6am the next morning Lou told her husband that she was going to leave. The money she'd raised from the stall was the money she lived off over that week.
11. When they spoke on the phone towards the end of the week she told him that she'd made a "a list of stuff that needed to change if we were to go forward" and said that he should do the same. When she returned he admitted to her that he had become controlling. They compared their lists and agreed on the different points, including recognising their need for space and time apart from one another, for example going to separate exercise classes than to the same ones.

Task resolution (12): In session we agreed that Lou was seeking to preserve the independence that she'd experienced from taking the step that she had done. (And these new arrangements held with her husband for all the rest of our time together).

Perhaps the most obvious therapeutic difference in this second narrative is the invitation to Lou to envisage a simple, achievable goal – that of raising money from the stall. That and the subsequent reflection on its significance might be considered an example of Preparation in Prochaska and Norcross' (2001) Transtheoretical Model. This was a therapeutic device I deployed instinctively that was useful for Lou in this context, and is thus perhaps too context-specific to be generalised from. Note that as with the first event, a significant 'step' within this event was a critical moment in which her husband returned home drunk and acted as though she didn't exist.

5.6.2.3 Third event: Lou goes swimming

During this sequence of sessions perhaps the most important therapeutic work of our time together was done. After making substantial progress in her relationship with her husband, Lou had admitted in the nineteenth session that actually she found it much harder to take a stand within a triangle which involved her mother, her sister and her. Within this triangle Lou typically had played the role of the Peacemaker which might be considered to be the Rescuer as described in Karpman's (1968) drama triangle, although as Lou went on to provide frequent examples of these dramas between the three women it was evident that the roles of Persecutor, Victim and Rescuer were interchangeable between them. By session twenty-two almost the entire session was devoted to elaborating on Lou's experience and behaviours within that triangle. Session twenty-three was unfortunately curtailed to only about 15 minutes as Lou arrived late. However in session twenty-four she was reporting behavioural examples of being able to withdraw from the triangle and within her experience of withdrawal making contact with important insights about herself.

In session twenty-two Lou identified at the beginning of the session something that had happened the previous day which served as the latest example of the dynamic between

the three women. Lou's sister had mistakenly assumed that Lou would drive her daughter (Lou's niece) to a hospital appointment. Lou believed that her sister should be taking her own daughter, and Lou's Mum intervened to argue the same – meaning Lou's sister had to leave work to take her daughter. Lou lamented feeling terrible guilt she'd felt from her sister afterwards who wouldn't speak to her.

(Session twenty-two)

Beginning marker (1): I reflected that there is a parallel issue to her thoughts about what her sister believes and how she twists the meaning of events; that in the passive-aggressive nature of those 'twists' Lou herself gets dragged in and is made to feel like the Persecutor. **Lou endorses this idea relatively passively, as she has done several times in recent sessions**, indicating some preparedness to take a meta-position.

2. I suggested to Lou that at times of conflict, as with the latest fall-out over the hospital appointment, Lou's feelings of responsibility and guilt are particularly triggered, which again Lou endorses but in a relatively passive way.
3. I went on to ask Lou that when conflict does break out, what she imagined she might be able to do otherwise.
4. She replied that she could just say "you don't have to argue about this" and walk out of the room, but that she'd still be "churned up" about it. However Lou concluded the session with more conviction, recognising "I do need to take a step back".

However, despite this promising conclusion to the session, Lou did not report any behavioural gains in the next session. In the following session we were curious together as to how Lou had forgotten that tonight she had her session and as such had arrived so late. She found this very disturbing as it was out of character. I suggested that perhaps confronting her relationships with her Mum and her sister were causing her a lot of anxiety. She recognised that it was a possibility but stressed she really didn't understand why.

(Session twenty-three)

Beginning marker (1): She reported on another conflict within the triangle. I highlight this because Lou appears now to implicitly understand the importance of taking a meta-

position. Her sister owed their mum money, but insisted she couldn't pay as she was in financial difficulty.

2. I offer thoughts on the way that Lou gets drawn in as being a "game", alluding to the passive-aggressive behaviour of her sister.
3. I re-invoked our theme of the previous session about being able to take a step back and I asked Lou to imagine how she could practically do this in the seven days between sessions.
4. However she couldn't think of anything, instead reiterating her understanding of the position of Peacemaker she appeared to be taking in the relational system.

(Session twenty-four)

When Lou arrived for session twenty-four, she reported on a tangible way in which she had been able to withdraw from that dynamic, which is described in more detail in chapter six. One of the ways that Lou, her sister and their Mum were continually in contact is through a group chat on a social media app on their phones. However Lou reported being able to decide more consciously how and when to engage with the chat.

5. In this case Lou had chosen to spend the day ignoring the chat whereas ordinarily she would pick up and respond to the messages virtually instantaneously. Instead Lou spent the day knitting, an activity that was personally meaningful for her.
6. When later in the day Lou's Mum enquired as to why she's been so quiet Lou replied that there was nothing to worry about and explained to her Mum that it's just "not normal" (e.g. to be so constantly involved in one another's lives)
7. Following the exchange Lou enjoyed a feeling of calm and security which felt very significant

Task resolution (8): In the session Lou linked her experience of ignoring the chat to her experience of swimming, which is the one situation in her life that she felt completely safe, calm, insulated from the demands of others; in her own private world.

This third event became symbolically powerful for Lou, as a blueprint of how she might disentangle from the relational system involving her Mum and her sister. Where here it

is carved up as a sequence of steps in task resolution it appears fragmented and even noisy. The 'event' spans three counselling sessions, and seems to be initiated once unsuccessfully before being completed in a second revisiting of the same idea. This third event is thus not necessarily the 'purest' example of task resolution and I am mindful at this stage of Greenberg's (2007) advice that we require the purest samples of gold. However I also feel as a therapist that events such as these reflect the clinical reality of working with ideas that are often on the cusp of a client's awareness. In session twenty-two Lou appeared to generate a behavioural template for how things might be different in the relational system; whereas she seems to lose contact with – or belief in – this idea in the following twenty-third session. What is also significant is that unlike the previous two events described, Lou's own participation appears to be somewhat more passive; I appear as the therapist to be doing more of the linking work and suggesting interpretations. This perhaps reflects Lou's own admittance that creating space in her relationship with her mum and sister was actually much harder for her to do that with her husband, or indeed her husband's parents. I return to this question of purity vs impurity in selected events for task analysis in the concluding section of this mini-study.

5.6.3 Towards a rational-empirical model of task resolution

Given the sheer volume of data processed in this analysis, I present the steps – as carved out of the narrative accounts of change events – in the following table, in parallel to demonstrate the comparison of these steps and thus the emergence of a rational-empirical model that is congruent with the available data.

Table 6: Comparing client and therapist steps across three change events

| No. step | First event | Second event | Third event (first initiation, unresolved) | Third event (second initiation, resolved) | Description of step in therapeutic process |
|----------|---|--|---|---|--|
| 1 | Lou observing that her husband was “a big factor in how I’m feeling” | Lou reported feeling validated and would be able to frame what had happened to her differently. | Lou endorses the idea that she gets dragged into a game involving her Mum and sister | Lou ‘brings’ another conflict in the triangle – recognising now a repeating pattern | <i>Lou says something in session that indicates she’s taking a meta-position in her reflections on the system</i> |
| 2 | John suggests a common theme: how much does Lou feel in control? | John recognises that Lou has never before expressed doubt that her husband would actually leave her. | John proposes that what the conflicts have in common is that feelings of responsibility and guilt are activated | John describes the way that Lou gets drawn in as like a game | <i>John draws attention to what appears to be a significant statement by encouraging reflection</i> |
| 3a | Lou sees opportunity to have a conversation about her marriage more generally John suggests that the opportunity is to realise a degree of control she presently doesn’t feel. Lou links the theme of control to her previous experience of rebelling against | John suggests that in many different areas there appears to be a power struggle between Lou and her husband Lou links her having to use her husband’s debit card to the idea that he may consciously appreciate being in control. | Lou reiterates her position within the relational system | Lou reiterates her position within the relational system | <i>Through a cycling of exchanges Lou derives a greater sense of the underlying pattern of relation that appears to be at work in the system</i> |

| No. step | First event | Second event | Third event (first initiation, unresolved) | Third event (second initiation, resolved) | Description of step in therapeutic process |
|----------|--|--|--|--|---|
| | <p>the diet.</p> <p>John suggests that it was one way that Lou could derive a sense of control</p> | | | | |
| 3b | | <p>Lou reflects that her and husband could benefit from time apart.</p> <p>John asks Lou if there is one thing she can do to foster independence.</p> <p>Lou identifies raising money for herself from the stall</p> | <p>John goes on to ask Lou what she might do differently when conflict breaks out</p> <p>Lou proposes that she say “you don’t have to argue about this”, leave the room.</p> | <p>John goes on to ask Lou what she might do different when conflict breaks out.</p> | <p><i>Through a cycling of exchanges Lou derives a template for how she might do things differently within equivalent relational scenarios.</i></p> |
| 4a | <p>(In seven days between sessions)</p> <p>Husband takes call from his parents inviting themselves on the walk</p> <p>Lou reacts by declaring that “I don’t have to do this”</p> | <p>(In seven days between sessions) Husband returns home drunk/as though she didn’t exist</p> | | <p>(In the seven days between sessions)</p> <p>Lou hears the phone pinging (for the group chat)</p> <p>Her Mum enquires as to why she has been so quiet.</p> | <p><i>In the seven days between sessions, an activating event and an implicit recognition: ‘this is one of those times we’ve talked about in therapy’</i></p> |

| No. step | First event | Second event | Third event (first initiation, unresolved) | Third event (second initiation, resolved) | Description of step in therapeutic process |
|----------|--|--|--|--|---|
| 4b | Lou planned what she would say to her in-laws in advance of their arrival | Lou spent the whole night deliberating whether she should leave | | | <i>Lou deliberates and plans for the actions she is about to take within the relational system</i> |
| 5 | Lou explains to her husband and in-laws that she will not go. | At 6am the next morning Lou tells her husband that she will leave | | Lou is able to ignore the chat. Lou explains to her mum that it's "not normal" | <i>Lou performs an innovative action within the relational system</i> |
| 6a | Lou felt guilty afterwards but also proud of herself. | Lou and her husband agree a set of resolutions; he admits he has been controlling | | Lou feels calm and safe after withdrawing from the chat | <i>Lou receives subsequent 'feedback' from the performance of the relational system</i> |
| 6b | (In the following session) John suggests that what Lou modelled was a "polar opposite" strategy to her being the Peacemaker Lou reports feeling stronger. | (In the following session) Lou and John link the event and subsequent resolutions to a desire to preserve a degree of independence | | (In the following session) Lou links the experience of ignoring the chat to her experience of swimming | <i>Lou's learning from the successful performance is consolidated by therapeutic reflection in the next session</i> |

What appears to emerge from the comparison of the change events with the original hypothesised model is a sequence of six 'steps' however with some importances. Where steps have been broken into two parts, the first part 'a' is observed as necessary to the completion of the task, whereas the second part 'b' is observed as appearing in some instances and may have a reinforcing effect on completion of the tasks. Steps 3a and 3b have been grouped together because they appear in each of the change events and appear to serve the same purpose. Whether the therapeutic work is about attempting to discern the core patterns of relation present within the relational system being described or whether the reflective work focuses on envisaging how things might be done differently, both of these processes appear to 'prime' Lou to recognise when these relational dynamics appear to be at work in the seven days between sessions. As we saw from the first event, therapeutic reflection on how things might be done differently was not necessary in order for Lou to perform the successful behavioural innovation associated with that event. What is also significant about step 3 - the hypothesised 'priming' process - is that it is characterised by a cyclical exchange between Lou and I as her therapist in which meaning tends to deepen and become more intelligible with each speaking turn. A separate task analysis could be produced in more fine-grained detail about this step in the change event. The specified task could be phrased as: *How was Lou primed to recognise key relational scenarios in the 'real-time' of the seven-days between therapy sessions?* However what I came to understand through this process was that it was very difficult to discern linear patterns in the exchanges between Lou as client and myself as therapist. Much as in systemic therapeutic approaches, I believe it is more appropriate to consider meaning as emerging in a circular (or cyclical) fashion - in this case as circulated between client and therapist - without any clear resolution or end to that process. Circularity in systemic therapies, as described by Jones (1993), better reflects the way Lou was 'primed' to recognise key relational dynamics rather than a linear account.

Likewise steps 4a and 4b have been grouped together mostly because Lou's planning and preparation for the subsequent behavioural innovation only appears to be explicitly present in the first two events. It could be that some behavioural steps require more conscious planning than others, or it might reflect Lou's increasing competence in creating space in relational systems, such that she was able to calmly withdraw from the

group chat and later communicate why to her mother in a way that would have been distressing several months previously. What steps 4a and 4b have in common is that Lou was 'mobilised' – to refer back to the language of the Gestalt cycle – following a recognition in real time that 'now is one of those situations we've been talking about in therapy'. In chapter six I go on to describe this process as 'bridging' and explain this concept further in chapter eight when delivering the emergent thesis. Finally steps 6a and 6b have been grouped together because they reflect the reflection and learning following the successful behavioural innovation: perhaps being captured by the 'final contact' and 'satisfaction' stages of the Gestalt cycle. These steps are more properly identified as the resolution of the task than the performance of the innovative behaviour as I proposed in the original model.

Therefore the following rational-empirical model emerges. The blue cells represent the apparently necessary steps in the completion of the therapeutic task, the green cells represent additional processes that may be observed implicitly or explicitly that appear to reinforce those necessary steps:



Figure 18: The rational-empirical model, as emerging from the task analysis

5.6.4 Observations

It is important to observe the model that emerges from this mini-study applies specifically to my work with Lou. However the theoretical expansions around 'priming' a client to recognise situations that index back to the therapeutic conversation, and the event of recognising that pattern of relation within the 'real-time' of experience in the seven days between sessions, are concepts that may be mapped onto other client work as I will consider in the coming chapters.

I raised the point earlier about the difficulties in selecting 'pure' examples of change events, and this indeed raises the question of what is meant by purity. In the pursuit of data from therapeutic process that may be easily carved up into sequential steps we may be in danger of attempting to filter out the complex networks of causality underpinning these steps. We might consider for example the second change event, where it appears from analysis of the tenth session that Lou had wondered for the first time whether her husband and her might benefit from some time apart. For the purposes of producing the task analysis this utterance is considered as a discrete moment, and indeed an *innovative moment* in the therapeutic dialogue leading up to that point. However it is reasonable to assume that Lou hadn't just thought for the first time in that session that her and her husband might benefit from some time apart, but that rather that idea had been on the cusp of her awareness for some time. We might call such processes 'pre-conscious', and these are much harder to track through the conventional approaches to analysis in the change process research tradition. Likewise what I think this mini-study highlights is the necessity of steps that occur beyond the therapy room; in the seven days between sessions. Such observations reduce the 'purity' of the selected change event further but they enhance its relation to reality.

A further critique that may be lodged against the application of task analysis to a series of therapeutic events that succeed one another chronologically during one person's therapy is the question of how we can be sure that the successful resolution of a task in one event was not supported by either successful resolutions or unsuccessful attempts from previous tasks. In other words, is it possible to treat these as discrete therapeutic events? My own view is that we clearly cannot treat these as discrete therapeutic events, for the same reasons that the concepts of a task having a 'beginning' or an 'end' are similarly only practical constructs so that we can perform an analysis on the data.

From a theoretical point of view I do not believe it is necessary to think of therapeutic tasks as discrete events in order that we might derive meaning from them. I am mindful of Marks-Tarlow (2011) and her observation of fractal patterns within the therapeutic work i.e. therapeutic sequences that have a 'self-similarity' about them, even as they operate on different scales of time. Marks-Tarlow observes repetitive psychotherapeutic patterns that take an iterative form, with each iteration 'setting the stage for emergent novelty'. With respect to task analysis, it may be conceptualised that each therapeutic sequence sets the stage for the next and indeed ultimately for the breakthrough of a successful task resolution. This is demonstrated by the way in the third event of this task analysis Lou seems to repeat the steps traced in session twenty-two, again in twenty-three, before a successful behavioural performance in the week preceding session twenty-four. Therefore this present task analysis demonstrates that the process by which Lou is able to create space is cyclical rather than linear - each cycle feeds the next and perhaps only by degrees of refinement- Lou, as the client, is honing her skills. The emergent critique then feeds into a wider critique expounded earlier in this chapter about attempting to define discrete longitudinal stages within the therapy process. Rather, the most useful ideas that emerge from the task analysis indicate the importance of threshold *states* in which the client successfully realises change at whatever stage of their therapy they are at. In particular, this exercise has highlighted the importance of Lou being 'primed' in the therapeutic discussion to recognise key relational dynamics in her life between sessions.

5.7 Conclusion

What the analyses of this chapter do highlight is the client's growing capacity for metacognition – to take a meta-position in relational systems is to consciously reflect on one's own psychological state and how one is engaging with others – as a basis for therapeutic change. This is the event – though it may be more properly described of as a process – of a client transcending a certain way of thinking about their experience and entering into another frame

of reference in which experience is understood differently. We will see, in the coming chapter, that *Michael* was able to realise the pressure he felt upon himself in those moments where his spasms became aggravated, was internally generated, rather than necessarily attributable to the harsh world 'out there'. Recognising also the theme Michael introduced of the 'two shoulders' and developing a habit of reflecting back at the end of each day (as referenced in the mini-study in chapter four), Michael was starting to realise a degree of psychological flexibility (Kashdan, 2010) to stand apart from and question his ways of experiencing. *Jennifer* in reference to her 'hand in the bucket of water' motif which will be explained in the coming chapter, described her process as "turning negatives into positives" – which for her meant a capacity to stand apart from her patterns of thought and to derive new ways of thinking about things. And as we will explore in the mini-study at the end of the coming chapter, *Myrtle* recognised the function of her intense crying in the first session may have been as a 'crystallisation of discontent' (Hayes et al., 2007) – a 'line in the sand' emotional experience which enabled her to stand apart from lifelong patterns of relation and consider how things might be different.

My theoretical attention therefore turns in the next chapter towards 'higher order' concepts of change. As will be observed, sufferers of chronic pain may experience flare-ups of their pain in relational situations for which they lack an adequate cognitive map, and thus experience subjective incompetence (Figueiredo and Griffith, 2016). I therefore frame the analytic template described and applied in chapter six around the generation of cognitive maps.



Until you make the unconscious conscious it will direct your life and you will call it fate.

Carl Jung

Chapter Six, 3rd template: The generation of cognitive maps

6.1 August - November 2018: where I was

In August and October of 2018 my supervisors received the case reports I had produced with *Jennifer* and *Myrtle* respectively. John was particularly critical of these case reports, and we will go onto explore these critiques later in this chapter. John's basic position was that he couldn't get a feel for my clients from the case reports who came across only as "shadowy figures". Where was my descriptive depth; where were my rich practitioner insights? As John saw it, I seemed only to be writing about Jennifer and Myrtle on a shallow, superficial level. In my diary entries I mused on a theme that I described as 'cack-handedness', which on a literal level came down to a lack of dexterity. I am a musician and I used to play guitar in a band, however I only ever played rhythm guitar as I simply didn't have the dexterity to play lead. Likewise I remember my Dad playing the piano each and every morning, as the anchor point of his entire day. However he too played busker versions of the pieces he played which I understood reflected his own lack of dexterity. Once he told me about a recurring dream that he had: that he would go into a music shop and all the keys on the pianos had been changed, such that he could no longer play them.

During my Master's dissertation one of the feelings that appeared to be invoked for me in the situations in which my own chronic pain flared up was a feeling of impotence: the kind of impotence we feel when we simply lack the strength or the skills to navigate through a situation. On Monday, 24th September 2018 I awoke and jotted down two dreams I had had that night:

The first: I (am in my sixties and) have a heart attack (basically me blacking out) but am saved. I am told my heart is very weak and I only have 12-18 months to live. I am devastated to be dying in my sixties – at the same age as Dad. I stress to my wife the importance of our son getting his heart looked at - if they can identify any weaknesses now they might be able to help.

The second: I am to go to Christopher Reeve⁸'s house to assess him for counselling. My Grandma doesn't see how I can help as I'm not a doctor, and counselling is just talking. I'm amazed to see that he can move his arms and his legs a little.

The first dream is a reference to the generational chain. Though during this period my focus was on hands, and more specifically the symbolic quality of dexterity that I felt I was lacking, in John's critique of my cases it was as though he was telling me that the case reports lacked heart. In the second dream the symbolism evoked by Christopher Reeve is clear. He was Superman. Much as in my own recurring dreams, he was able to fly, and in that cruellest of ironies the man who was Superman ended up paralysed from the neck down: impotent in the literal and wider meaning of the word. My Grandma is saying that "just talking" can hardly mend the physiological reality of a broken neck – the intervention is futile. And yet the dream does offer some glimmer of potential as Reeve isn't completely paralysed: he can move his arms and legs a little. Might this have been an Innovative Moment: the first sign that something new was about to emerge?

In a similar way each of the four participants might be considered to have arrived for counselling with a similar sense of impotence or frustration: I don't know how to get past this, I don't have the skills, I don't have a map. During this period my sensibility as a therapist thus shifted from an emphasis on my clients migrating from one I-position to another, towards an appreciation that each of my clients was searching for a map, something useful they could take with them, that might be described as a 'game changer'.

⁸ Christopher Reeve was an American film actor who played Superman in a series of four films in the 1970s and 1980s, before being paralysed by the neck down following an incident in which he was thrown from a horse.

6.2 August - November 2018: where my theory was

I first came across the concept of a 'cognitive map' in a paper by Figueiredo and Griffith (2016) in which they proposed that a person's experience of chronic pain was modulated by their experience of being 'demoralised': if a person lacks a 'cognitive map' they experience a state of 'subjective incompetence' – they simply don't know how to navigate within or through the relational worlds they inhabit. People with subjective incompetence 'are puzzled, indecisive, uncertain, facing a dilemma, unclear as to ways out of the situation, placed in a deadlock, impasse, quandary, or plight' (Figueiredo and Griffith, 2016, p.169). Interestingly Figueiredo and Griffith observed that subjective incompetence can be highly context specific and thus that a person's mood might be observed to fluctuate dramatically based on the present situation they're navigating through. I note a parallel with the context specificity that can be observed in the flare-up of somatic symptoms, including my own. With more direct application to living chronic pain, Figueiredo and Griffith observed that the loss of a cognitive map may have the effect of diverting attention back towards pain and potentially also the fear associated with pain – e.g. fear of its intensity, or fear of its meaning.

As identified in chapter one, Bowlby (1971) identifies with the concept of the cognitive map as laying the groundwork for his own concept of the *internal working model*. Bowlby helpfully conceptualised the map as a 'coded representation of selected aspects of whatever is mapped' (Bowlby, 1971, p.110). The emphasis in that statement is on the selectivity of a map – Bowlby observed that because our internal and external environments are so complex that we necessarily have to construct maps selectively based on which information is most necessary to us in achieving our goals. Bowlby argued that all psychopathology ultimately comes down to dysfunction in our organismic and environmental models, and that these models are none other than the 'internal worlds' described in psychoanalytic theory. More recently Batista et al. (2019) observed that interpersonal schemas were cognitive maps, and that these determined our expectations, interpretations and behaviours, enabling us to successfully navigate the social world. Batista et al. found evidence associating rigid interpersonal schemas with clinical depression, and that conversely flexibility and adaptability were associated not just with well-being but symptom improvement in psychotherapy for depression.

Figueiredo and Griffith warn that not all people with chronic pain and other medically unexplained somatic symptoms may be observed to be 'demoralised' i.e. lacking a cognitive

map. This warning echoes in a more specific sense, Brown's (2004) warning that not all medically unexplained symptoms will be observed to be psychological in nature. Nonetheless in their invocation of cognitive maps and degrees of subjective competence as psychological mediators of our experience of pain and other somatic symptoms, the question of aetiology – e.g. whether a somatic symptom may be considered to be organic or psychosomatic in nature – becomes a secondary consideration. Indeed, Wiech et al. (2008) in demonstrating the neurocognitive factors underpinning pain perception identified three key mediators: attention (e.g. towards pain), expectation (e.g. of how much pain will be felt), and interpretation (e.g. of what the pain says about one's bodily integrity or their capacity to function). A cognitive map, as I understand it, would place conditions not just on where attention was channelled, but also on one's expectations and interpretations of their psychosomatic experience. Furthermore one's psychosomatic experience may be sublimated within wider cognitive maps that mediate our interactions within the relational worlds we inhabit. I recall Patel (2016) who provided her own autoethnographic account of how chronic pain became a central determining factor within her self-concept and her 'world'. Thus assisting clients to develop new cognitive maps may directly help in terms of their appraisal of their somatic experience, but perhaps more importantly can help to sublimate somatic experience within wider, renegotiated images of self and world in which attention is channelled elsewhere and somatic symptoms are less 'loaded' with significance for the person. This indeed fits with contemporary cognitive behavioural approaches.

Building on the earlier transformations of my model of change, I thus then began to think of I-positions as originating within wider cognitive maps which included representations of self and world. Fraser (2018) in offering his own transtheoretical account framed change in psychotherapy around what he described as a 'systems view'. Fraser drew a distinction between 'first-order' and 'second-order' change. First order change might appear at first glances to be significant change, for example a client taking a behavioural step that 'resolves' a problem such as a relational conflict. However in first order change the client has not stepped outside of their original frame of reference, they are as such in Fraser's words 'walking in circles' and he associated this with the emergence of vicious-cycle type dynamics as are often observed in cognitive behavioural formulations. Second-order change for Fraser means moving to a 'meta-level' outside of the problem, which I understand as the client discovering a completely different frame of reference in which to make sense of their experience. Fraser's account of change reminds me of the famous, though possibly apocryphal, quote attributed to Einstein that: *We cannot solve our problems with the same thinking we used when we created them.*

Interestingly Van Hennik and Hillewaere (2017), published about the same time, advocated a ‘third-order’ change which occurs when we learn how to learn. They appear to be describing in new language the older concepts of reflective function and metacognition.

The development of this template – that my clients were a) generating cognitive maps and b) learning that they could derive a degree of subjective competence by discovering a better map to navigate through a situation – thus became a theoretical platform on which I would encourage my clients to realise second-order, and perhaps third-order change.

6.3 Michael

In Michael’s eighth session he introduced a new theme which became a template which he came to refer to as his “Inner Being” around which he modelled a new set of behaviours in situations over which he would have traditionally heaped pressure upon himself. This template he went on to apply in future equivalent scenarios as described in the final sessions. Michael had already introduced a dialectic in the third session which he described as “two shoulders”, with one side being his “inner demon” and the other an exploration of what I described as the “other voice”. In that session Michael had identified the cognitions associated by the inner demon. They included:

- The belief that he was going to fail e.g. by spilling a drink and thus making a scene of his disability in public
- That he would let his wife down in the process, and
- That he would beat himself up about his failure afterwards

Michael had suggested that that “other voice” was encouraging, and assented to my summarising that it was “someone that believes in you”. The passage from the eight session in which Michael elaborates on his “inner being” is found from page 176. The fact that he’d given this alternative style a name was a helpful device in that it meant he could refer himself back to it more easily. I encouraged my clients to do this based on a technique from narrative therapy where it was helpful to give alternative self-narratives a name so that they might be more easily

recalled (Monk et al., 1997). The inner being evidently contains several new cognitions including:

- A recognition that Michael was generating his own pressure i.e. that the source of the pressure was not external
- The internal self-talk of the Inner Being is “the way you might address a child” (this appeared to reference back to the original observation in the third session that the other voice was something that believed in you)
- When noticing pressure building, being mindful enough to “take a step back and slow down”, which Michael went on to contrast with the way he would get anxious and tense if the “inner demon” had the influence.
- The inner being is a sign of maturity – when Michael observes that he’s not getting any younger – he is observing that this is something that he expects to develop with age.

More direct contrasts with the original cognitions of the “inner demon” can be tentatively suggested. Accessing his inner being as an alternative map Michael is observed to transition from a belief that he was going to fail to an alternative attitude in which he’ll be able to successfully navigate through a situation by regulating the pace and the rhythm. Likewise the paternal self-talk associated with the inner being does seem to directly contrast with his tendency to beat himself up about a failure when his inner demon is in the ascendancy. During this passage from the eighth session what made the biggest impression on me was the different embodied experiences that Michael was communicating through his descriptions of whether the inner demon or the inner being was in the ascendancy. The former was associated with heat, a fast pace, muscle tension, and a rhythm that was overwhelming with thoughts and behaviours overlapping. The inner being on the other hand was cooler, the pace slower, muscles more relaxed, and a rhythm that allowed Michael’s thoughts and behaviours to flow more smoothly. Indeed Michael often made references to his movements being “smoother” in the final three sessions.

Returning to Bowlby’s (1971) conception that our cognitive maps are both organismic (i.e. maps of self) and environmental (i.e. maps of world), Michael did present descriptions of the society we lived in as an aggressive, competitive world. Onto the genuine aggressiveness and competitiveness that there is in society, it was as though Michael was projecting the same

punitive, pressuring characteristic he had described in his inner demon: one slip up and the world would pounce with criticism and/or mockery. However written into the Inner Being map is an understanding on Michael's part that that pressure was internally generated. Removing that projection from the world meant it was experienced as a less aggressive place to inhabit as indicated by his positive experiences of exposure, deliberately allowing his disability to be seen and observing the reactions of others, both during and after our time together, as Michael confirmed in his three-month follow up.

Michael began therapy with a cognitive map in which he had to 'keep his head down' because the world was an aggressive place that would react to his disability with hostility. Within this map Michael's arm was an 'it' – something with a life of its own that he needed to fight against in order to conceal. As I observed in the Introductory chapter, all maps have a function and it may be said that this map served the purpose of maintaining Michael's invisibility – so that he might 'pass' as 'normal' and thus be able to have a normal life – find work, get married⁹, have friends etc. It appears to have served this purpose relatively well for Michael in early adulthood but was now failing him. Michael never arrived at a position of understanding why it was that this coping strategy was no longer working, however it wasn't necessary for him to make progress. During our sessions together Michael presented with a series of 'innovative moments' – which I have described in the mini-study in chapter four – which may be reconceptualised here. Michael demonstrated his own motivation for change, that he couldn't go on like this, and that he needed to act, notwithstanding the ambivalence also reported in the mini-study. I believe my pro-active and pro-change attitude in our sessions together helped to instil in Michael a belief that we could achieve something together. Thus when Michael introduced the 'two shoulders' device, it evidenced on the one hand an emerging, idiosyncratic image of 'psychological flexibility' (Kashdan, 2010) but also that Michael appeared to be reflecting back to me the model of change that I took into our sessions at that time – of migration between alternative I-positions. These innovative moments I came to think of as 'bridges' from one map of self and world, into a new one. To convey this visually I imagine the way two floors of a high-rise building are linked by a stairwell. Verticality here - the quality that determines which map is 'higher' in that image - is determined by how functional that map is in enabling the person to realise their higher goals or directions in life. There is perhaps some theoretical congruence here with Stiles' concept of the *meaning bridge* (e.g. Mosher and Stiles, 2009; Stiles, 2011) however my understanding of this concept is that the meaning bridge is the discovered point of

⁹ Although Michael's wife had always accepted his cerebral palsy and understood the special needs that he had always had.

'agreement' between two different voices (or versions of self) within a horizontal, intra-subjective system. Stiles' bridges, like the ones I envisage here, drive therapeutic change because they enable clients to break out of problematic patterns of relation and make contact with alternative positions and associated experiences.

When and where Michael was able to pick up that alternative map, i.e. to 'arrive' at that higher platform, his experience of self and world appeared to take a different hue. Away from the harsh, pressured environment he had experienced, he was able to experience a kinder, gentler version of the world. He himself physically inhabited that space differently – standing taller, his head held higher. Michael reported being able to assert his own views better when they contrasted with those around him. He also appeared to associate this new map with getting older and wiser, recognising this to be a different coping strategy from the one he had derived historically. This is perhaps also reflected in his newly developed habit of reflecting back at the end of each day on what might have been the critical moments of the day and realising that those moments had passed without incident. Within this 'space' Michael was more hopeful about his marriage and the future – as well as standing taller Michael seemed to have discovered he was able to look forward.

6.4 Jennifer

In our second session Jennifer introduced a metaphor that grabbed my attention as she used it to explain her own experience in the social worlds she inhabited. A hand in a bucket of water which, stirring the water, cannot be missed, both in its presence and its influence within the bucket. However when the hand is withdrawn from the bucket, the water immediately settles and it is though the hand were never there at all. The idiom is not unique to Jennifer, it is located for example in the poem *There is no indispensable man* by Saxon N. White Kessinger (1959), which I discovered after Jennifer and I had completed our work together, including the verse:

Take a bucket and fill it with water,

Put your hand in it up to the wrist,

Pull it out and the hole that's remaining

Is a measure of how you will be missed.

Whilst Kessinger's intention in the poem is to remind us of the importance of humility when we feel driven by our egos, for Jennifer the possibility of being dispensable was troubling. She explained that what it meant for her was that she felt she always had to say yes; always had to be at the centre of activities – e.g. at her local church group - for the moment she withdrew it was like she was never there.

In the third session she provides a description of the somatic impact of putting herself forward; not giving herself the permission to withdraw:

It's been a bit ((exhales with a slight chuckle)) Because on Sunday when I got home I was sick... physically sick. Because it was just all too much. It was far, far too much. And what I... you learn by your mistakes, is that I shouldn't have done that really. All those people, every one individually coming to me, because I was serving teas that meant I had to speak to every one as they went past. And it was just... Ahh when I got home I was all gurgly, and then I was sick [...] I've got to learn... when to say "well actually no I've had enough now". And I think that's kind of a cross between the chronic fatigue and the anxiety.

Physical sickness is one of the primary associated symptoms in Jennifer's experience of chronic fatigue. In this passage she's making the association between her anxiety and chronic fatigue in that pushing against her anxiety, what I understand as overriding it to meet her commitments, led to the flare up of her chronic fatigue symptoms. The hand in the bucket of water is used as metaphorical device by Jennifer to describe and communicate to me the cognitive map underpinning her thoughts and behaviours in her social experience. As with Michael's presentation, I infer the following cognitions associated with this map:

- The measure of my self-worth depends on being noticed and appreciated by others
- I am only noticed and appreciated to the extent that I am active.
- The moment I withdraw or cease activity it is as though I am invisible.

Moreover, where she introduced the motif of 'Generous Jenn' (see chapter five) it was as though a primary condition of Jennifer's worth was that of being the remarkably reliable (or

generous) one. However Jennifer also appeared to be anxious about letting people down, as though once committed to a social activity she would have to remain fully committed as others depended on her, regardless of her personal limitations, including her chronic fatigue.

In the third session, I invited her to return to the metaphor, and particularly that idea that if she withdrew it was as though she was never there. In her own reflections she began to conceive of an alternative perspective through the metaphor:

Je: Well I think that ((choosing words carefully)) what... I... I would always know that I was the hand... nobody else knew that – but I would know it. And that has to be more... in my psyche really. I've got to be quite accepting that when I'm in there my hand's making the... I'm doing it all, and I take it out and say ((slaps thigh)) "Well done hand", done all that. The people down there, they might not remember that I did that, but I've got the hand that did it. So... I think taking... Erm I don't want to say praise, it's not the right word. I don't know if you understand. I would have my own satisfaction, I would have my own satisfaction that as things are happening I'm able to say: "I can't", I'm taking my hand out earlier but I'm not feeling guilty about it. And that's a great big step from thinking that my hand needs to be there all the time and keeping things moving.

Jo: And you can still say "well done hand"

Je: Yes! However soon you take it out it's done something. So it's a very visible – I can picture that in my mind.

In her written responses to her case report, Jennifer observed how much she'd appreciated the extended work we did on this metaphor as she was a visual learner, as is reflected in this passage. In this third session an alternative set of cognitions is already emerging. These can be inferred as:

- It (perhaps) does not matter whether or not I am noticed or appreciated by others for the work I do.
- I know my contribution and I can take pride in this.

Jennifer's continued application of this new cognitive map thus became one of the core themes of our work in the remaining sessions. She would observe that what she was doing was "turning negatives into positives", which again suggested to me an idiosyncratic example of developing

psychological flexibility. As a behavioural consequence Jennifer would be able to withdraw from the situation once she'd had enough and be satisfied in herself with the contribution she had made. By the fifth and penultimate session she was continuing to apply this new cognitive map to her social experience and importantly was experiencing alleviation from her symptoms:

Je: You've seen that it's not just working, working, working that I can take it out and not feel a failure because that's not there. Cos I think that's... you get very anxious, or I got very anxious about... because I wasn't in the water. I must be doing it wrong if I'm not in the water. You know, I should be there and I should be in it.

Jo: You should be in it ((Overlapping speech))

Je: Yes irrespective of how I feel about it.

Jo: And anything else is a feeling of failure almost, letting people down

Je: Yes yes absolutely once I took the hand out that was failure and letting people down because I wasn't doing. But... I just seem so much better by having had that.

If my suggestion about the function of Jennifer's map is correct then it appears that from this new position she occupied, her conditions of worth had also shifted. Not needing her good works to be witnessed in order that she herself would be validated or approved, the hand in the bucket of water device appeared to enable (or permit) her to appraise her own good works, such that she relied less on the approval of others. As a consequence of Jennifer being able to assert her own boundaries in those commitments - for example in terms of withdrawing when she felt her energy levels were being tested - she appears not to fall into the 'trap' of others becoming dependent on her, such that then she might be afraid of letting people down.

6.5 Myrtle

As observed previously, one trap that I felt Myrtle and I fell into, was that during our brief time together – just five sessions – we seemed to switch back and forth between either 'working on'

Myrtle's feelings of guilt, particularly in her relationship with her Mum, and her experiences of living with and learning to manage her fibromyalgia. Myrtle made great progress in renegotiating her relationship with her Mum during our time together and there is the indication that reduced anxiety in those situations helped to alleviate her ectopic heartbeats. Although Myrtle didn't experience any such significant transformation in her experience of living with fibromyalgia, nonetheless through our work she was able to clarify her own set of strategies and attitudes to manage her fibromyalgia symptoms.

The notion that Myrtle would have to withdraw from activity was unpalatable because it just wasn't her – it was contrary to her identity. I could see that she wanted to push on through her pain; she didn't want to adapt. In that spirit then I suggested a 'bank account' metaphor which is often deployed by clinicians who are trying to train their patients to manage their pain and fatigue. So the bank account metaphor goes, I suggested to Myrtle that she could imagine she has a bank account of energy levels that is topped up by a certain quantity every day e.g. this could be thought of as a certain number of hours of activity. If Myrtle was to go into the red she would experience a flare-up of her symptoms; but if she was able to consciously gauge the hours of activity she could 'spend' without going into the red then she could keep active and manage her symptoms. Myrtle saw the logic of this approach but instead argued that in maintaining a quality of life sometimes it would be necessary to go into the red. She highlighted her dance classes particularly as an example:

M: Even if I've got pain I'll still go to my dance class, because... I'll take a couple of pain killers to try deaden it off a bit. I find, although it's hurting it's not worrying you as much that it's hurting because you're doing something else, and your mind is on something else, so...

J: And you're enjoying it?

M: Dance class? I love it! I'm absolutely rubbish but I do it! ((laughs))

Myrtle is describing in an applied form what Crombez et al. (2012) described in the abstract – that chronic pain sufferers who commit to their goals experienced a reduced sensitivity to pain, ultimately because of the redirection of their attention. What the bank account approach would have meant for Myrtle in practice was sometimes cancelling a dance class *before* she began to feel really bad, which might have had the unintended effect of redirecting Myrtle's

attention back to her pain. Although Myrtle would then suffer more pain the day following a dance class she conceptualised this as a “price worth paying” – to return to the bank account analogy, going into the red was a debt worth having. During our time together Myrtle came to another significant understanding about the nature of her somatic experience: that perceived weakness in her muscles did not correspond to actual weakness and this could be tested out as this passage from the fourth session explains:

It's not that your muscles are weak it's that your muscles feel weak. So... say for instance I want to walk to my greenhouse. And my muscles feel "I can't lift this watering can" but in actual fact if you get hold of it you can lift it. It hurts and it feels awful but you can lift it. So it's not that the muscles are weak it's that the muscles feel weak

Myrtle seems to be pushing against a conventional wisdom that stresses we need to listen to our bodies. Instead what she learned about herself that she was inaccurately perceiving physical weakness – as though the signals to her brain had somehow become confused - and in that knowledge she could take behavioural steps to compensate for this. In that same session Myrtle spoke of a friend with multiple sclerosis who had the attitude that: "*there are things I can't do... but you know what, there are things I can do*" which clearly articulated Myrtle's own attitude towards living with a chronic condition.

As such it is useful to note that the map that Myrtle found that 'worked' for her, was very different to the map that Jennifer found that 'worked' for her. Existing clinical approaches for working with patients living with fibromyalgia or chronic fatigue may emphasise the person's skilfulness in knowing when to withdraw and recover – as Jennifer learned – or a person's capacity to divert their attention towards activities that gave their life meaning – as with Myrtle. What both strategies have in common is that they afford the person a degree of *subjective competence* even as they live with chronic conditions.

With respect to Myrtle's relationship with her mother, Myrtle described herself through her mother's eyes as: "bring me, fetch me, carry me". Implicit in that idea was that Myrtle was a supporting character in her mother's own drama. As observed previously, Myrtle's cognitive breakthrough appears to have been able to declare that "none of this is my fault" and therefore "I'm not playing the game". Becoming aware of the game, and the huge burden it had placed on Myrtle throughout her life, appears to have been the idea that landed during our time together,

and thus the new map that Myrtle discovered may have simply have been a new layer of awareness about what it means to be drawn into the game, and so in avoiding that tendency, to keep hold of her sense of self outside of her relationship with her Mum, which she would say was positively represented through her black sense of humour.

6.6 Lou

Throughout the course of her therapy, Lou was able to demonstrate increasing competence in recognising relational situations in which she was becoming entangled, and in protecting and asserting herself within her marriage and in a dramatic triangle that typically involved her mother, her sister and herself. As previously observed, in the year before Lou began therapy Lou could only assert herself very indirectly by rebelling against the diet that she experienced as being imposed on her husband and a mutual friend. As the diet fell apart and Lou started to gain weight again, she couldn't understand why she wasn't more troubled by this. Then just before we met, Lou had taken a direct stand against her husband associated with intense panic and vomiting. When Lou and I met for the second session, a similar blow-up with her mother saw her driving off in the car with the door open and frantically texting afterwards to repair the rupture. During our sessions Lou was increasingly able to assert herself – first with anxiety and ambivalent feelings but as time went on with increasing calm.

Between sessions twenty to twenty-five Lou's understanding of the dramatic triangle involving herself, her Mum and her sister, became more conscious and explicit. By the twenty-fourth session Lou was not only starting to report behavioural examples of extricating herself from that dynamic but also demonstrated her growing understanding and modelling of an alternative style of relating:

L: Today I've literally just knitted all day and I've just ignored the chat [social media group message with Mum and sister] and just been like: I don't want to read it. Whereas normally I'm like: you know read it straight away and then I'll reply. But they're saying to me 'Where are you, where are you'. But I've been trying to just pull myself out of it, like we've said before.

J: Yes, yes, so that's a step forward.

L: And my phone's been pinging all day. And I literally glanced it before I came out and I just came out

J: You've started to put this into practice, you're not getting embroiled as much [...]

L: And I thought: I'm not just going to drop everything to take you out with [niece] like I'm not doing it. So I didn't reply to her and then about one o'clock I just rang her and said are you alright? I've seen your messages this morning but I can't go out today, I've got stuff to do and this and that, I didn't say: we're not going out, I just said I can't go today but we'll go tomorrow because I didn't want to go out today.

J: Be on your terms?

L: Yeah, at one point I'd have gone: yeah I'll be right there, whether I wanted to or not. But this morning I just thought no I'm not doing it.

J: Mmm. Ok. So there is something happening here?

L: Yeah but definitely today, well I've been ignoring my phone now for a few days because I've just been like 'no I want to do some knitting'. And I know it's really stupid but I feel like I can just switch off. It's like when I'm swimming (J: Yeah ((whispered))) and then like you know when I'm swimming and I don't think about anything? It's the same when I'm knitting ((laughs))

The reference to swimming was important because we had observed how in previous sessions it's the one situation in which Lou feels completely at peace – I'd encouraged Lou to describe how her experience was different when she was swimming and she identified qualities such as having a clear mind, and being unpressured and at ease with herself. Whilst these sessions preceded my explicit interest in cognitive maps, the swimming that we modelled together became a template for what it could look and feel like for Lou to disentangle and create space for herself. This passage is interesting for a few reasons. Not only has Lou demonstrated a capacity to disentangle by not replying instantly to the chat but also being able to communicate on the phone to her mother that she had things to do so wouldn't be able to go out today. I note also Lou's increasing skilfulness about asserting her own needs, her positioning is less black and white – she didn't say they wouldn't go out, but rather that they'd do it tomorrow. Where I observe "So there is something happening here" I'm suggesting the idea that there is a process;

that these individual steps take on meaning as part of a pattern. Likewise when I affirm Lou's link with it being like when she's swimming I whisper to communicate something exciting, even sacred, about what she's learning about herself in those moments when she is able to disentangle. This new map that Lou is modelling has several new cognitions embedded within it as indicated in the passage. Lou's relation to the phone shifts – she realises she has an option as to whether or not she replies to the messages. She also realises a state of calm having made the decision not to reply – this contrasts to one of the core ideas bound up in the Peacemaker I-position described in chapter four that to assert herself is dangerous.

I encouraged further exploration on this theme and Lou made an important association between her entanglement within that triangle and her somatic experience:

J: So in terms of how you relate in that trio of you, [sister] and [Mum]. Being able to filter them out and come back to them is a very different way of relating. Cracking on with what you're doing, and coming back to them when that feels right for you.

L: Yeah because [Mum's] been like '[Lou] what's wrong with you – you've been very quiet today'. She's been like that for a few days, because I've not really been looking on the phone, so she's been worried about it, but it's literally nothing to worry about – I'm just switching off from it but because it's not normal. ((J: Your Mum doesn't expect you to be...)) My Mum's like what? Where is she?

J: This is... And again I think about that time you went for the DWP assessment and your Mum is weeping because you are not that person that you used to be. You're not being that person who will drop everything and just say yes to everything.

L: Yeah and I feel sad because I'm not that person, but then also I feel like: did I become in this situation that I'm in now, where I've gone through a really rough time, possibly because of a bit of that? Like too much pressure, too much people relying on me all the time. So although I am sad that she doesn't feel I'm the same, I just think like for all these years I have done everything whenever anybody wants, maybe that's part of why I got like I got – you know just absolutely exhausted!

J: Exhausted – you've never used that word before

L: No but that's what I felt like. And when I got signed off sick for the first two weeks, I just slept for two weeks, two weeks solid.

My own highlighting of Lou's use of the word exhaustion was important because as we increasingly came to understand – this was the experience of fatigue that would come across Lou unpredictably and mean that good days were often frustratingly followed by bad days. Here is the beginning of the conscious association Lou made between her experience of being relied upon by everyone and her feelings of fatigue. What is also notable is the phase Lou used to explain her changed behaviour on the group chat: “I'm switching off from it because it's not normal”, by stressing that the dynamic with Mum and her sister is not normal, I understand that word to mean that Lou understands the dynamic to have been dysfunctional, unhealthy, and perhaps also inward looking in that Lou is implicitly evoking others and how she imagines they relate. By challenging what had been before an unquestioned style of relating involving her Mum and her sister, Lou is realising a psychological flexibility she didn't have before – other maps are available.

As we have previously observed, Lou's baseline position, as she began therapy, was: 'I'm the one in the middle with warring people all around'. Replaying the childhood environment, she was the person who had to hold everyone else together, intervening to keep the peace, bending over to accommodate others' demands, and not having a life of her own beyond that family system. Thus Lou was dogged by feelings of intense guilt whenever she did do things for herself above and beyond family life, for example taking a course or setting up her own business. However what emerged during our therapy were bridges into new patterns of relating, indeed into new internal maps of self and world. The themes of control and later of “protecting myself” were being incubated within our sessions, which I understood as ‘priming’ Lou to take an alternative position in those critical relational situations which were taking such an affective toll upon her. And in Lou's account of her experience of what swimming means to her, and later in this idea of what's ‘normal’ in a relationship between a mother and two daughters, she has seen that there are alternatives to continued entanglement. Thus Lou finds the confidence to withdraw from the social media chat and to set boundaries where ordinarily her sister would expect her to be caring for her daughter (Lou's niece). Core cognitions associated with Lou's emerging map, of “Fire in my belly”, included “I don't have to do this”, and “whose benefit am I doing this for?”. As I suggested earlier we might uncover the function underpinning different cognitive maps through reference to the client's higher goals or life directions. The ultimate function of Lou's Peacemaker map appears to be more than simply keeping the peace, but rather of preserving life. Within that system, Lou's withdrawal was dangerous, and perhaps even deadly – what would happen if she were not there to protect the other family members from one another? The function of having “fire in my belly” thus appears very different. The

phrase that Lou landed upon to describe this was that she was learning to protect herself. I might also suggest that this map enabled her to self-actualise in a way that she hadn't been able to before. When I spoke to her in the three-month follow-up she had established her dressmaking business and it was growing rapidly, which I understood as symbolic of her blossoming identity. However another possibility, which Lou and I discussed on a number of occasions, was that the "fire in my belly" position was itself transitional; a means of breaking out of a family system in which she had felt trapped and completely undermined, and thus a step on the way to somewhere else. It would be interesting to learn of the words, images, and motifs Lou would use now to describe herself, her world, and especially her relationships with those key significant others.

6.7 Mini-study: A qualitative (hermeneutic) analysis of accounts of change and causality

This third and final mini-study originated from the process of producing the case reports. After each client had finished their therapy I got to work in producing their reports, highlighted data from the cases that appeared significant as interpreted through the theoretical frameworks underpinning innovative moments coding, longitudinal analysis of therapeutic events, and the qualitative (hermeneutic) analyses of accounts described here. The qualitative (hermeneutic) analysis of statements made about change and causality provided a framework for temporarily stepping outside of my theories as they stood and considering whether alternative accounts of change might be made, or whether indeed what I have evidenced as change in the cases reported may be considered as substantive in the first place.

Underlying my core research questions about what change looks like and how change is facilitated are inevitably questions about causality. Even where we observe change, how may we account for the chains of events or conditions that precede or permit change? The question of how we account for cause and effect has had considerable attention in psychotherapy research, centred around questions such as how we might identify the mechanisms of change (Kazdin, 2007), and the common and specific factors associated with change (Wampold, 2015).

In this mini-study however I draw attention to two of the leading theoretical frameworks for understanding and appraising accounts of causality in psychotherapy case study research.

Elliott's *Hermeneutic Single Case Efficacy Design* (2002) is a protocol for building into the design of the case study mechanisms for accounting for and scrutinising claims of effectiveness (efficacy) made about the therapy. Bohart et al.'s (2011) *Research Jury Method* establishes a further protocol, based on a courtroom-style prosecution and defence structure, for appraising the validity of causality statements made in relation to psychotherapy process and outcome. What these protocols have in common is that they advance general theory about the nature of causality in psychotherapy before developing and exemplifying a series of practical, guiding principles for a qualitative analysis of the data and commentary in the case study. The end result of both of these protocols is that the case study is supplemented by a realistic and informed evaluation of the trustworthiness of claims that a therapy was effective, including an indication as to what extent observed changes may have been attributable to the therapeutic work.

In the mini-study that follows, I apply the principles of qualitative analysis as established in the Elliott and Bohart et al. protocols to my appraisals of two cases – my therapeutic work with *Jennifer* and *Myrtle*. These analyses are supplemented by commentary from the clients themselves during the member checking process. Following these appraisals I provide commentary from my research supervisors Jane and John as they engaged with the process before arriving at some observations about the use of these protocols, and of the nature of placebo effects and 'relational artefacts'.

6.7.1 Procedure

The beginnings of the qualitative (hermeneutic) analyses per se were in the production of the case reports as received by the clients. Following the final session with each of the participant clients I spent a week to two weeks gathering together all the different pieces of evidence for that case in a meaningful structure based on my working hypotheses about change with specific reference to that case. In those case reports I provided theoretical snapshots of what I believed to be the patterns of change that appear to have been observable in my work with that client, as understood and recognised to some degree by both myself and the client. These theoretical

snapshots were supplemented with passages of dialogue between myself and my client following the 'key extracts' principle offered by Sullivan (2012) in his dialogical approach. Whilst the structure of each case report was slightly different to reflect the different work with each client, I did include commentary in each report about my own sense of how well or otherwise claims of effectiveness – that therapy might be considered to account for observed changes – were evidenced, and each report included a section called 'Research Effects' in which I explicitly considered the effects participation in the research might have on the client, any evidence for these, and an explicit invitation for clients to comment on their own views as to how research participation might have affected their experience.

During the period in which the clients themselves received their case reports, these reports were also distributed to my three research supervisors for their appraisal. Inspired by the jury-based dynamic modelled in Elliott's (2002) and Bohart et al.'s (2011) protocols, we established that Jane and John would take the roles of prosecution and defence respectively in their appraisals of the case reports. By prosecution I mean the arguments and reasonings that suggest that claims of effectiveness may not be plausible or grounded in the evidence, that change claims per se may be superficial, or that change as evidenced may be attributable to extra-therapeutic factors. By defence I mean the arguments and reasonings that support claims of effectiveness: that claims of change per se are well evidenced and that those observed changes may be attributable to therapeutic factors and processes. The agreement between us was that across the appraisal of each of the case reports, Jane and John would alternate in their roles as prosecution and defence. However, this approach ran into conceptual difficulties which I will return to later, from section 6.7.7 onwards, with myself and supervisors becoming acutely aware of the limitations we faced in appraising cases in this systematic way.

Jane and John received the case reports by email and provided initial responses via email, the points of which were taken up and developed further when we next met for a supervision meeting. From the two protocols I identified some guiding principles in the forms of questions that I requested Jane and John ask of the case data and associated commentary, though of course their appraisals were not to be limited by these questions. Whilst not an exhaustive list, these guiding questions included:

- Did changes correspond to specific events, aspects, or processes within therapy?
- Were the apparent changes only trivial?

- Were ‘relational artefacts’ responsible e.g. that apparent changes were only superficial attempts to please the therapist/researcher?
- Can we see evidence of expectancy bias e.g. ‘Scripted descriptions [...] standard or clichéd phrases, such as ‘someone to talk to’ or ‘insight into my problems.’?’ (Elliott 2002, p. 12)
- Could apparent changes be attributed to extratherapy life events?

(Elliott, 2002)

- Could clients have said they changed out of enthusiasm for the process?
- Did clients themselves observe that therapy had helped?
- Were clients relatively specific about how therapy had helped?
- Were outcomes relatively specific and idiosyncratic to that client?
- Were the changes observed plausible given the degree of difficulty of the problem?
- Did the client provide plausible reports that others had noticed they had changed?

(Bohart et al., 2011)

Following these supervision meetings I wrote up my reflections as the practitioner receiving feedback on my work e.g. any thoughts on what I was surprised by, what might have been in my blind spot, and therefore what I might have learned, and sent these back out to Jane, John and Dawn as representing a completion of that cycle of qualitative (hermeneutic) analysis. These insights fed into a much wider analysis of the four cases that was ongoing and continually evolving – presented in a distilled form through the longitudinal structure of this thesis.

As has been explained in sections 1.7 and 2.2.2, the most significant deviation of the approach described in this mini-study from the pure protocols described by Elliot (2002) and Bohart et al. (2011), is my decision not to use independent researchers to occupy the roles of prosecution and defence. Ordinarily the prosecution and defence would be made of teams rather than being represented by individuals, and these researchers would have a greater degree of independence from my research project. It may be argued for example that my research supervisors would be too much ‘involved’ and ‘invested’ in my research project in order to appraise it fairly. I consider

to be another iteration of the argument about the meanings of independence in qualitative research and have explained my epistemological position in 1.7 and 2.2.2.

The arguments that might be made against the approach described here are:

- 1) That the case studies will not receive the same scrutiny given the involvement of the researchers
- 2) That the analyses provided here may be considered relatively superficial, less expansive, and less rich, in comparison with true *HSCED* or *Research Jury* studies.

Indeed both of these arguments may be shown to have merit in appraisal of the mini-study presented here. Whilst researcher independence had not been achieved in this approach, the case I have made earlier in this thesis is that the scrutinising of the findings of the mini-study is an ongoing process achieved through dialogue: most notably the dialogue between myself as therapist and my client during the case reporting stage, but also the dialogue between myself and my research supervisors, and beyond these to the dissemination of my thesis – and in particular – my accounts of change. The argument I have made in this thesis is that my own involvement as the therapist in the appraisal of the cases is of central importance as myself and my client are the ones that understand the meanings and significance of data the best.

Therefore I reject the suggestion that an analysis of a case study in which the voice of the therapist was excluded, or was treated as supplementary, would provide the soundest appraisal of the case study. However it is clearly a limitation of the present study that more voices were not directly invited to comment upon the case reports discussed here. The addition of voices, both those of other practitioners but also those of people with experience as clients, would have enhanced the quality and richness of the analyses offered here and would have been in keeping with the dialogical approach I have championed.

Whilst the approach here described is therefore limited, it is appropriate to observe that appraising effectiveness and claims of causality per se is not the purpose of the present research study, which from its inception was about modelling change. The present mini-study then should be properly considered as supplementary to that greater objective. As I explained in section 2.2.2 I believe what I have done in these mini-studies is to exemplify how established research methods may be adopted and adapted by practitioners researching their own case work in the everyday process of theory-building.

In that spirit, and in the sections that follow, I demonstrate some of my findings through the appraisals of the case reports as guided by the Elliott (2002) and Bohart et al. (2011) protocols,

with particular reference to the cases of *Jennifer* and *Myrtle*, in determining to what extent claims of change might be considered trustworthy, and I provide more substantial accounts of my learning from this process in sections 6.7.9 and 6.8.

6.7.2 Measuring change

6.7.2.1 Jennifer

Elliott (2002) advised that designers of case study research should always include some quantitative measures of change to triangulate qualitative evidence with and thus support the account of therapeutic change being advanced. As observed in chapter three, the routine psychometrics recorded by the charity were the Patient Health Questionnaire-9 (PHQ9) (Kroenke and Spitzer, 2002) and Generalised Anxiety Disorder-7 (GAD7) (Spitzer et al., 2006) measures. As Jennifer only had six sessions, and Myrtle five, only beginning and end measures were recorded.

Jennifer's pre-therapy scores were 18 (Moderately severe) on the PHQ9 and 10 (Moderate) on the GAD7. Her scores upon completing therapy were 3 (Non-minimal) and 0 (Normal) respectively, indicating clinically significant change, both in measures of depression and anxiety (McMillan et al., 2010; Robinson et al., 2010). The qualitative evidence which we will go on to consider appears to support and elucidate this general indication of therapeutic change, however with some important caveats which application of this method has helped to highlight.

Jennifer did not report any change in either the frequency of her chronic fatigue flare-ups and related symptoms, nor their intensity. However Jennifer did report change in her somatic experience, as we will go on to consider: resolving that it was ok to withdraw and to rest when physical symptoms flared-up, rather than to follow the inclination to push on through which she came to believe would be dangerous for her in the long run. Notably, in Jennifer's assessment she answered an item on the PHQ9 about 'Feeling bad about yourself, or that you've let yourself or your family down' with 'nearly every day', but at the end of her therapy answered this same item 'not at all'. In this way I experienced items of the PHQ9 and GAD7 measures to take on meanings within the contexts of implicit frames of reference which the clients brought to therapy and evolved during therapy. For Jennifer the meaning of this item was embedded

within a wider belief that she had to be ever reliable, ever dependable for the people around her and as such that her physical and psychological vulnerabilities meant she let other people down.

6.7.2.2 Myrtle

Myrtle's pre-therapy scores were 13 (Moderate) on the PHQ9 and 10 (Moderate) on the GAD7. Her scores upon completing therapy were 4 (None-minimal) and 1.5 (Normal) respectively indicating clinically significant change, both in measures of depression and anxiety (McMillan et al., 2010; Robinson et al., 2010). Likewise qualitative evidence which we will go on to consider appears to support and elucidate this general indication of therapeutic change, nonetheless with important caveats. Interestingly, Myrtle reported the exact same shift on the PHQ9 item 'Feeling bad about yourself, or that you've let yourself or your family down' as had Jennifer. However as we will observe through the qualitative evidence, unlike for Jennifer the meaning embedded in that statement was related by Myrtle to guilt in relation to her mother.

Myrtle's embodied distress was represented in global pain and fatigue associated with her fibromyalgia, insomnia, migraines and ectopic heartbeats. Only the latter of these symptoms had been associated by Myrtle, following consultation with her GP, with anxiety. Myrtle experienced no change in either the frequency or intensity of her fibromyalgia symptoms but our brief work together affirmed and consolidated her own coping strategy and illness identity. However whilst at the beginning of her therapy an attack of ectopic heartbeats could last up to two hours, at fifth session she reported "hardly having them at all", estimating having about one flutter a week. Likewise Myrtle reported having not had a migraine since just before her assessment at our service and that this was highly unusual as she'd never in her life gone more than three weeks without having one before.

Given, therefore, these general indications that both Jennifer and Myrtle experienced clinically significant change during their therapies, in the following sections I consider particular lines of scrutiny, as advanced by the Elliott and Bohart et al. protocols, to consider whether those changes did appear substantial and to what extent they might be attributed to the therapy.

6.7.3 Expectancy effects

One of the qualities that is notable in both the work with Jennifer and Myrtle is that their therapeutic gains appear very early on, with both clients reporting significant gains made from as early as the second session in Myrtle's case and the third in Jennifer's. As such, it is pertinent to ask to what extent the clients may have been reporting on change to please me as their therapist and/or to be a 'good' client or research subject.

6.7.3.1 Jennifer

During my work with Jennifer and particularly as she began to report very dramatic gains in such a short time, I experienced a niggling sense of my own power of suggestion - that at times it felt as though I were implanting these ideas for Jennifer and she was taking them on so enthusiastically. The following passage from Jennifer's third session demonstrates that she too was surprised by the pace of change:

Je: I'm amazed how far I've gone on this journey in so few weeks. That... I'm getting there.

Jo: Yes. Yes. So there's a tentative... hopefulness.

Je: Hmm yes. But you know, I still stumble. Like I was sick. It was just "this is ridiculous, being sick just because you've had to speak to those people" ((in self-chastising voice)). So there are stumbling blocks. But the most important thing is that you're aware that you've got the tools to just get over them really. And they are working, it's... it's amazing John. I wouldn't have thought it would have happened ((laughing)).

On the one hand this passage indicates that Jennifer understood that such dramatic and rapid change is unusual, not what is 'expected' of her as a client. However on the other there is perhaps an indication here that Jennifer wanted to be a good research subject, and give me positive material to report on. One event in particular made me aware of the influences that Jennifer may have experienced on account of participating in the research project. In the fourth session when she was reflecting on the progress she was making, she commented on the credit that I should receive in the context of my studies:

You know, I've still got the same things which I do and don't do, but I want control over them. Which by having that control... your anxiety just goes ((said breathlessly))... so you can get a gold star ((both laugh))

I knew the gold star was a reference to an awareness that my study would be assessed and so I followed this up with an explicit reminder that she didn't need to provide a universally positive appraisal of our work together.

As such a question mark emerged over whether Jennifer was genuinely experiencing change or whether the change was either superficial or performative in nature. Whilst we celebrated the rapid gains she appeared to be making I was left with a deeper wondering: if Jennifer fully expects to make progress and she runs with that, would this prevent deeper, more unexpected therapeutic change from taking place? I questioned in my notes at the end of her third session whether these gains would be followed by a period of disillusionment in which the superficial 'halo' or 'honeymoon' effect had passed and the problems prove too great for those transient solutions. It was for this consideration that I built into the design not just the initial member checking process but also the three month follow-up. In Jennifer's case three months following the end of therapy was approximately twice as long as the therapy itself had been, and at this point she was still celebrating the gains of our time together. Likewise, in the fifth session Jennifer's reports of change are further bolstered by examples of others who have noticed a difference in her (Bohart et al., 2011), as the following passage explains:

Je: But people have noticed as well so that's... outwardly noticed

Jo: Ok? ((interested))

Je: Well today for instance, I set up all the café and everything but today I sat and had a coffee with the lady and she said "Ooh isn't it lovely when you're on this side of the counter". I said "yes, I'm not doing it today, I'll just have a chat with you". You know they were noticing that... because... while ever somebody always does something you just take it for granted don't you? And not in a nasty way it's just "well that's what they do". So when they do stop they sometimes make you... Not that the next person's doing it any better you know the hand in the water has not got any better. But they've actually realised that that's what you did.

Invoking the perception of others as an index of change does appear as a genuine rather than a generic or scripted example. Likewise in the sixth session Jennifer provided further evidence of the way others had noticed a change in her:

Je: Both of the girls have been home and they both noticed a difference... so that's really...

Jo: Ok, what did they have to say?

Je: Well they actually said: "you weren't so uptight Mum, and you weren't busy doing everything you actually gave us time... without thinking I've got to go and do something else".

These supportive pieces of evidence suggest that even if expectancy effects were an active ingredient in Jennifer's therapeutic gains, nonetheless those gains appear have been translated into her relationships with others and maintained beyond therapy.

6.7.3.2 Myrtle

I similarly maintained a scepticism about the extent to which therapy was genuinely benefiting Myrtle given her own rapid gains following the first session. However my understanding of what might have been going on was slightly different. I do not think Myrtle was performing as such for me and indeed she described our work with her fibromyalgia as like "flogging a dead horse". Instead I came to suspect that the significant reorientation that Myrtle had taken with respect to her mother had been a developing idea for Myrtle for some time, and that the first session brought much of Myrtle's already developing thoughts about her relationship with her mother into direct conscious consideration in a way they had not been before. Myrtle appeared to demonstrate a 'sudden gain' between the first and second sessions (Abel et al., 2016). Whilst the first session was not recorded, it was by some way the most emotional of our five sessions together. The core theme of that session was around the guilt that Myrtle experienced in her relationship with her Mum and how she had subsequently felt deep guilt in relation to other significant life events. For example, when her mother in law withdrew from all her medication and subsequently died, Myrtle blamed herself – perhaps her mother in law felt like a burden; perhaps Myrtle could have done more to reassure her? My role as an observer or witness in that situation was simply to give Myrtle the space to express these feelings of guilt and responsibility explicitly; feelings that she had been simply been taking for granted all these years, and thus to consider them in a different way. I therefore believed Myrtle's intense emotion in that first

session might have been described as a 'crystallisation of discontent' (Hayes et al., 2007). As such in the fourth session I alluded to this crystallisation theory with Myrtle:

J: You seem to have come to this clarity really quickly - you know it seems to have something that's been... 'in the air' before you started counselling and it just happens..

M: I think it has, and I think the other thing is that... a lot of the stuff, I can't... I don't want to talk to my family about because I don't want to upset them. But I've been able to get a lot of this stuff out by talking to you about it and by making you take it home with you ((laughs))

This passage may be seen as an endorsement of the crystallisation theory, though it may also represent a kind of scripted expectation of what counselling should be like – people go to counselling because they can talk about things to a person not connected to their lives that they can't talk about otherwise. When I checked out this latter possibility with Myrtle during the case report consultation she argued against it, writing:

'The thing is that for probably last 30 years I have coped, looked after everyone, always had a firm belief that problems could be solved, that I was strong, never down, carried on regardless etc. etc. To find myself suddenly in floods of tears, pouring out my angst to someone I had actually just met was a bit of an eye opener to me. It made me think that actually – this isn't how I am – I need to take stock and get a more sensible hold of myself.'

Hayes et al. (2007) argue that the crystallisation of discontent can be considered to be a catalyst for significant life change and indeed Myrtle's style of relating with her Mum, and her experiencing of it, does appear to have significantly shifted during and beyond our time together. I note also Myrtle's experience of being witnessed, both in the reference in the fourth session to me taking 'a lot of this stuff' home with me, and in the member checking phase about her pouring out her angst to someone she'd just met. My best understanding of this is that my witnessing of Myrtle's feelings of guilt, which had widespread impacts on her quality of life, did indeed bring about a kind of tipping point where she could no longer minimise or dismiss those feelings.

6.7.4 Correspondence of change to specific events or processes within therapy

Because of the behavioural nature of change as experienced by both Jennifer and Myrtle it is relatively easy to evidence correspondences of those changes to specific events or processes within therapy.

6.7.4.1 Jennifer

In the third session Jennifer arrived with positive news – she had successfully practised an exposure we had previously designed in a social setting. She had crafted it so that it was more authentic – and more subtle – in the social situation, such that the phrase deployed was "I'm ok but I'm getting some help". Admitting to "getting some help", meant for Jennifer breaking out from the façade that had been built up in her various social roles; she was able to start introducing limits on how much she put herself forward. It is notable that the most emotional content of Jennifer's therapy is expressed in the second session when she remains mainly mystified by what is happening for her and thus about how it may be possible for her to bounce back from the protracted collapse in confidence she was presently experiencing. From the third session onwards her confidence was much greater. The triggering event underpinning Jennifer's rapid gains appears to be her successful practising of the exposure between the second and third sessions, which enabled her to begin to redefine her role within her social groups, and move on from the façade, as she put it, that had been maintained in the years before her bereavement. Likewise statements about belief in the possibilities for change made in the third to the fifth sessions, give way to statements about actual shifts in experience and alleviation from symptoms in the fourth to the sixth sessions. Jennifer evidenced the continued practising of this new orientation in her three-month follow-up phone call:

The lovely thing is I'm talking openly about it to people now – which is a big departure. It's all open and good.

6.7.4.2 Myrtle

Likewise Myrtle saw the clear behavioural consequences of her new-found clarity on the guilt she'd lived with in her relationship with her Mum. Each subsequent session she provided behavioural examples that demonstrated how this clarity had been converted into behavioural change.

6.7.5 Outcomes that were specific and idiosyncratic to the client

Bohart et al. (2011) argued that a plausible account of therapeutic change should identify therapeutic outcomes that were relatively specific and idiosyncratic to the client, rather than mere generalised outcomes such as those captured by the PHQ9 and GAD7 psychometrics.

6.7.5.1 Jennifer

As was standard policy at the charity, when each client began their therapy they were asked to identify some therapeutic goals that they would like to achieve, that we could return to in a review session to consider whether and to what extent those goals had been reached. As was observed in chapter two, a significant event for Jennifer was reviewing her therapeutic goals in her third session. Where in her assessment she had stated her aim to 'get back to being me', by her third session she had realised that she had to re-author what it meant to be 'me' as the version of herself she had wanted to restore was not sustainable in the longer term.

By the sixth and final session, Jennifer was able to describe a migration from an original position of feeling guilty when chronic fatigue symptoms meant she had to rest, to an emergent position of being able to make a positive decision to rest:

Now I'm learning that nothing isn't bad. To do nothing isn't bad. You know, I used to think it was just a waste of time: "what could I have done in that time". But now I think: I've made myself feel better, I'm more rested, so that time has been used purposefully and positively.

What these examples indicate is that at least for Jennifer, the terms in which she understood the meaning of change in her life was at least as important as being able to state in a review session that those changes (outcomes) had been realised.

6.7.5.2 Myrtle

In Myrtle's assessment she identified the following therapeutic goals:

1. To be able to relax more and reduce anxiety and stress.
2. To find my own 'self' again
3. Be able to face health issues

The first goal appears to have been evidenced by the reduction in Myrtle's ectopic heartbeats and migraines by the end of the work together. Likewise her desire to find her own 'self' again may have been bolstered by her reaffirming her own illness identity – a stoic style of coping – of having her black humour witnessed by me, and perhaps most importantly of all by learning to assert a different version of herself from that projected onto her by her mother. The final goal was probably not attained: Myrtle described work on her fibromyalgia as like flogging a dead horse, and elsewhere that it felt like a "life sentence". This didn't change during our sessions. It was however ironic that just a couple of months after declaring a wish to face her own health issues, Myrtle would then discover she was faced an even more serious health issue in the form of her breast cancer.

When she wrote her replies to the questions I sent her at the three-month follow-up, she reflected on the importance of retaining her sense of self; of not allowing cancer to become the centrally defining feature of her life:

'I feel it's important not to be Cancer Patient. I am still me. Still wife, mum gran, friend, zany person who happens to have cancer. I'm also not saying "why me" because why not me. I'm no different to anyone else. I'm finding it a bit hard to cope with stuff like not being able to play my accordion or go to band but am just telling myself it's all temporary. I've also been very humbled by the support in getting off my lovely family and friends and also by people who are just texting me every week that you'd think wouldn't bother...like the young bloke who teaches me accordion and the lady I got my wig from. It means a lot to realise these people value me.'

6.7.6 Plausibility of changes given the degree of difficulty of the problem

The accounts of change in the brief therapies of Jennifer and Myrtle appear then to be contingent on just a handful of perspective shifts that both clients learned to apply not just to their experience but in shaping their behaviours and relationships. These perspective shifts appear to be modest and straightforward, however they held a great deal of significance for the clients. In terms of addressing Bohart et al.'s argument that changes should appear plausible given the degree of difficulty of the problem, the plausibility appears to be supported by the following evidence in which the clients elaborate on their changing thought processes which appear to describe with more subtlety the headline changes observed in these two cases.

6.7.6.1 Jennifer

In her fifth and penultimate session, Jennifer made the following observation which demonstrated what she'd learned about herself through extended application of her hand in the bucket of water narrative:

My thoughts are my personal belongings and I can think... I'll just verbalise one: "that was really good [Jennifer], well done, you did alright there didn't you?" Nobody else knows that but I know that and that's ok... Cos that's like working the other way isn't it? Because they're my thoughts, that I can keep.

This new-found understanding that 'my thoughts are my personal belongings' was particularly significant given how troubled she had been by the possibility that Alice's daughter had harboured such negative thoughts about her.

6.7.6.2 Myrtle

Likewise Myrtle had been able to observe how coming to a new understanding about the guilt that she had lived with had ripple effects beyond how she related to her mother. At the three

month follow-up Myrtle applied the same experience to her feelings of grief for her Dad who had died a couple of years ago, writing:

'Again organising my brain and getting things into perspective made me realise I had to let it go and stop worrying if I'd done all I could for him. I did my best. Also I think I was "hanging on" to my grief as it felt like a betrayal to 'let him go' But talking through other stuff with you made me see that same rules applied and I needed to move on.'

That final phrase 'the same rules applied' indicates for me that when Myrtle experienced such a powerful release of emotion in the first session and the subsequent perspective shift in relation to her feelings of guilt, she picked up a template that she was able to apply to other situations beyond her relationship with her Mum. Whether she was describing her relationship with her dying mother in law, her eldest daughter, or her grief for her Dad, the same rules applied.

6.7.7 Commentary from Jane

As observed above the original design of the project involved my research supervisors Jane and John taking oppositional – defence and prosecution – roles in order to scrutinise the accounts of change and causality that I provided in the original case reports. In practice, the emergent critiques of the use of these protocols, and of the ways I was framing my case work through those reports, provided more valuable insights than simply staying true to the identified methods. Jane's application of the methods to the case reports, including those of Jennifer and Myrtle, did highlight further criticisms of the accounts of change in those reports.

In the case of Jennifer, Jane highlighted the 'gold star' comment made in the fourth session as indicating evidence of expectancy or social desirability. However Jane recognised – in keeping with the emphasis on transparency made in the Elliott and Bohart et al. protocols – that as the author of these reports I had drawn particular attention to disconfirmatory evidence such as these and weighed these up against other pieces of evidence. This practice is contrasted by Bohart et al. (2011) who observed a tendency in historical psychotherapy case study reports for authors to select only those pieces of evidence which supported theoretical claims being made. Jane furthermore observed that Jennifer didn't perform exclusively a 'socially desirable' role as evidenced by the difficulties she reported with a homework that I had set her, which she hadn't seen the point in. Jane also picked up on Jennifer's realism about what to expect from her

future – that she will have challenges and her health will suffer but that she can use her tools to cope.

In considering the case of Myrtle, Jane picked up on the possible role of extra-therapeutic factors (Elliott, 2002) in Myrtle's epiphany and sudden gains between the first and second session. Jane observed that Myrtle was on holiday when she gave herself a 'talking to' and that the holiday environment may have created a 'holding space' which gave Myrtle the space and time for reflection not normally available in her daily routine. I found this theory quite plausible – that in advance what I believe was a necessary factor, the crystallisation of discontent which was brought about by my witnessing in the first session, that Jane is suggesting that that gain might also have depended on the holding space that Myrtle subsequently experienced on holiday. By this same logic, if Myrtle hadn't have departed on holiday after that first session, it might have been that Myrtle's daily routine would have drowned out the more subtle reflections that Myrtle was to make following the experience of that first session and the opportunity for change would have been missed. Jane also highlighted the possibility that Myrtle's expressed desire to contribute to the research might have shaped her responses. She furthermore observed that because Myrtle had never had therapy before this might have heightened her implicit need to perform as she imagined she was expected to perform in therapy. This latter point Jane believed may have been supported by what Myrtle had said in the fourth session about being able to 'get a lot of this stuff out by talking to you' which she suggested may have been a scripted expectation of how therapy worked. Jane also drew attention to my feeling at times that I was an audience for Myrtle's amusing stories about her Mum. Jane wondered whether perhaps these were attempts to win me over as her therapist, or perhaps to deflect from more difficult emotional content.

However by the point at which Jane was feeding back on the case of Myrtle she was increasingly articulating her reservations about the limitations of appraising psychotherapy case data in this way. Jane observed that framing 'relational artefacts' (as in Elliott, 2002) as evidence against accounts of change and causality did not sit well with intersubjective accounts of therapy that emphasise the use of the therapeutic relationship, for example through transference and counter-transference. I identified an emergent understanding that I'd been writing the reports from a 'helicopter view' which was almost a hypothetical position of objectivity, when in reality as the therapist described in the cases the richness of the analysis depended on my accounting for my subjective experience. Jane came to believe that by writing the case reports mindful of

the guidance meant I was unwittingly inclined towards the 'helicopter view'. In other words by trying to meet all the 'criteria' as I perceived them I'd objectified the work. It is possible that this objectification may be apparent in the accounts of the mini-studies as made in the present thesis. Jane concluded that a key learning point from the case report work for me was that in the thesis itself I needed to 'express the very human drama' present in these cases as the reports felt 'at one or two removes from the interior of the therapeutic process'.

6.7.8 Commentary from John

John's own reservations about using these protocols to scrutinise the case reports meant that his responses focused on his theoretical objections to the method and his critiques of how I was framing the case studies themselves, rather than weighing up the different pieces of evidence supplied within the reports. John believed that my reports had two significant short-comings: firstly that they were not grounded in a narrative i.e. that he couldn't get a feel for the client from the report. I responded by explaining that this probably reflects the nature of the data processing, which was focused on mechanisms of change. The second short-coming John observed was that the reports were not sufficiently grounded in existing theory. For example John could see failures of mentalization at work in the cases both of Jennifer and of Myrtle. I responded by explaining that I believe that these references to existing psychotherapy theory would come through more strongly in the cross-case analysis where I would look for patterns of change that were analogous between clients.

Crucially John believed that the protocols used a kind of language that sought to generate the *impression* of objectivity, and elsewhere described them as 'an attempt to make the subjective objective by means of a few tricks'. John believed we should call a spade a spade and own our subjectivity. John was the first to identify two ideological 'camps' in psychotherapy research, both of which I seemed to be trying to 'please' within my research project: the tribes of constructivism and (post-)positivism as framed in this thesis (as discussed in chapter one). It was to the latter camp that John believed the Elliott and Bohart et al. protocols belonged. My response to John was that I was trying to achieve a synthesis between these two positions, recognising the merits of both.

Debates around the case reports and how they were framed led to a greater discussion about the identity of my research project, and indeed my identity as a practitioner and researcher. My

supervisors' pushback against the way I was framing my cases helped me to realise that my focus on longitudinal change had created a blind spot for me in terms of not noticing the significance of micro-processes. I likened it to the difference between watching a sad film – which has the power to make you cry – and just reading the synopsis, which could never have the same emotional impact. Despite these theoretical concessions I maintained my belief that a dialogical frame of reference – accounting for multiple parallel subjectivities – was the appropriate theoretical platform for bringing out those micro-processes.

6.7.9 Observations

Putting the aforementioned theoretical limitations to one side for the moment, scrutinising my case reports using the guidelines set out in the Elliott (2002) and Bohart et al. (2011) protocols I observed that there was a case to be made that Jennifer wanted to be a 'good' research participant and to give me positive material to report on in my project. At first glances this recognition might have been considered to delegitimise her therapeutic gains and her experience of the therapy that coincided with those gains. However there is also good evidence that Jennifer's gains were substantial e.g. in giving herself the permission to rest and be vulnerable, as witnessed not just by her but by her daughters, and sustained beyond the therapy itself, as reaffirmed at the three-month follow-up. If then Jennifer – either consciously or perhaps subconsciously – set out to be a good research participant, perhaps this extra 'active ingredient' (Kirsch et al., 2016) in her therapy actually had a beneficial placebo effect. Kirsch et al. have argued that it makes no sense to control for placebo and expectancy effects if they are indeed 'active ingredients' in a client's recovery. Elsewhere Bohart and Tallman (2010) observe that the term 'placebo' is something of a misnomer and argue that a client's expectation of progress can mobilise their own resources for change. In their own research on sudden gains Abel et al. (2016) hypothesised that client hopefulness was a key ingredient in creating the conditions in which sudden gains could take place. In the sixth and final session, as Jennifer filled out her PHQ9 and GAD7 psychometrics and observed the stark change between then and her answers at the beginning of the process, this evidently made an impression on her. She said it was "quite frightening really" being able to look back and see what a bad place she was in, and what may have happened if she had not taken up counselling when she did:

The steps that have been taken... that have meant that I could come for counselling that made so much difference, because I wonder where the steps would have gone after that. I mean I've never ever had thoughts of just ending my life or anything but things were obviously not going to get any better.

It is evident in this passage that Jennifer saw coming for counselling as a significant event in her life and something of a turning point. The almost ritualistic way in which the PHQ9 and GAD7 scores are compared in the last session perhaps serves to further consolidate what might be considered the placebo effects – the beneficial qualities that Jennifer has associated with coming for counselling.

As argued above, I believe that Myrtle experienced a sudden gain between the first and second sessions as a result of a 'crystallisation of discontent' in the first session brought about because I was a witness to her guilt and its widespread impacts upon her life. In being witnessed I believe those feelings could no longer be minimised or dismissed and as such that the witnessing created the conditions for the crystallisation of discontent. This in turn created the conditions in which Myrtle could take a different stance with her Mum, and over the guilt she had felt within that relationship. Unlike in the case of Jennifer, there is no evidence that Myrtle's participation in the research project was an influential factor in the sudden gain observed. Indeed Myrtle commented in the three-month follow-up that she "totally forgot about the recorder being there" and that "everything felt totally natural". It is reasonable to argue that the impact that my witnessing of Myrtle's discontent had in the first session – which was not recorded - would have occurred whether or not Myrtle went on to participate in the research project.

Returning to the example of Jane's wondering about the possibility that Myrtle's sudden gain depended on her going on holiday following our first session, I found a binary conception of what was inside and outside of therapy to not accurately reflect the subtlety with which therapy serves as one 'ingredient' for change within the wider tapestry of a person's lived experience. On balance I believe that the evidence from both the cases of Jennifer and Myrtle is that they experienced changes which were both substantial in improving their quality of life and relationships, and sustainable in the longer term. However it was not possible to tease apart the different influences of expectancy effects from more 'legitimate' therapeutic effects; nor was it possible to tease apart which changes were owed to therapy and which to external factors.

6.8 Conclusions

What emerges from the qualitative (hermeneutic) analysis of change and causality statements made about the work with Jennifer, and with Myrtle, is that change is evidenced, but with some caveats. The most interesting theoretical possibilities that emerge from the mini-study are the roles of placebo effects and 'relational artefacts' in supplementing and perhaps even amplifying change processes that have been accounted for with reference to other mechanisms. We saw Jennifer idealising the therapy and possibly by association idealising me in that process. I observed in chapter three for example how listening back to Jennifer's three-month follow-up I sound like a vicar calling one of his flock, and in the mini-study just concluded how Jennifer attributed wonderful qualities to her therapeutic experience. We also saw how potentially part of the power of Myrtle's 'crystallisation of discontent' experience in session one may have been in the fact that in me she had a witness to her pain.

Production of the mini-studies therefore brought into my attention the under-representation of the therapeutic relationship in the accounts of change provided thus far. I understood both with reference to theory and through clinical experience that psychotherapy is a co-creative process. Meanings, insights, epiphanies and indeed change processes that emerge in psychotherapy emerge dialogically in the meeting of and negotiation between two subjectivities. They may indeed be more than two subjectivities present: I recall the work of Sedgwick (1994) in which the therapist meets many different versions of the client in the transference; and the client meets many different versions of the therapist in the counter-transference. As such, in the coming chapter seven, the final chapter of analysis, I return to the data to consider what I have termed as 'dialogism in the therapeutic relationship'. As a dialogical process how does this meeting of subjectivities drive and perhaps augment the change processes described through chapters four to six?



Chapter Seven, 4th template: Dialogism in the therapeutic relationship

7.1 November 2018 – April 2019: where I was

The night following John's critique of the case of *Myrtle* I woke up screaming from a night terror. I woke with a numb arm and was convinced I was dying, I was calling for help. When my wife finally managed to get through to me I was out of breath and my heart was pounding so fast I thought I could have had a heart attack. The next day I felt dejected and ashamed.

On a rational level I had problems with John's emphasis on mentalization – some of my clients I'd only seen for five or six sessions but nonetheless in that time they had demonstrated metacognition. Hadn't they experienced personally meaningful change, and picked up blueprints that they could take with them beyond their therapy? In reality I'd internalised John's critique and was debating with myself. What I projected onto John was my own doubt about the quality of my work and my own awareness that the work might have touched my clients on one level but had left them 'untouched' on others.

As my research supervisors helped me to unpack my own thoughts and feelings in relation to John's critique we appeared to situate our debate within a theoretical dualism that had been present in our discussion for some time between positivist approaches to knowledge on the one hand and constructivist approaches on the other. Jane, recalling an older debate around the science underpinning effectiveness and efficacy research (Nathan et al., 2000), invoked the

mythical binary pair of sea creatures Scylla and Charybdis, as described in Homer's *Odyssey*. Sailors navigating along the Straits of Messina between Sicily and Italy's Calabrian Coast had to carefully avoid passing too close to either monster in avoidance of the other. The Professor's and John Lees' polar opposite critiques of my work became the hazards I would need to carefully navigate between, but Jane wondered who would get to be Charybdis and who Scylla in this projection? In the *Odyssey*, Homer is forced to choose and opts to confront Scylla as the lesser of the evils. During this period I became conscious of how Michael's and John's voices were present in my research project. Accompanying all the work I was doing at the time was an internal commentary; a dialogism in which these different voices were represented. In that dialogism I perceived a creative tension – the influence on my project was not merely about avoiding hazards, as in the Straits of Messina, but that my project would be enriched by the tension.

Over the previous summer, in my personal therapy, I had reflected on what was during that time something of a fixation for me. I noticed that on one level my thought patterns couldn't get past the physical reality of my Dad lying in a coffin in the graveyard – his body bearing his form, yet permanently closed. No reanimation would be possible – like the way the electric jolts bring the person back to life in the movies - he had already passed a point of no return. I told my therapist about a dream I'd had about my Dad in which he was dead and alive at the same time. We reflected together that I appeared to be battling with two realities – a physical reality and a spiritual reality. I reflected with my therapist that I often met with a version of my Dad that I experienced as someone who'd lost interest in life; and had narrow horizons; however through music I connected with what I described as his 'energy body'. I have caught myself on many occasions since his death listening to John Lennon's *Jealous Guy*, or Puccini's *E lucevan le stelle*, or Bill Conti's *Gonna Fly Now* from the Rocky movies; my face flooded with tears.

In November 2018 for the first time I brought myself to listen to a piece of music that my Dad had recorded on the piano shortly before his death. He'd called it *Twins* – it was a piece for my son and daughter; his grandchildren, just three years old when he died. I imagined his hands playing those strokes on the piano – unmistakably his style. I wondered where he was going with it but I knew that the individual motifs would represent different images or moments from the scene he was trying to depict, as I knew this was how he used to 'read' the music of the composers. There came such a passage that reminded me of the twins playing hide and seek round the settee and I was moved to tears – I understood; we'd connected. Another motif invoked an image of him raising them up to sit in his lap. There were splashes of sadness,

perhaps reflecting toddlers quickly going through the different emotions, or maybe his own sadness in it being time for us (and them) to go. I thought about my own dialogism with Dad – one of us living, one of us dead, yet still communicating.

7.2 November 2018 – April 2019: where my theory was

Throughout the early months of 2019 I participated in a succession of good pieces of work with clients; each of whom discovered a new map during our time together. What I began to learn from my clients was that what was also significant were the ways in which they were using therapy i.e. the significance was in the *how* of the therapeutic working, not just in *what* was worked on. This growing awareness subsequently added another layer of detail onto my evolving model of change as I will now locate in the existing literature.

As I studied different longitudinal models of change, one of the important distinctions I observed between the classical psychoanalytic model (as envisaged by Cashdan, 1973) and the other humanistic models I studied, was the emphasis of the former on the transference cure. More particularly Cashdan argued that as clients began to bring their conflicts into the therapy room the symptoms they were experiencing ‘out there’ in the seven days between sessions were observed to fall away. This emphasis on the use of transference as curative did not fit with my experience of change in work with my clients nor my style of working. However contemporary psychoanalytic accounts support Cashdan’s framing of the work. During this period I had a growing awareness that my model of change, such as it was, did not include any theory with particular reference to the therapeutic relationship, or indeed more generally how my clients were using their therapy (not just what they worked on during the time they were in therapy).

Stuthridge (2017) demonstrated through her work as a transactional analyst the processes of ‘story breaking and story making’ as being at the heart of therapeutic change. With the emphasis in transactional analysis on scripts and script change, I envisaged theoretical contact with the theory of cognitive maps that I had become affiliated with. Stuthridge described a piece of work with her client John over three years in which she experienced being cast into multiple roles in the transference – from ‘cold shrink’, to lover; from an idealised ‘guardian

angel', to John's 'authoritarian father'. Gradually John came to know Stuthridge as a 'real person' and the evolution of their relationship paralleled John's re-scripting of his own life. Mosher and Stiles (2009), reflecting the importance of the therapeutic relationship from a dialogical standpoint, used case study evidence to demonstrate the assimilative processes by which a client internalises the therapist voice to such a degree that it becomes no longer consciously associated with the therapist. Kirsch et al. (2016) called into question whether the person-centred account of the therapeutic relationship had captured what it was about the relationship that was beneficial. They observed that the approaches advocated by Fritz Perls or Albert Ellis – perhaps as modelled in their demonstrative sessions in *Gloria: Three Approaches to Psychotherapy* (1965) – could hardly be considered warm or accepting, but perhaps their clients came to believe that the 'difficult work' would be for their own benefit.

Timmer et al. (2006) emphasised the importance of motivation in psychotherapy clients with somatisation syndromes, relaying evidence that a client's acceptance that they were receiving a valid treatment and/or beliefs about the beneficial effects of the therapy were associated with better long-term outcomes. Timmer et al. highlight the importance not just of a client's initial motivation going into therapy but also how motivation develops during therapy as being a significant determinant of its success.

Finally, McLeod (2013) observed that a client's social and cultural concepts of therapy will heavily influence how they articulate their experience of therapy e.g. whether the emphasis is on learning coping strategies, on the importance of the relationship, of the interpretive brilliance of the therapist and so on. I propose that this expectation of what therapy ought to be like does not just influence client's retrospective accounts of their experience of therapy, but perhaps more importantly influences how they use their therapy whilst they are sat in the chair. Given the theoretical possibilities in the therapeutic relationship thus highlighted in the existent literature, in this final layer of analysis I consider how my clients used their therapy e.g. as a dialogical process in which we find ourselves occupying certain stances (I-positions) in relation to one another, and thus how an account of the therapeutic relationship might be incorporated into my emerging map of change.

7.3 Lou

I noticed two different ways in which Lou would use her therapy which seemed to reflect an implicit understanding of what it meant in her life. There are passages in which Lou appears to view therapy as almost a confessional experience, like a Catholic confessing to the priest, one can only be absolved of one's sins if the priest knows about them all. Lou was courageous in sharing with me details of her contemporary sexual experience that she'd never been able to share with anybody, and likewise she shared details of her sexual history before she got together with her husband for which she had felt intense shame about. In the tenth session she arrived relaying a conversation that she'd had with her husband in which they'd agreed that I needed to know "everything". I understood the meaning of that to be that Lou (and her husband) believed she needed to get everything out into the open as that would be the only way that we'd be able to get to the bottom of the problem. This potentially cast me as the expert psychologist – give me all the information and then I'll be able to fix the problem. However in being able to share such intimate details with me, Lou experienced something she had not anticipated – that as alternative perspectives were made available the feelings of shame that she had been carrying around were challenged. Perhaps most significantly, when Lou was able to share with me that when she was just fourteen she had been in a relationship with a much older, married man. I emphasised that in that situation, which amounted to childhood sexual abuse, she was the vulnerable one. Having never had a witness to what happened before, she had never treated herself with the same compassion. She had wept: she was being bullied at school during that period and "I just wanted to be loved". It is also possible that in Lou using therapy in this way she was making the most of a kind of therapeutic exposure (Carey, 2011) – by sharing secrets loaded with personal shame in this relatively safe situation she no longer had to battle so hard to conceal them or alternatively to go on in fear that they would be exposed. By taking control of the exposure she no longer had to fear it.

The other way in which I found Lou used the therapy was to see me as a mediator. When she shared with her husband these details of her past life he was furious, framing his reaction as: "you've lied to me for all these years" but therapy provided Lou with the opportunity to hold her own position rather than to fall into line as the guilty one, as the following passage indicates:

J: So it was a big development. For you to tell [husband] about something you'd never told him before, all these years later, it was a big deal that it came out now.

L: Well I think he struggled with it, and I struggled with it then because I felt like I'd done something wrong, but then after speaking to you I felt better in myself about it and explained it more to [husband] like probably how I needed to explain it.

That last point about Lou being able to explain what happened properly after seeing me is important – it's one example of how Lou would often come to me in the midst of an unfolding drama, we would reflect together and she'd arrive at a degree of clarity about what was going on, what she needed to do, and so on. As this passage indicates I was not necessarily an impartial mediator – I think that Lou always experienced me as on her side. This was not the same as me taking sides, e.g. against her husband, but rather than she experienced my unconditional positive regard, and as such that I was there to help her. There were other times when what might have been described as a mediator role morphed into something more closely resembling a Winnicottian parent 'hovering' in the background (Winnicott, 1965). For example in the seventh session I noticed Lou speaking with a more defiant voice, which reminded me of her account of how she'd rebelled against the diet she experienced as having imposed on her. I understood at the time that Lou was rehearsing an assertiveness that she'd only been able to perform up to that point either implicitly or with intense anxiety. I didn't initiate these rehearsals but it was as though Lou was preparing herself to be more assertive; to develop the clarity and the resources she would need to reposition within what she experienced as power imbalances.

In hindsight it is interesting that Lou never projected onto me that I was the one to be rebelled against – she never acted this out in our sessions. I wrote in my notes once or twice a concern that I was in some respects an 'enabler'. This was most apparent when Lou left her husband for a week between the tenth and eleventh sessions. At the time I was troubled by my own feelings of responsibility – had I emboldened Lou to do this; would it not have happened had she not been in therapy? In this frame of reference I would be almost a co-conspirator rather than one to be defied against. Looking back, Lou's departure and subsequent resolutions with her husband had been a beneficial experience for them both, however at the time I shared a small part of the anxiety of that step into the unknown. There was an additional dynamic within our relationship that might shed some light on this. For the first three sessions there was a mutual anxiety between us – we were still trying to work out how we would work together and relate comfortably. However by the fourth session I noted from the recordings that the tone of my voice was different – subtly a tone deeper, sharper and more confident. Perhaps not coincidentally in the previous session Lou had made the identification with the Peacemaker I-

position, and by the fourth session Lou was also starting to report the first few signs of being able to take alternative behavioural positions with respect to her husband. In other words by the fourth session it was as though we had implicitly discovered a template for how we would work together.

Lou reported that she felt an anxiety about coming for the sessions and as we explored this together she linked it to an anxiety she had with friends in social situations that she'd run out of things to say, there would be an awkward silence and they would perceive her as an awkward person. It was as such a relief to Lou that there were never awkward silences between us, but moreover I note that at no point did either of us speak because we were trying to avoid an awkward silence. On the one hand this could be viewed positively – that through our relationship Lou was learning that she wasn't an awkward person and that she was actually easy to get on with. Indeed during the middle stages of our work together Lou reported several significant breakthroughs in managing her social anxiety and feeling more socially confident – perhaps her experience of our relationship was one of the facilitative factors underpinning those breakthroughs? However it might also be suggested that our sessions were too good natured and civil – perhaps with us finding a comfortable way of relating that 'worked' there was no space for a rupture, or acting out, to occur. Lou and I ended our work together with an awareness that there was still more work we could do, however we had got to a point. It is possible that beyond the thirty sessions we worked together, there may have been future phases of the work in which the style of relating that had worked for us broke down, to be superseded by a different working style.

7.4 Michael

In stark contrast to Lou who aimed to tell me everything, Michael set implicit boundaries on what we would talk about. I experienced our work often as being 'in a box' with clearly defined edges, and I found this difficult in early sessions, before, much as with Lou, Michael and I found a way of working together. My ordinary way of working, which was to reflect back to my client my own appreciation of what they were experiencing and what they themselves appeared to be working out, didn't seem to be productive with Michael. He seemed to be closing down reflective discussions, preferring definite and tangible language. Listening back to those early

recordings my voice lost some of its tonality, became less musical and slightly higher pitched, perhaps reflecting my anxiety that my style wasn't working. I reflected back to him on several occasions about the lack of emotive content in our work and he insisted that was his style – he just wasn't an emotional person. Michael's pre-therapy scores on the PHQ9 and GAD7 measures were 1 and 1 respectively. The statements he endorsed were 'feeling bad about yourself' and 'feeling nervous, anxious or on edge' (several days over the previous fortnight). In other circumstances one might look at these low scores and consider why the person had sought counselling, but as Michael himself explained: his experiences of anxiety were acute and intense, though limited to those moments where he felt exposed in his tremors – hence the low scores. I wondered whether Michael was exhibiting alexithymia – the inability to access or to articulate one's own feelings which is often apparent with clients who present with somatic symptoms – or whether to take his description of himself as not an emotional person at face value.

In his assessment Michael had identified difficulties in his marriage – he and his wife weren't being physically intimate, and instead he was using pornography. He had admitted to feeling shame about this, particularly because this was a secret he was keeping from his wife. However during our sessions together whenever I encouraged Michael to return to this theme he would only do so indirectly, endorsing better communication with his wife. It is as such distinctly possible that Michael's participation in the research project was a contributory factor to his implicit limiting of what we could work on together. Michael remarked in an early session that "you seem to be more interested in the physical side" which I picked up on, and reminded him that although my research took an interest in the physical side that he could talk about anything in our sessions which he said he understood. Nonetheless this was an early indication of the boundaries that Michael perceived and that perhaps helped to alleviate some of the anxiety that he might have otherwise felt coming for therapy. In the fourth session, I noticed his eyes frequently glanced towards the audio recorder during a passage in which I invoked those issues with physical intimacy. In the next session as part of ordinary continuous consent I asked him explicitly whether he was aware of the audio recorder and he said he was not. It is potentially significant that Michael was the only participant who opted to collect the case report from the charity building rather than for it to be delivered securely to his home.

In Michael's assessment he was asked to identify his therapeutic goals. He specified that he wanted strategies for managing his anxiety and for asserting himself. A trained engineer himself it was as though he cast me in a mechanic type role, or perhaps as a kind of physiotherapist of

the mind, deploying certain techniques, working on certain areas but not delving where it wasn't relevant to the job at hand. As such our way of working together was an unusual hybrid between a directive cognitive behavioural and exposure-based approach on the one hand, and a narrative-dialogical approach on the other. In a sense it was almost an implicitly negotiated compromise between our different styles of thinking. However in holding two different theoretical positions at the same time Michael came away from our time together with learning that seemed to reflect both of these theoretical positions. On the one hand Michael embraced the ideas of openness as had been modelled through the cognitive behavioural approach, and on the other hand Michael developed his own "inner being", a compassionate self-talk which can be traced through to the narrative-dialogical strands of our work together.

Michael seemed ambivalent about the value of the therapy in the early stages and whether or not he would invest himself in the process. As observed in the mini-study on innovative moments in Michael's therapy, his ambivalence was particularly present in the fourth and sixth sessions. I understand that this 'hot and cold' motivational pattern reflected an ambivalence about two conflicting strategies that Michael and I held together in those early sessions. I advocated a strategy of openness – as embedded within the exposure-based approach - as the vehicle through which Michael could overcome his fear of being seen. Michael's traditional strategy had been concealment – as reflected in the 'keeping my head down' I-position – and in the fourth and the sixth session in the subtext it is as though Michael is leaning back towards concealment as the appropriate strategy for him.

Michael's subsequent embracing of openness as opposed to concealment may also in part have been facilitated by his experience of openness in our relationship, as this passage from the second session indicates:

Daft as it may sound I actually feel quite comfortable with you, you know it's ((said while laughing)) it's credit to you, it's not... it's not a threatening situation or anything like that. And... like I said, it's ... comfortable talking about it because it's... you're not trying to find fault with it

The reference at the end of that speech turn to 'finding fault' takes on a particular relevance as Michael and I went on to develop an understanding of his perception of the social world as aggressive and competitive; that if his disability was to be seen he would be berated and mocked. What is reasonable to say is that throughout our time together Michael felt accepted by me. This modelling of openness through our therapeutic relationship was further affirmed by Michael in his final, tenth session:

I've been a very.. erm... sort of self-conscious person and I've kept things just to myself and not really done anything else about them. Just dealt with it myself. Probably to share it a bit more... sort of talk to other people, you know... about... you know, say "I've got this problem" sort of thing. Like I said, I've told you more than what I've probably told anyone ever and that's... just the way it is. Even your best friend, sort of thing, because you think well 'they've got their own lives, it's not ...'. When you do get over that hurdle of telling them and actually they're not... "Yeah fine, it's not a problem" ((imitating higher, reassuring voice)).

Picking up on that higher, reassuring voice at the end of that speaking turn, it is also possible that my acceptance and encouragement of Michael offered a template through which he would develop his "inner being" voice (see page 176). This may be an example of the internalisation of the therapist's voice as advocated by Mosher and Stiles (2009). However there are clearly other factors present. Michael is himself a Dad and may have learned to talk with the same compassion to himself that he would give one of his children if they were upset. Also Michael's Mum, whose voice we hear through Michael in his second session (see page 173), appears to model the compassion that is later embedded within his inner being.

7.5 Observations

The primary theoretical outcome that appears to emerge from this analysis appears to be to introduce a new dimension of depth. To locate the theory in metaphorical space: if cognitive mapping were to be viewed as a horizontal process, dialogism in the therapeutic relationship may be viewed as a vertical process. Whilst therapeutic work may present with a plethora of transferences in each direction, the depth of the discussion is determined by how much the client feels safe enough to disclose, or indeed at how much of the client's internal world they feel the therapist could contain if they put it out into the room. What I observed in this stage of the analysis is the way my clients were prepared to do what I've described as cognitive mapping on a level, and I have also identified some barriers to the therapeutic work 'dropping down' a level. Some of these barriers may be viewed as natural limitations of the therapeutic work. However in other cases the barriers may have been negotiable. For example I am clear retrospectively about the lines that *Michael* implicitly drew around our work, however at the time I was not able to offer Michael substantial reflections of what I perceived was happening in

the room. At the time as a therapist I wasn't able to effectively take the meta-position of observing how Michael was using his therapy, how we were relating, and so instead we remained focused on the content of our discussions, with me implicitly modelling narrative-dialogical change as I understood it during that period. However the hypothesis that emerges from this analysis is that by observing how clients are using their therapy we have the opportunity to take a meta-position together and in that process potentially to 'drop down' a level.

What I do observe taking place in my sessions with *Lou* and *Michael* is that in some respects our styles of relating to one another model the cognitive maps that emerged as the platforms for their own experiences of change. Being able to 'confess' shameful episodes of her life history to me and for me to acceptance and unconditional positive regard enabled Lou to move beyond an experience of shame which was one of the driving forces behind her Peacemaker role – she would bend to suit others' demands because she didn't deserve to assert herself. Likewise with Michael it may be observed that our relationship modelled both openness in the way he was able to bring his disability into the room with me, and perhaps also the compassionate self-talk which Michael then goes on to develop (or internalise) in the latter stages of his therapy.

7.6 Conclusion

We thus come to the end of the formal accounts of analyses. I have sought to demonstrate at each stage that application of each successive template for change drew out different meanings and patterns from the data. In the following chapter, entitled *The Emergent Thesis*, I offer a summary of how what answers have been offered to the questions I identified in the Introduction, and go on to bring all these insights together into a coherent account of change in my work with my four participant clients, and as shadowed in my own parallel, internal experience. I will thus advance my *map of change* as it emerges out of the writing of this thesis.

7.7 Belfast

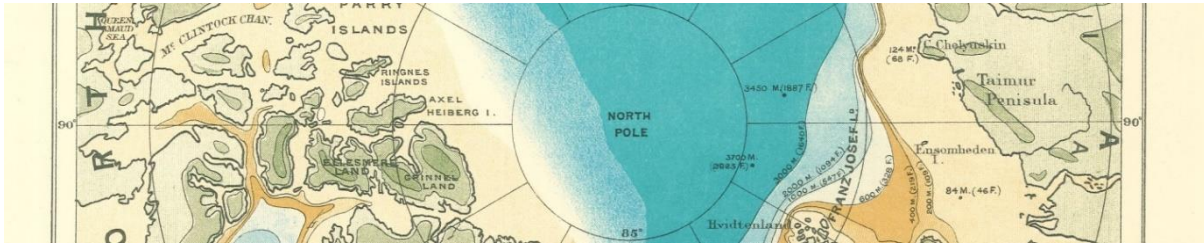
Friday, 17th May 2019

Belfast was much nicer than I'd always imagined – a European city: clean, not too busy, nice bars and cafes, a walk by the harbour, restaurants on barges, little side streets lit up, and live music everywhere - proper Ireland. The conference itself was like any other BACP conference in any part of Britain. I had recently been offered a lectureship at Leeds Beckett University and so I had something of a spring in my step. I spent most of the Friday supporting Leeds people – the five from Leeds Beckett who all presented, and seven from the University of Leeds, most of whom I saw. I felt confident, and intellectually heavier than I had been in Amsterdam.

However during the session in which I was to speak I heard a voice from behind me asking questions about the presentation just delivered. I knew that voice. It was John McLeod, another conference rock star. I always liked John McLeod's work – he wrote the book on case study research for counselling and psychotherapy and in Amsterdam he had offered a radical response to the NICE Guideline on Depression – that the psychotherapy research community should produce an alternative Guideline produced entirely from qualitative research. This made him something of a hero in my eyes. And yet in that moment I feared another 'Amsterdam incident': like the Professor he would cut through my research design and I would be exposed again. I was supposed to be speaking but instead I dashed off to the toilet to compose myself. The anxiety was almost physically unbearable. Yet I found the mental space to think back to 2014: the year we were married and the twins were born, and our most perfect wedding day. I thought about the salmon swimming back upstream to their home rivers – I would make it, I just had to keep on swimming. I returned to the room where I would deliver my presentation. And somehow I managed to present my thesis in a relaxed, authentic way (perhaps a part of me had resigned myself to my fate!). And when questions and comments came around McLeod was the first to speak, responding positively, thanking me for doing the research and complementing me on the way it was produced – innovating in the communication of case studies. He asked me about the ethical process at the University, alluding to the cultural resistance that exists on many research ethics boards to therapists researching their own client work (Jenkins, 2019). I credited the progressive nature of our own School's board. When another enthusiastic audience member asked what advice I would give to someone just beginning a piece of case study research, I explicitly observed some reticence given that the man who 'wrote the book' was sat in the audience, before landing on the idea that the most important advancement in case study

research, as I saw it, was the visibility of the therapist; that too often therapists were invisible in their reports. McLeod agreed with me on this and went on to make some suggestions about where I could look to get my thesis articles published. I was elated – it lifted me as high as the ‘Amsterdam incident’ cut me low - and I kept thinking back to it for several days afterwards.

Jane and John would later reflect back to me how the key critical incidents in my own research journey involved male academics: the challenge from the Professor that left me flailing, and the subsequent deconstructions of my work by John Lees. I had internalised both of these male voices in critiquing my own work in the months immediately preceding Belfast. I knew that Jane and John were alluding to my relationship with my own father – and my experience of not having had a lived example of how we ‘make it’ in the world out there; of being a good enough father-provider. The experience with John McLeod, although almost as fleeting as the dinner exchange with the Professor in Amsterdam, Jane suggested had had a restorative effect upon me. Here was a male academic who didn’t stand on either epistemological pole – neither Scylla nor Charybdis - but might appreciate both the art and the science of my research. I thus internalised an additional male voice as I set to work - immediately upon my return from Belfast I began writing my thesis.



It is thus, if there is any rule, that we ought to die – neither as victim, nor as fanatic, but as the seafarer who can greet with an equal eye the deep that he is entering, and the shore that he must leave.

E.M. Forster, *Howard's End*

Chapter Eight: The Emergent Thesis

As presented in the previous four chapters, my emergent model or map of change passed through a series of evolutions in which new theoretical templates were layered to form new syntheses. Each of these was continually being tested out in practice – not just the practice work with my participant clients but as extended into all of my clinical working. In this chapter I present the emergent thesis in its most developed and distilled form. The thesis that emerges rests upon three axioms derived from the existing theory which are evidenced in this research:

- 1) Embodied expressions of distress – where they are observed to be context-dependent – are associated with a person's perception of subjective incompetence in that context.
- 2) A capacity for metacognition or mentalization, realised within those contexts, is the basis on which a person is able to transcend the patterns of relation associated with flare-ups of symptoms.
- 3) Where the person is able to transcend these patterns associated with their flare-ups they will experience symptom relief. This could be either an 'objective' reduction in symptom intensity or frequency – as observed with *Lou* and *Myrtle* – or an improvement

in the perception of symptoms, and subsequent cognitions and behaviours – as observed with *Michael* and *Jennifer*.

Through this thesis three further generalised statements emerge:

- 1) The participants' capacity for metacognition depended on their discovery of cognitive maps – essentially platforms of meaning – within which cognitions and behaviours were arranged according to their fit or congruence within the emergent map.
- 2) Relief from embodied distress was bound up in a more generalised shift in the participant's I-position: their experience and performance of self in relation to others and the world.
- 3) A participant's I-position was located within a wider cognitive map which included representations of self, others and world

My thesis as such builds upon a synthesis of existing theory in which metacognition (or related terms) emerges as the primary mechanism of change in psychotherapeutic working with clients who presented with embodied distress. What this thesis offers that is novel is an account of the development of cognitive maps as the vehicle through which clients are able to realise this capacity and transcend their present circumstances.

8.1 Answering the research questions

In the Introduction I offered a deconstruction of my original line of questioning into five more formal research questions which I will now consider in turn: how have each of these questions been answered through this study?

8.1.1 As a therapist researching my own practice, can I observe mechanisms of change?

In section 8.5 I will return to my review of existing literature and theory on mechanisms of change in psychotherapeutic working with this client population. However throughout chapters four to seven I have proposed and evidenced several mechanisms which are congruent with the emergent thesis which is set out in this chapter. These mechanisms include:

The client identifies with an I-position

We see this mechanism evidenced across all four cases, such as where *Jennifer* identifies with Generous Jenn (section 5.4) and when *Michael* contrasts ‘keeping my head down’ with ‘standing taller’ (section 4.2). However the richest examples of this mechanism come through the case of *Lou* and her identification with the Peacemaker I-position, as evidenced in section 4.1, and in chapter five, linked to progression from a pre-contemplative to a contemplative stage, as in section 5.3, and taking ‘ownership’ of the I-position in section 5.5.1.

The client demonstrates an awareness that different I-positions are associated with different cognitions, behaviours, and embodied experience

This mechanism is evidence throughout chapters four and six. Notable examples are *Lou’s* changing beliefs about what will happen if she asserts herself, and whether or not she should be pursuing her dressmaking business (sections 4.1 and 5.5.1). It is also significant that Lou is able to locate the waves of physical exhaustion that had meant she had had to leave her work within the Peacemaker I-position as evidenced in section 6.6. Also in section 6.6 we are able to discern cognitions associated with the alternative I-position of ‘fire in my belly’, including: “I don’t have to do this”, and “whose benefit am I doing this for?”. Lou and I also came to understand the wider significance of her swimming motif – when Lou is swimming, in this version of herself, she occupies a private world (in contrast to the entanglements that had been so exhausting for her), she can move at her own pace, she has a clear mind, and space for herself.

When *Michael* was able to access an alternative I-position associated with ‘standing tall’, cognitions associated with this new position included ‘openness’ (as opposed to concealment), and the capacity to assert himself (as opposed to avoiding confrontation). Whilst the ‘keeping

my head down' I-position was associated with an 'inner demon', a critical inner voice that placed somatic pressure of Michael to move faster, and to tense up, the alternative I-position was associated with a kind and soothing 'inner voice' which Michael associated with a gentler pace and muscular relaxation (sections 4.2, 4.3 and 6.3). Also in section 6.3 we observe how Michael's worldview changes from one in which the world is aggressive, competitive and critical to one that is worth knowing about, and which is also inhabited by supportive voices.

That change is performed outside of the therapy room

If we consider the experiential value for each client in behaving differently within the relational systems to which they were a part, these alternative behaviours were modelled in the therapy room but were crystallised out there in the world. See the case of *Lou* (the mini study on creating space in section 5.6 and her withdrawing from the drama triangle in 6.6) and the case of *Myrtle* 'I just sat back in my chair' (5.5.2),

8.1.2 Are these mechanisms common from one client's experience to another?

As is established in the previous section, I believe the three mechanisms identified were common from one client's experience to another. However other mechanisms of change were observed in individual case work which could not be evidenced across the four cases. For example, *Myrtle's* 'crystallisation of discontent' (section 5.5.2) which is not observed in the other cases, it may be conceptualised as a particularly acute example of what I am describing as 'identification' (see section 8.3.1).

Likewise in sections 4.1, 5.6 and 6.6 I was able to trace an increasing relational competence in *Lou*, which progressed gradually from implicit acts of rebellion, to more direct expressions of assertiveness which were associated with unbearable levels of distress and panic, towards ambivalent feelings which included pride as well as doubt, and ultimately towards *Lou* being able to calmly and confidently assert her position. This gradual development of relational competence is not observed in the other three cases however it is notable that *Lou* is the only longer-term client to have participated in the study, having had 30 sessions, whilst the other three clients had just 5-10 sessions each.

8.1.3 How might clients identify and describe these mechanisms of change in their own words?

Clients' own comments on change, where evidenced in this thesis, are delivered in the language associated with their emergent cognitive map. For example where *Jennifer* declares in section 6.4 'once I took the hand out that was failure and letting people down because I wasn't doing. But... I just seem so much better by having had that'. And later in section 6.7.6 credits learning that 'my thoughts are my personal belongings'. This latter example might also reflect Jennifer gaining an implicit sense of what is meant by 'metacognition' – that it is possible to watch one's own thoughts, however it is also congruent with her hand in the bucket of water motif: in that she is saying that it doesn't matter what judgement other people might make on her internal experience.

In keeping with the innovative moments theory advanced by Miguel Gonçalves, António Ribeiro, and colleagues (see section 1.3.2), clients' comments on change can be seen to take the form as either observations about change *process*, or making a *contrast* with how things were before. This is seen for example in *Michael's* comments on change in the mini-study in 4.3. We do also see Jennifer commenting on change process in section 5.4 she talks about pre-empting a need to put boundaries on how much she will volunteer for, and observing that 'in time I won't even need to do that'.

8.1.4 What particular aspects of my therapeutic approach appear to support observed change processes?

There are a few particular therapist behaviours or interventions that I have evidenced as supportive of observed change processes. For example in the mini-study in section 4.3 I identify some of the ways I help to draw client's attention towards innovative moments, channel attention energy to these through vocalisation, and offering a language to describe them.

In addition to these I have helped clients to develop their understandings of cognitions and behaviours associated with their I-positions. For example in section 4.1 when *Lou* is talking about not pretending conflict with a friend had never happened I remind her that this is what the Peacemaker would have done. Likewise in section 4.2 I offer to *Michael* that part of his motivation for concealing his disability is that he wants to "pass as normal" which he endorses.

In keeping with the earlier observation that change was performed in the client's relational worlds outside of therapy, it is also true to observe that work with each of the four clients involved analysis of particular relational situations, and identification of problematic patterns of relation within them. For example in 5.5.2 where *Myrtle* and I are exploring the particular experience of her arriving to visit her Mum including exploring her somatic experience.

There are also frequent examples of where I implicitly model a sense of therapeutic purposefulness and directionality in my responses to my clients which is as a consequence of holding a coherent model of change (which might be imagined as a road map) as we were working together. For example in section 4.2 where I speak of Michael shifting into a different role, and in section 6.6 where I observe with Lou that she had made 'a step forward, so there is something here'. Similarly in section 6.7.3 when in working with Jennifer in the transcript I observe 'Yes. Yes. So there's a tentative... hopefulness' there is the implicit expectation that hopefulness is our direction of travel. Additionally where in transcript I am whispering my approval of Lou's introduction of the swimming motif – as something sacred and special - I am encouraging productiveness in the direction of richer fantasising, developing the imagery further. These observations should be considered alongside the observations in section 4.3 that I on occasion alienated Michael by challenging his ambivalence. In other words a sense of directionality may be helpful and appropriate when the client already has a sense that they are making progress but is less helpful when the client needs to explore their ambivalent feelings. I am mindful of Cooper's (2019a) observation that it is part of a therapist's responsibility to ensure that they and their client continue to move in the same direction – if the client changes course then the therapist must move with them.

8.1.5 What qualities of the therapeutic relationship are facilitative of change?

Chapter seven offers the most evidence and commentary on qualities of the therapeutic relationship per se. The dynamic that I identify in working with *Lou* in which she treats counselling to some degree like a 'confessional' (section 7.3) I believe to relate to a more universal dynamic within the therapeutic relationship which is the extent to which clients feel they can disclose material associated with discomfort, fear or shame. The most powerful moment in therapeutic work with *Myrtle* was when I was able to bear witness to her vulnerability (see sections 5.5.2 and 6.7.3).

As previously observed, the therapeutic relationship may have modelled alternative styles of relation for the four participants. This is evidenced for example in working with Lou (section 7.3) in which achieving a state of flowingness with me appears to have preceded Lou gaining confidence in situations which she had traditionally struggled with social anxiety. (However it is much harder to make a causal link between those two experiences). I also observed how in section 7.4 as throughout my reporting of the work with *Michael* how his ability to trust me and feel safe with me so far as having his disability seen may well have facilitated the development of the compassionate paternal 'inner being' voice he reports.

Identifying – to some extent – with a pluralistic approach to practice, there are examples across the four cases of a collaborative approach to designing therapy, not least client's identifying their goals, having therapy targeted towards these goals and checking in on these in the review sessions. Sections 3.2 and 7.4 document the collaborative nature of work between Michael and I in which I present our meeting as at first a compromise between and then increasingly a synthesis between my 'narrative-dialogical' approach and his desire for a more mechanistic, skills-based approach.

This latter observation also indicates the co-creativity which was at work in the work with Michael as is evidenced by the characterisations of I-positions and the development of cognitive maps with each of the four participants. I observe in section 4.2 how Michael's early presentations put me in mind of an LS Lowry painting which gave me a vivid and fantastical insight into Michael's 'keeping my head down' I-position. Michael goes on to generate a series of motifs which appear to directly borrow structures that I have modelled in the work, for example the 'two shoulders' – which may be considered to be Michael's innate sensibility of the ambivalence between dominant and alternative self-narratives, and the 'inner being' voice, reflecting my own modelling of the development of alternative I-positions (see section 4.3.3).

8.2. The best synthesis

From offering answers to each of the formal questions explicitly identified in the Introduction, I will now in this chapter go on to offer my best theoretical synthesis and thus my best answer to those seminal questions which were a constancy throughout my project and which were

succinctly put. As a practitioner working with clients who presented with embodied distress, I wanted to know:

What does change look like? And how is change facilitated?

The best and most integrated answer that emerges from this thesis is that change is realised through the client discovering cognitive maps and performing behaviours which are aligned with the internal logic of these cognitive maps. These maps may be only subtly indicated which is why the sensitivity of the therapist to underlying patterns can be facilitative. By learning to map existing cognitions and behaviours the client acquires, perhaps for the first time, the ability to stand apart from their problematic patterns of relation and to realise they are not fated to play them out. They then have the opportunity to discover and develop new maps around which to arrange their thoughts and behaviours in the relevant context. Here too a therapist's sensitivity to the indications of alternative maps – which might come in the form of innovative moments or alternative self-narratives – can be facilitative in helping the client find a new foothold. I will now go on in the coming section to identify three states of change which are congruent with this emergent thesis, that the client may be observed to occupy and which, as evidenced through chapters four to seven, are associated with desired therapeutic outcomes.

8.3 A three state model of change

In the analytic chapters I applied four templates of change to the data in order to draw out different inferences. It may be considered that the third template, in which the client develops their own cognitive maps, was a natural development of the first template, in which the client migrates from a dominant I-position to an alternative I-position. Likewise the fourth template – which considers the dialogical influence of the therapeutic relationship – may be considered to build upon the longitudinal stage or state based concepts considered in the second template, in that the client's motivation is observed to fluctuate and the therapist is charged with responding consciously to these changes in motivation. Throughout the second half of 2018 my interest and engagement in longitudinal concepts of change surged, but what emerged from that period and informed my clinical working was a preference for state-based as opposed to stage-based concepts of change. In relating this emergent thesis more directly to the drivers or mechanisms of change within the therapeutic process, a *three state model* thus emerges. The three states represent syntheses of ideas metabolised in previous chapters and may be referred to in the

shorthand as: identification, bridging, and mapping, as will be explained below. There is no necessary sequential relationship between the states, as there would be in a stage-based model. Rather, these three states could be and were realised simultaneously and at varying degrees of depth in driving the therapeutic changes observed in this study. These may therefore be represented graphically thus:

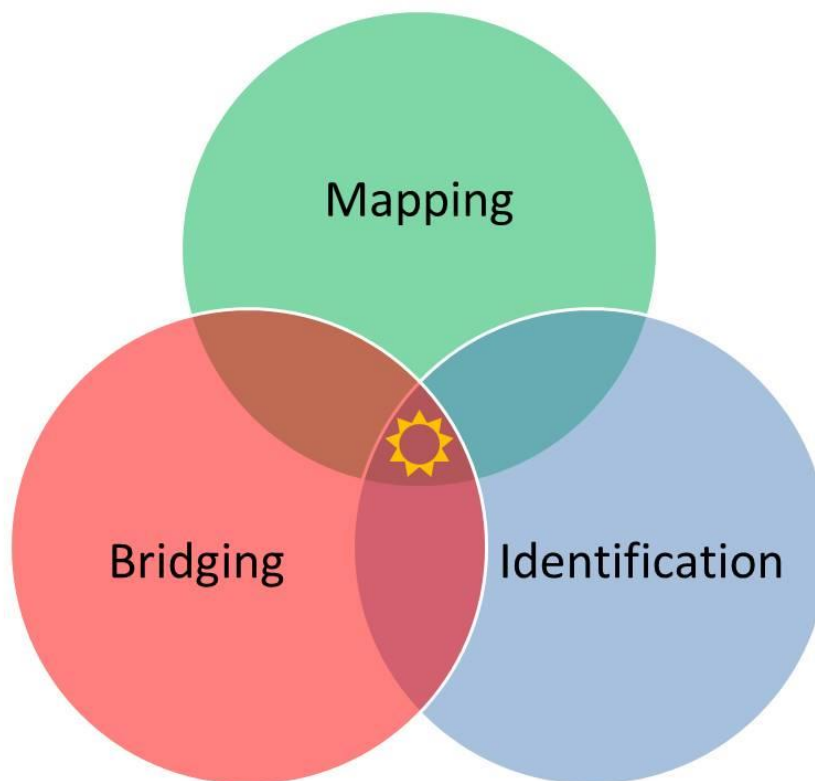


Figure 19: A three state model of change

The sun symbol at the centre represents change in the quality of the person's psychosomatic and psychosocial experience. The development of each of these states also supports the (further) development of the other two, hence the overlapping nature of the Venn diagram. None of these states is a singular event, although at times they may be experienced as moments of epiphany or watershed moments by the client and the therapist. Identification, for example, which as we will see is the state of a person coming to understand and take ownership of their own role within problematic patterns of relation, is something that can occur frequently throughout therapy, or indeed outside of therapy. With each new instance of identification the

person may gain a deeper, more contextualised understanding of those patterns of relation, which may in turn be supported by the development of a richer, more contextualised cognitive map. Therefore, with some imagination, one might imagine this diagram emerging from the page and taking on a three-dimensional shape. The deeper (or higher) the person realises these different psychological states the greater the capacity for change in psychosomatic and psychosocial experience. I will now explain these three states in turn:

8.3.1 Identification

I introduced the phenomenon that I am describing as ‘Identification’ first in chapter five. This concept first began to become meaningful for me in the middle of the data collection window. Identification as I understand it is the client developing understanding and taking ownership of the part that they are playing within the patterns of relation that are associated with the

aggravation of somatic symptoms. We saw it for example in the case of *Lou*, who was able to identify her role within interpersonal dynamics involving first her husband, and then her Mum and her sister, in which she had to play Peacemaker. We saw how Lou became so distressed in those situations where



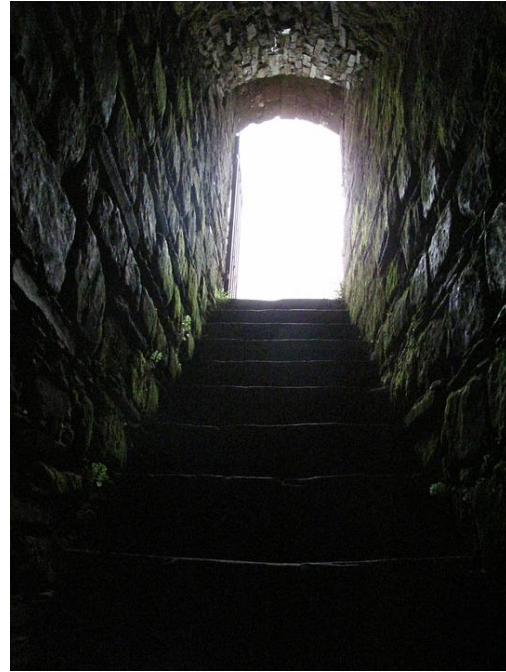
she attempted to assert herself that she would have a panic attack and would vomit. Without Lou being able to pinpoint what her part was within those interpersonal dramas she may have been left mystified by her affective experience, and indeed her embodied expressions. We saw this also in the work with *Michael*, who had to first take ownership of a fear of having his disability being seen before he could entertain an alternative strategy from his lifelong approach of concealment and trying to ‘pass’ as ‘normal’. To apply the cartographic metaphor, identification is the state of the person looking down upon whatever rudimentary map they have of the relational situation and within that symbolic topography place their finger and say: “this is me, this is where I am”. Implicit in Identification is a perhaps newly-discovered sense of agency. If the client can reach a point of understanding that life isn’t just happening to them but rather than their attitudes, words, behaviours etc. have influenced unfolding events then it follows that they have some agency to influence those unfolding events differently.

Identification is not a binary position of either the client does or does not identify, rather a client will only be able to realise agency and effect change *to the extent* that they identify their own part within those relational dynamics. When a client is able to consciously take ownership of their part within a pattern of relation they are able to realise the condition described in Acceptance and Commitment Therapy as defusion (Hayes and Lillis, 2012). To 'de-fuse' is to stand apart from the patterns of relation that one has been playing out repeatedly and unquestioningly. When one is able to defuse from these dynamics they discover that they are not fated to play them out forevermore but that other cognitive and behavioural strategies are available to them.

Identification might involve therapeutic working with a husband who finds himself embroiled in explosive rows with his spouse – these escalations might feel to be mystifying in the way they unravel, or they might even be seen as all down to the other partner: they can't control their anger, they are being completely unreasonable etc. Identification may be facilitated by replaying such a row in slow-motion, recognising not just what was said or what was done, but moreover what was *communicated* and thus creating opportunities for the husband to recognise his own part. Alternatively we might imagine working with a mother who gets so frustrated by what she sees as her partner's laissez-faire approach to bringing up the children. With some sustained reflection on why it is important to her to have such a regimented approach to parenting she may come to identify her own need for more consistency and structure in contrast to the chaotic and neglectful childhood environment she grew up in. Note how the distress indicated in these examples might have an embodied component but that identification may be considered an important state of change in working with 'non-somatising' clients too.

8.3.2 Bridging

Whereas identification might be a process considered mainly to happen in the therapeutic hour, or where a person has some space to reflect and take stock, bridging as I understand it is a process that happens in the ‘real-time’ of our day-to-day living, especially those key relational situations that might have come to be associated with embodied distress. We saw examples of bridging where *Michael* was able to realise his behavioural exposures in real time, for example taking the cup of tea from his customer, shaking a little bit, but learning that that was ok, or simply taking a moment in a busy social environment to



watch other people and to discover that they weren’t all watching and scrutinising him. We also saw examples of bridging in the work with *Lou*, for example the way she was able to extricate herself from the social media group chat; and where *Myrtle* was able to sit back in her chair: “not playing the game”. What I understand then by bridging is that it describes moments of lucidity, where the client is ‘primed’ through therapeutic reflection to recognise ‘this is one of those moments that we’ve been talking about in therapy’. In that moment where the client recognises the significance of a here and now situation they may then realise an opportunity to do something differently – this may have been planned out in advance, for example where *Michael* and I created the hierarchy of exposure, or may occur spontaneously, such as in the actions *Lou* took. I earlier described the bridge as somewhat like the stairwell joining one floor of a high-rise building to another. In other words, the client doesn’t need to already hold the whole map in their hands in order to cross the bridge. Indeed in performing lucidly in some key here and now moment, they may only come to map the experience retrospectively: this is how it happened, this is how I felt, and this is what I learn.

We might also encounter bridges in the therapy room – for example where *Michael* was able to introduce the dialectic of the “two shoulders” he introduced a motif that would enable us to make excursions into alternative frames of reference, for example into the later development of *Michael*’s “inner being”. Where *Myrtle* found herself, in her first sessions, in floods of tears as a consequence of having her pain witnessed by me, this might also have been considered a

bridging event. In that intense emotion Myrtle had momentarily stepped outside of her normal pattern of relation, of shouldering heavy and endless guilt, and to locate compassion for herself. The sense she would make of that experience came retrospectively; in the two weeks following that session during which she went on holiday.

Therefore whilst identification is a reflective process, bridging is a more active and emergent process, and its effects and directions are less predictable. In reference to existing theory, bridging events are the true 'innovative moments' as these are the moments where the client makes contact with an alternative version of self and world; the first glimpses into a different way of being.

8.3.3 Mapping

In chapter six I drew on each of the four cases in demonstrating how I understood cognitive mapping to have worked for each of my four clients, indeed how these emergent cognitive maps became the platforms of therapeutic change as they experienced it. Cognitive mapping is the process of going beyond reflection on innovative moments – as with bridging - or indeed taking responsibility for our role within problematic patterns of relation – as with identification – in discovering and developing new contextual frames of reference in which to make sense of our experience and organise our behaviours. As observed in chapter six, cognitive maps have a function and that function is to enable us as human beings to successfully navigate through the real world towards our highest goals, values, or directions. Clearly not all cognitive maps are equal, and the story of each of the four cases described in this thesis might be conceptualised as the story of how a person was able to appreciate the limitations of one map and replace this with another map that was 'better', 'higher', more life-affirming, or liberating. As previously observed, the theoretical benchmark which discerns which maps are 'higher' than others is functionality – how well do these maps enable us to realise our higher directions in life?

The actual process of mapping is a reflective rather than an active process. Mapping may begin from the very first session as clients reflect on their experiences with their therapists. My approach during the period of data collection was broadly described as 'narrative-dialogical' – enquiring as to what were the meanings and contextual significances of these experiences, could the client name them, and who was the client – what version of themselves were they performing - in those moments? As we develop our cognitive maps either through therapy, or

through ordinary reflection on our experiences, we go back out into the world with more sharply defined, more functional internal maps of self, others and world. These maps reside in what Freud might have called pre-conscious: we don't need to recall how we tie our shoelaces during the actual event of tying them, but if asked to we could talk through the steps we take. In a recent paper by a Dutch clinical psychologist, Arntz (2019) offered a new theoretical account of desensitisation as understood in cognitive behavioural treatments for experience avoidance. An example of experience avoidance might be that of a child avoiding school following an accident in which they hadn't got to the toilet in time. They avoid school because they associate school with that event and in a relatively primitive coping strategy, avoiding the scene of the original event would mean not putting themselves in the same vulnerable position again. Arntz argues that exposure to previously avoided experiences does not somehow purge the original memory to which the person has become highly sensitised. Rather, each exposure enables the person to build more contextual information into the stored mental representation, thus they're able to appraise the situation more realistically; to be able to discern the true 'danger' if it is present. In the same way I believe cognitive mapping is the process by which we are enriching our internal representations of our selves and our worlds, through the layering of contextual information, to better appraise the situations we are trying to navigate through, and thus to derive a higher degree of *subjective competence* in those situations. To return back to the cartographic metaphor I'm thinking about the way human civilisations' maps of the world developed through the centuries – with each new circumnavigation more information was added to existing maps, so that they better represented reality and were more functional.



Figure 20: Three representations of the British Isles. From left to right, maps produced by: Martin Waldseemüller (16th century), John Speed (17th century), and James Wyld (19th century)

In a cognitive mapping approach the therapist practises a certain form of active listening. They are listening out and highlighting for the client those indications of where and how they appear to be constructing their maps. Clients may be coming into awareness for the first time of the maps – those platforms of meaning – that are presently organising their cognitions and behaviours. They may also locate the genesis of these maps – at what age, and in what relational drama, did these maps first originate? The therapist’s own curiosity may shed a spotlight in these directions and thus encourage development.

Likewise the therapist is listening out for those innovative moments where clients appear to be doing something not anticipated by a dominant self-narrative: by highlighting these and encouraging reflection clients may then go on to develop new maps in which their cognitions and behaviours are organised differently. Throughout this process the therapist is offering their own intuitions about the patterns that appear to be emerging, for the client to take up or reject as they see fit. As observed in the first mini-study in which I considered my responses to innovative moments in the work with *Michael*, there is theoretical overlap here with the therapeutic approach described as ‘thickening’ in narrative therapy (White, 2007). I observed how my responses included explicitly observing the novelty of something Michael had just told me, offering Michael some new language with which to understand the innovation, framing that innovation as part of a change process, and other techniques to draw attentional energy to it including offering my own take on what these different positions might sound like and asking Michael if he could describe their different tones. Furthermore the therapist may notice areas

where clients seem not to be doing any processing such as Michael not bringing his own feelings of shame into direct consideration in our work. Here too a therapist can highlight the absence of processing and offer to direct the spotlight onto those areas.

As an extension of the person-centred ethos which has been at the heart of my work since training, the client in this frame of reference is the cartographer. What this means is that it is not the job of the therapist to construct the map for the client, but rather to take the meta-perspective of observing what maps the client appears to be constructing for themselves. Observations of this sort can help to crystallise and make tangible thoughts which for the client might have only been on the cusp of their awareness. In this frame of reference the client is journeying, and the therapist is the fellow traveller. Nonetheless, as the therapist, our client 'peers into our soul' to learn how we ourselves solve our problems. Each time we offer our reflections and intuitions we are modelling for our client different styles of cognition. This is of a level of subtlety beneath the frameworks of meaning offered through different therapeutic modalities. It is about the personhood that we as therapists bring. The Boston Change Process Study Group (2010) wrote about the lasting 'signature' of a therapist's personhood that remains with the client beyond their time together and I believe they are describing the same phenomenon. It follows that the journeys we therapists continue on in our own lives benefit our clients implicitly as we continue to be cartographers ourselves – the processing is always in parallel.

8.4 Threshold states

In recognising that the three-state model above is three-dimensional in nature, two other therapeutic conditions might be identified that determine the depth to which cognitive mapping is able to take place, or indeed whether any therapeutic progress is possible. I have described these as 'threshold states' because they appear to be barriers that the client and therapist need to pass through in order to deepen the agenda and realise change.

8.4.1 Appreciation of symptoms as signposts

What might have been noticeable in the thesis as described so far in this chapter is that the account of change may be applicable in a transdiagnostic fashion, and more particularly across both 'somatising' clients and those for whom their embodied experience isn't problematised. It may actually be impossible to discern in therapeutic reality which of our clients might be considered somatising and which not. For the purposes of this project I recruited clients to the study where they complained of somatic symptoms in either their assessment or first session, but in the reality of therapeutic practice our clients might present with embodied distress at any point along their therapy journey. Furthermore, and as observed in chapter one, the lines between which symptoms might be considered 'organic' and which 'medically unexplained' are becoming increasingly blurred. From neuropsychology a unifying concept of 'functional overlay' accounts for the myriad ways in which *all* somatic sensations are modulated through their processing in the central nervous system, and thus that organic sensations may become symptomatic, or more distressful or debilitating than they ought to be (Bromberg, 1979; Wilson, 2019).

What is implicit in this thesis is that my baseline attitude towards somatic symptoms or embodied expressions of distress, is the same as it was at the beginning of my PhD journey. Symptoms are signposts. Whether a condition is tangibly organic and can be traced to a physiological cause, or whether its character is of a *medically unexplained* quality, the interest of the physician or the psychotherapist is in the underlying context in which a symptom emerges or is aggravated. Where we are talking about physical symptoms that can be discerned to flare up in specific psychosocial contexts then the somatic is bound up in the psychological, and as Winnicott (1966) observed, there is pathology in the loss of association between these two planes of experience.

The client does not need to 'come round' to a psychosomatic interpretation of their own embodied experience in order that we may do some meaningful therapeutic work. Rather, whatever aetiology the client ascribes to their symptoms, we might consider a threshold state in which the client is able to reflect upon the meanings that they map onto their somatic symptoms, for example that one is cast into a 'sick role' as described by Allen and Woolfolk (2006). Alternatively the threshold state may be realised when the client is prepared to reflect on those situations in which those symptoms are aggravated, if indeed there is such a context-sensitivity. I therefore describe this as a threshold state because once realised, the attention of

the client and the therapist shifts away from embodied experience per se and towards the intersubjective contexts in which embodied experience takes on meaning.

In practice treating symptoms as signposts means that the interest of the therapist is in the patterned incidence of somatic symptoms – their embeddedness within psychosocial contexts – or if such patterns are not discernible, then their impacts upon a person’s sense of self and their relationships with others. In the early stages of therapy this might involve the client keeping a symptom diary in which to record flare-ups – what was happening at the time, who was there, co-occurring thoughts, feelings etc. however these diaries did not come into play in the four cases described here. Whilst some fantasising about the intrinsic meaning of somatic symptoms may be transiently useful, the therapist is seeking to engage on the level of those revealed psychosocial contexts.

8.4.2 Transference

There is an additional dimension to this concept of threshold states as observed in chapter seven and the application of the fourth template to analysis. Whilst transferences have manifested differently with each of the four participants, one dynamic seems to have been particularly important in considering the nature of change. I observed with particular reference to *Lou* that at times it was as though she was using counselling like it was a Catholic confessional, and indeed had experienced relief being able to confess her ‘sins’ to me. However in other contexts – most notably working with *Michael* – things were clearly left unsaid. I have considered with Michael that he sought almost a ‘physiotherapist of the mind’ who would work on the problem itself rather than delving deeper. The dynamic that thus emerges is a question of the extent to which the implicit becomes explicit - or even that the unconscious becomes conscious - and this is something that is determined by the quality of the therapeutic relationship. It may be centred upon implicit questions such as ‘how much can I trust this person?’ However as discussed in chapter seven, it is highly idiosyncratic to the client.

The implicit map a client takes into and establishes in therapy determines how they will use their therapy, how they will relate to the therapist, and the meaning the therapy will have within the greater fabric of their life. Each client thus derived benefit from the therapeutic relationship *on a level*, but these therapeutic styles may actually become barriers to doing work on deeper

levels e.g. with content that includes more shame, more pain, or more vulnerability. Whilst the story of the present research is not of sea changes in any of the therapeutic relationships described, it is possible that identification of these styles of working – bringing into conscious awareness *how* the client is using their therapy – may offer opportunities to drop down levels and to do that deeper work.

Yalom (1980) once described a therapeutic oscillation in his own clinical process between rich passages in which he and his client are talking about something, followed by reflections on what it was like to talk about that. I envisage a similar oscillation here. As well as helping the client to make explicit the maps that they are constructing of their relational worlds ‘out there’, I propose that the therapeutic work could be enhanced by also helping the client to understand how they are using the therapy i.e. the map that organises their performances in the therapy sessions. This meta-position is not evidenced positively in the present study – as it was barely on the cusp of my awareness during data collection - and yet as suggested in chapters seven and eight the influence over how a client uses therapy appears to have determined the depth of the work possible.

Being explicit about these maps of the therapeutic process I propose can bolster the positive influences of the therapy – if I am aware of how the client is using the therapy well I can help to maximise those benefits. However this may also be particularly relevant if the performance in session is preventing us from dropping down a level. It may also be the case that different phases of the work are marked by differences in how the client is using the therapy.

8.5 Discussing these findings in relation to existing evidence and theories of change

In chapter one I reviewed existing case study and other qualitative evidence from which I discerned four general mechanisms of change that appear to have been at work for participants who had been able to achieve subjective relief and in some cases recovery from somatic conditions across a variety of therapeutic settings. It is thus appropriate here to consider the findings of my study in comparison with those existing studies and the mechanisms advanced through them. To what extent are the mechanisms evidenced and supported, or otherwise, by my own four studies?

First mechanism observed across previous studies: *Developing competence in symptom management - deepening understanding of somatic experience, and development of techniques, associated with less fear and reactivity to symptom flare-ups*

As discussed in chapter one, Doran (2014) observed that ‘embodied awareness’ was the core theme in her observations of successful therapeutic work with a group of people living with back pain. The development of an enhanced somatic or embodied awareness appears to be under-emphasised across the four cases here studied. We do see evidence in the case of *Myrtle* that she came to understand and appreciate her embodied experience better – in section 6.5 I have included passages of speech in which Myrtle reflects on the difference between her actual physical capabilities and the capabilities she perceives. However it may be observed that Myrtle learned that she couldn’t always trust the signals she was receiving about the weakness in her muscles, as I observed, it appears almost contrary to the conventional wisdom that she would need to learn to listen to her body. Doran (2014) found that within her participants the idea of ‘pushing on through’ pain was problematic and associated with poorer outcomes. However Myrtle’s rejection of the bank account method (see section 6.5) and regard for pain as a ‘price worth paying’ to continue doing the things that she loved also appear to contradict Doran’s observations. What is necessary to observe is that unlike the people living with chronic pain in Doran’s study, Myrtle did not experience any relief from her fibromyalgia pain per se, rather what improvement Myrtle did experience was functional, as evidenced in 6.5. As previously observed in chapter six, *Jennifer*, in contradiction to Myrtle, did learn to respond more effectively to her chronic fatigue symptoms and rest – learning that time spent resting was not wasted time but was health promoting. Jennifer’s experience more closely reflects those of Doran’s participants who spoke of the importance of breaking the vicious cycle of their symptoms by giving them space. In reality therefore the phrasing I have used about ‘developing competence in symptom management’ may mean very different things to different clients.

In the case of *Michael* we observed how an exposure technique in which Michael would deliberately choose to have his spasms and tremors observed by others, was not only successful but led to transformations in how Michael viewed himself and the world he inhabited. Similar exposure techniques were advocated in studies by Allen & Woolfolk (2006), Colognori et al. (2014), and Okita et al. (2013) and are thus positively evidenced in the case of Michael.

However the direct association between emotional expression and symptom relief, was not positively evidenced in this study as it was in the Cooper et al. (2014) study of successful therapy with medically unexplained symptom presentations. *Lou* was frequently emotional in our

sessions but these expressions were not in any way associated with improvements (or otherwise) in the feelings of exhaustion she reported, which she would credit much more confidently to relational competence acquired during our time. Likewise *Myrtle's* emotional expression in the first session we understood as a 'crystallisation of discontent' and the subsequent reflective work and behavioural planning was at least as important in managing subsequent affect.

This could be because these mechanisms were under-emphasised in the framework for practice I took into the data collection window, that I subsequently 'steered' the work away from these domains in my capacity as therapist. Or it could be that the mechanisms associated with change in my four cases and earlier studies are not the 'true' underlying mechanisms, which have been missed in the reporting of a more superficial mechanism.

Second mechanism observed across previous studies: *Psychosocial linking – clients learning to link their somatic experience within wider psychosocial contexts, either in present relational systems, or to associate them with historical traumas*

In the review I observed that Abbass (2005) had described therapeutic working in which he'd been able to help clients to associate symptom flare-ups with psychosocial context in the real-time of therapeutic process e.g. by observing what they were talking about when a symptom flared up. This process-based approach is not well evidenced in the present study. *Michael* did present with tremoring in session which provided us with the opportunity to reflect on the relational significance of the flare-up. He confirmed that he was comfortable with me, not troubled for me to see it and so the tremors were not aggravated as they might have been in an extra-therapeutic setting. Likewise in section 5.5.2 I include some dialogue which examples the situational work I did with *Myrtle* helping her to identify her somatic experience during those highly emotionally-charged visits to her mother. As previously observed however, what is distinctive about the four clients I worked with in this study is that they all arrived open to the idea of a psychological context to their symptom experience.

There was however an epiphany for *Lou* in ordinary therapeutic conversation when she discovered links between the waves of exhaustion she was living with and the exhaustion she would feel as a consequence of becoming entangled in the drama triangle with her mother and sister. This event in my study reflects similar linkages made by clients in earlier studies: In Kozłowska et al. (2016), Dimaggio et al. (2013) and in Quinn et al. (2012). Likewise during his

therapy *Michael* came to embrace the idea that his fear of having his disability being seen by others was exacerbating his cerebral palsy symptoms. The link to psychosocial context was less an epiphany moment and more about a gradual reframing of the meaning of his symptoms during our sessions.

Third mechanism observed across previous studies: *Developing relational competence and/or the capacity to mentalize, which in some cases resulted in changes within a relational system to which the person belonged*

In the review I found that Allen and Woolfolk (2006) endorsed the client learning to make 'I statements' which they associated with various benefits including increasing relational competence through assertiveness, and the client being able to take ownership of their own subjective position in an exchange meaning they were less likely to be repudiated by a significant other. This mechanism was positively evidenced in the work with *Lou*, for whom asserting her own position was deeply distressing at the beginning of her therapy but which she became increasingly competent and confident with during our time together. *Lou* also benefited from not being repudiated by her husband when she spoke from her own experience, as anticipated by Allen and Woolfolk. When *Lou* and her husband were reconciled after their separation her husband conceded that he had been controlling and agreed to give her some more space – this was a significant breakthrough for them in their relationship.

Additionally, in the case studies of Theodoratou-Bekou et al. (2012) and the study of Sara in Colognori et al. (2014), the client's developing relational competence was associated with wider change in the relational system – in the client's significant others. Systemic change was evidenced in the case of *Lou*, for example in the resolutions that she and her husband made and which she benefited from for the remainder of our sessions together, and the subsequent change in her relationships with her mother and her sister following her withdrawal from the drama triangle. Likewise in section 6.7.3 I have included evidence that other people experienced *Jennifer's* improving mental health and therefore the way she was relating to those others, including her daughters.

Michael endorsed better assertiveness, within positively and enthusiastically embracing a self-concept of 'openness' in how he would relate to others however it is difficult to evidence how others experienced and responded to this new approach, for example his wife, or his work colleagues, from the contents of our sessions.

Fourth mechanism observed across previous studies: *Transcending physical experience through the discovery of higher meanings or purpose*

In the Kornelsen et al. (2015) ethnographic study of people living with medically unexplained symptoms, a subtle but important distinction offered was that between states of resignation and states of acceptance (e.g. of chronic symptoms). This distinction is important from a psychotherapeutic perspective – it is the difference between a client feeling ‘defeated’ by their symptoms, or feeling as though there are positive steps they can take even in chronic reality of their condition. Not one of the four participant clients of the present study may be observed express resignation about their conditions, whether we are talking explicitly about somatic symptoms or more generally around mental health and relationships. Even in the case of *Myrtle*, who described working with her fibromyalgia symptoms as tantamount to ‘flogging a dead horse’ in the subtext to this discussion is a positive ambition to continue to do the things she loves doing despite her condition. As such acceptance of chronic symptoms, as framed by Kornelsen et al. appears to have been implicitly present in the work with each of the four participant clients.

In the review I observed how Liersch and Maher-Edwards (2017) wrote about the choice that clients have as to the kind of sick person they will be. We see this in the case of *Myrtle* who positively chose to go dancing even though she would pay for it with greater pain the next day, and in the case of *Jennifer* who chose positively to rest in managing her chronic fatigue and not to see this as wasted time. Likewise *Michael* made a positive choice during our time together to practise openness, which extended beyond the literal meaning of having his arm seen, in contradiction to his originally preferred strategy of concealment.

By a similar token, we may again invoke the Doran (2014) study, and in particular her concept of the ‘resolution of liminality’ through which the person discovers something through therapy which permits them to become unstuck. We saw this positively evidenced in *Michael*’s embracing of openness as an innovative strategy, and also where *Myrtle* declares: ‘*there are things I can’t do... but you know what, there are things I can do*’. *Jennifer* was able to realise a degree of freedom through her transformative re-interpretation of the hand in the bucket of water motif which I had expressed curiosity about when she introduced it into our second session.

As previously observed, I do not believe *Lou* broke through into a higher, and transcendent purpose, rather that the relief and recovery from her somatic symptoms was primarily associated with her improving relational competence and thus reduction in anxiety. My feeling as her therapist is that Lou's conception of the 'fire in my belly' was a transitional state, rather than a full expression of the kind of value-driven life that Lou would like to have. Perhaps if our work had continued beyond the 30 sessions, Lou may have discovered a more enriching cognitive map in which her highest values or directions were embedded. Perhaps, indeed, she has discovered this in the period since her therapy. In a similar way, and as previously observed, Lou did not successfully 'resolve' the drama triangle by transitioning to modelling a healthier role within it, but rather learned to simply withdraw. This strategy too might be considered to have been a transitional strategy rather than a final destination.

What must be observed then is that the thesis advanced here, of cognitive mapping as providing the basis for therapeutic change in psychotherapy with embodied distress presentations, should be regarded as a more integrated synthesis of ideas about change as I have reviewed them here. However I consider my thesis to be supplementary in nature to the wider body of literature already in existence which points to sister concepts mentalization and metacognition as the universal mechanisms of change in psychotherapy, as I explored in chapter one. In a hierarchy of mechanisms then, metacognition and/or mentalization sit at the highest point, whereas the mechanisms I advance are on a supplementary level. My thesis as such makes a contribution to a much greater dialogue about change in psychotherapy, rather than offering a comprehensive or universal theory in and of itself. Whilst my contemporaries may recognise examples of what I have described in my thesis as identification, bridging and mapping in their own practices, they may also perceive mechanisms of change which are not adequately captured by these three concepts. Likewise therapists from alternative traditions may continue to prefer ideas which centre upon the creation of illness narratives (Kirmayer et al., 2004; Launer, 2009), rescripting – to use the term from Transactional Analysis (Levin, 1998) – or the re-orientation of cognitions and behaviours around schemas (Young et al., 2003). Each of these concepts I believe is a mechanism on the same level as what I have called cognitive mapping – after the theoretical contribution of Tolman (1948) - and as such that there is much theoretical overlap between these. I envisage my contribution to a general dialogue on change in psychotherapy as looking something like this:

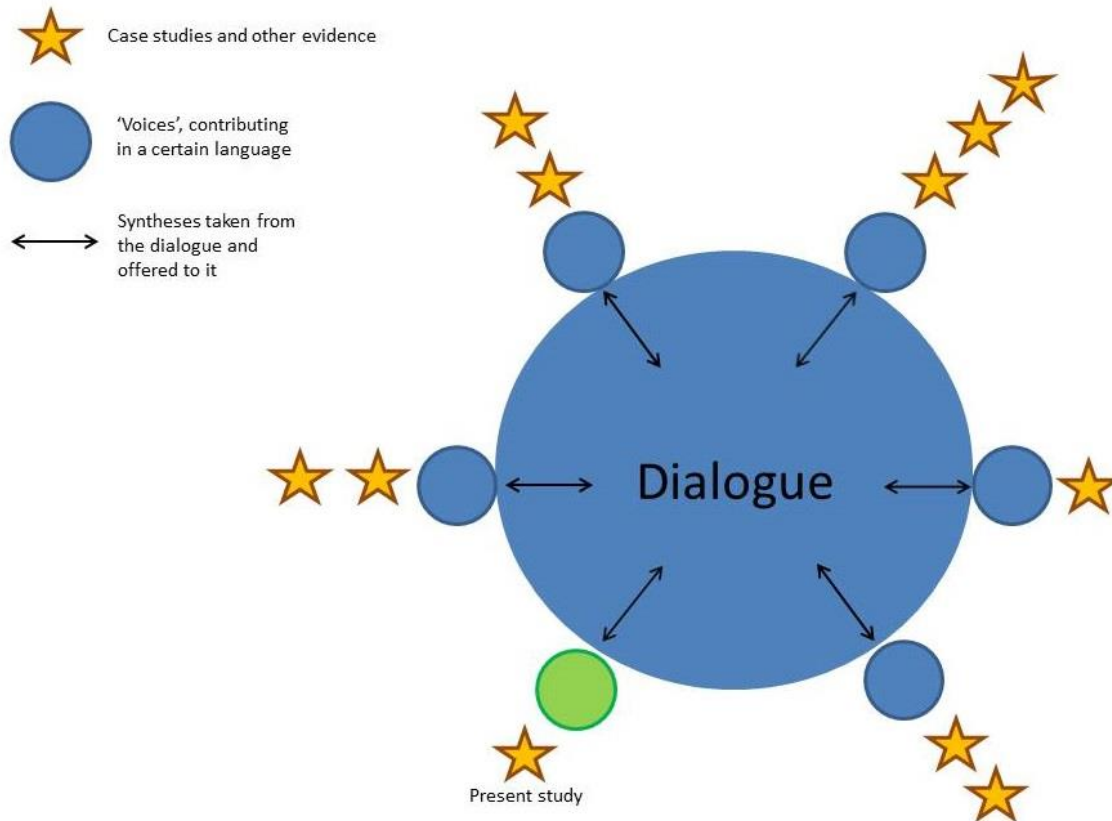


Figure 21: The different practitioner 'voices' contributing to the dialogue on psychotherapeutic change

The present thesis is represented by the green circle – and this thesis is communicated using a certain vocabulary; of identification, bridging and cognitive maps. Therapists and researchers using their own vocabularies contribute to the dialogue, which is understood and translatable between the participants. And as the dialogue evolves we will each draw out our own new theoretical syntheses, as supported by our case studies and other forms of evidence.

8.6 Antithesis

As observed in chapters one and two, the purpose of this thesis is not proof. There is no sense in which these theories could be proven on the basis of four case studies. Rather the thesis is advanced here as a set of hypotheses to be taken up by practitioners and practitioner researchers in application to their own clinical contexts; to consider how well they fit and/or how they might be developed further in those contexts. However, in my closing thoughts at the

end of chapter three I considered that the lingering presence of the otherwise invisible fifth participant within my thesis may leave it seeded with its own anti-thesis, delivered from just behind the curtain. Whilst I can no longer use data from the fifth disconfirmatory case, the event of their withdrawal had the effect of bringing that potential antithesis into sharper focus. Here then I will take some time to consider the nature of this antithesis.

Recognising that there were limitations in how far my clients were prepared to go, and thus that there were parts of their experience we did not manage to ‘touch’, also suggests at an antithesis present within my accounts of good therapeutic outcomes. Perhaps all good outcome therapies are pregnant with their own antithesis. Can any of us really say that we’ve already done all the ‘work’ of therapy that we need to do for one lifetime? It is realistic to expect that the closure of one therapeutic phase gives way to the next. Three of the four case studies included in this project were examples of brief therapy. In a different setting and context one therapeutic phase – with its own good outcomes – may well progress to the next, given a strong therapeutic alliance and enough awareness of the nature of the next frontier.

As observed in the previous section, in advocating a ‘state-based’ model of change I have identified two threshold states that I believe need to be realised before clients presenting with embodied distress can make meaningful therapeutic progress. However this begs the question: what if our clients don’t reach these threshold states? Are we wasting our time and theirs? In this thesis I have identified therapeutic strategies to help clients associate symptom flare-ups with patterns of relation, and each of the four participants who remained in this study responded well to these strategies. However I envisage good and meaningful work to be possible for clients who fiercely resist – and perhaps for sound reasons – psychological interpretations of their symptom experience. We may for example assist the client in growing their awareness of how their somatic experience influences their sense of self, identity, and relationships with others. Thus psychosocial context may be constructed without any argument about aetiology. Ultimately the threshold states I have described in this thesis are not black or white/on or off states. What I observe is that therapeutic progress can be made *to the extent that* my clients identify and take ownership of problematic patterns of relation. Rather than advocating a linear model of change, in which our clients pass through these thresholds into desired outcomes, a better representation is of a cyclical process in which conscious identification with problematic patterns of relation gives way to bridging events and evolutions in our cognitive maps which *in turn* may give way to further identification with subtler patterns of relation. I am mindful at this stage of a paper I read by psychoanalyst Karasu (1979) who

argued that in working with psychosomatic clients the first year of therapy may be typified by work negotiating the client's alexithymia – their inability to connect with or otherwise articulate their emotional experience. This first therapeutic year was thus to be spent working on illness beliefs and exposure-type exercises, before progressing to 'true' psychoanalysis beyond the first year.

However another antithesis might centre upon the responsibility I appear to be placing on the shoulders of my clients. Is it always up to our clients to take responsibility for problematic patterns and thus to be the agents of change? What about the hurtful and alienating behaviour of other people in their lives? What about the holes in our societal fabric through which many of our clients will fall? What about overwhelming, 'real' organic illnesses? In other words, what about all the factors that are beyond the control of our clients? What is suggested in this antithesis is the decentralisation of psychotherapy. The therapist is just one role-player in a wider circle of care which in an ideal circumstance contains the holistic needs of the client. Just because we offer psychotherapy does not mean that we should be blind to the social determinants of mental health, and may even mean that in addition to our everyday practice we should at times become active agents for societal change. However the client, the person, remains at the centre of their circle of care. In recognising the decentralisation of psychotherapy, nonetheless facilitating greater agency for the person, in whatever circumstances they are inhabiting, I believe to be a reasonable and beneficent aspiration for psychotherapy.

Recognising this, it is also true that I could have done more to facilitate the collaborative nature of the therapeutic work. Pluralistic approaches in which the client is actively involved in steering or designing their own therapy only came into my explicit awareness following the closure of the data collection period. There are some examples throughout the period of where I made suggestions to my clients about what we could do, and sought their views on what they wanted to try – this was especially the case in working with *Lou*. However these conversations tended to be reserved for the six-week review periods, and at the time of delivering the therapy I didn't initiate this kind of conversation in the first session. Likewise and as previously observed, if I was to undertake this study again I would ask my clients what they believed should have gone into the case report before I went away and wrote it. These approaches would have helped to foster a greater sense of client agency and may have led to better outcomes, possibly even for the fifth participant whose decision was to withdraw. Perhaps with a more refined approach to facilitating client agency my clients might have gained a greater degree of confidence to

progress into identification with deeper, or subtler patterns of relation than those we did successfully address.

A further potential antithesis stems from the possibility that by emphasising personal agency and responsibility my model of change is more applicable to clients who bring certain attachment styles. If we consider in Crittenden's dynamic maturational model (Landa and Duschinsky, 2013) that we each fall very generally on a continuum from Type A (anxious-avoidant), to Type B (securely attached), to Type C (anxious-ambivalent), it may be argued that my conception of change, which places identification and thus personal responsibility at its heart, is applicable to Type A and Type B clients but less applicable to Type C clients. What I believe is implicit and evidenced within this thesis is that the evolution of more adaptive cognitive maps has the effect of clients migrating into more open, and more interpersonal orientations. Whilst I've not considered attachment styles in this study, change for a Type A client according to my model may include the acquisition of Type B behaviours i.e. that a Type A client may move into a more securely attached space. A therapeutic framework centred upon personal agency may fit better in the experience of a Type A client for whom self-reliance is their ordinary inclination. It may fit less well with a Type C client whose needs have to be met by others. In her own clinical work with somatising children some exhibiting Type A and some Type C profiles, Kozłowska (2016) described her different therapeutic strategies. Type A children could be trusted to follow through on their therapeutic program, for example in doing their homeworks, and picking up the skills of affect regulation and reading their own somatic cues more effectively. By contrast Type C children required much closer supervision, training in interpersonal skills, and communication with their caregivers to ensure clearer, more consistent responses and expectations at home. In other words with the latter type, the emphasis shifted from the individual towards the individual within a family system. Whilst the clinical work described in this thesis was one-to-one work with adults, potentially for clients with Type C characteristics I could have employed some techniques and strategies associated with individual systemic therapy. However I do not believe work in this line would have radically altered the emergent shape of the models of change, which would have still been centred upon cognitive mapping. Indeed my work with *Lou*, and to a lesser extent with *Myrtle*, might be considered to be influenced by systemic theory. The threshold state of identification with problematic patterns of relation would still have been necessary but may have been achieved through a different route in which the client had an epiphany about the functioning of the family system as a whole and then worked backwards to discern their own part within that.

A further limitation to this thesis may simply be the limitations I brought into the clinical situations as a newly qualified therapist, still in the early stages of my own professional development. In this section I have identified some of the key limitations that come into my awareness now as a more developed and experienced therapist looking back upon that period. However I have no doubt missed essential subtleties in my own encounters and subsequent analyses that other therapists would have picked up on. The reality of producing a thesis in which my own subjective voice drives the theory development and thus what is communicated, is that this study is essentially non-replicable. If another therapist were to follow the same protocols described in chapter two, with the same original research questions, they would almost certainly arrive at different syntheses. However this may be said of all research in which case study is the unit of analysis: local contexts are highly determinant over the emerging theory, or perhaps which aspects of existing theory are highlighted within local contexts. What is advanced here is not a manualised concept of therapeutic change, but one possible synthesis; to be picked up and chewed over by fellow practitioners in application to their own practice experience and ways of thinking.

8.7 Seeing double

In his account of the *Wounded Healer*, Jungian therapist Sedgwick (1994) wrote of the client 'looking into the soul' of their therapist to learn from them how they worked through their own problems. If my journey during the year of data collection was around learning how to map, then implicitly I modelled this map-making process in application to my clients' own experience. This is what I have meant in reference to a 'thesis beneath a thesis'. I imagine the way that ocean currents – or even the currents in a river – at different depths flow at different speeds and at different temperatures. My own 'motion' might operate at a different depth to each of the four participants, and at a different speed, with different life travelling along those currents, but the basic motion is the same, and there is a transfer of energy – of heat and kinetic energy - between the currents.

What has emerged from the production of the autoethnography is that two versions of my self - and indeed two maps of the world inhabited by my self - appear to have jostled for the dominant place, such that in the narrative passages I appear to be seeing double, or rather

caught between two different lifeworlds. I consider for example the dream in which I'm blinded like a pit pony, or that I was caught between two epistemological positions; or that my first bereavement was a double bereavement, and that when I became a father I became a father of twins. This quality of seeing double is reproduced in the structure of the thesis itself – a multicase study and autoethnography operate as two parallel projects, with an exchange of information between them, bridged by the person of the researcher, as though donning two different costumes.

If I were to map these two parallel versions of self and world the following questions might help to illustrate some of their most fundamental qualities:

Could I identify a motif to serve as a 'shorthand' reference for those maps?

In what contexts are those maps functional?

What bridging events first permit me to make contact with these maps?

What are my compass points – my sense of directionality - in those maps?

How am I embodied in those maps?

What kind of researcher am I?

What kind of therapist am I?

And in what contexts does the functionality of those maps break down?

The first map is one that was dominant through my twenties when I first decided to train as a counsellor. It may be represented thus:

Can I identify a motif to serve as a 'shorthand' reference for this map? Flight. Of being able to fly anywhere I please.

In what context is this map functional? I am walking in the beech woods alongside the family farm. I am building a campfire. I know the names of all the constellations. I have a few friends that come to visit but mostly I'm on my own. I am meditating on the Tao Te Ching, impermanence, and the interdependence of all life. A bit like Thoreau by his pond (2008), I am scribbling down notes in my pad attempting to capture the profundity of the thoughts that I'm thinking.

What bridging event first permits me to make contact with this map? Aged 14 I discover a book that my Dad had bought called *Yoga Week by Week* (Yesudian, 1976) in which there are instructions on how to meditate, which I do and find very powerful. This is very impressive to me; that it is possible to transcend the current state of things.

What is my compass point – my sense of directionality - in this map? Towards 'communion with the cosmos' (but this cosmos is often a cold, impersonal and lonely place to inhabit).

How am I embodied in this map? I am somewhat disembodied; living in my head. However the pain in my jaw nags at me, a red raw feeling radiating through my face – undermining me. Likewise heart palpitations are frightening, and I can often believe they are a sign that I'm having a heart attack – my body could let me down and I could be 'pulled under' by it.

What kind of researcher am I? A subjectivist: truth is tested through first-hand experience. The view from the inside. Theoretically everything is to be related to the 'highest' principles: theories of everything, as modelled through Eastern schools of thought such as in Buddhism. However this constant reference to highest principles means that the form of those highest principles is consistently being challenged, meaning dramatic revolutions, and ideas being turned on their head.

What kind of therapist am I? I see counselling as a ritualistic process which enables healing and growth through symbolic quest. Because of the frequent theoretical transformations, the counselling process itself is unpredictable with different ideas being modelled week by week, leaving the client unsure about what work is being done.

In what context does the functionality of this map break down? During my counselling training. Fellow students are so much more articulate: so much more tuned in to the language of counselling, of therapeutic relationships, and attachment theory. I'm uncomfortable with the emphasis on the relationship. I am attracted to spiritual ideas and growth narratives and don't know what to do with this different framing, which leaves me nothing to get 'hold' of.

During my thirties a second map came into the ascendancy, which appears to have been driven by what I experienced as almost a primal motivation to become a Father-Provider. I never thought of my Dad as a Father Provider; he never took on such a serious role. He was instead a vulnerable, creative, comedic Dad. Dad was a pianist, but his hands were never pianists' hands – he lacked dexterity, and as such always played simplified, busker versions of the composers he

emulated. My own hands were similar and thus when I played live I always played rhythm guitar, never lead. I experienced my Dad as never having lived a conventional life and becoming self-sufficient, and I lived with a deep and continuous fear that because my father had never been able to realise that in himself, that I wouldn't either – it felt like some kind of fate. In my autoethnographic MA dissertation (Hills et al., 2018b) I described one particular scene from during that year, which was 2014, in which my wife had an ultrasound scan and our twins were revealed in the black and white images on the screen – our son and our daughter, healthy and growing. Stepping out from the scan excited and relieved, nonetheless I found my own pain flaring up and speculated at the time that now, having the luxury of knowing our twins were safe, other anxieties were activated: would I be able to provide for the family that was rapidly on the way? The following years, culminating in winning the scholarship in 2016, were driven by that serious Father Provider I-position and the emergence of the second map:

Can I identify a motif to serve as a 'shorthand' reference for this map? Paddling on a boat down a river, being buffeted against the banks.

In what context is this map functional? I am a new husband and father – and thus a man on a mission to be a breadwinner. The PhD is not an end in itself but a means to an end: a professional qualification which will advance my career. I have learned to 'play the game' – successful applications for research funding, BACP accreditation, and jobs. Locating my interests along a conventional academic pathway

What bridging event first permits me to make contact with this map? Being assured by Dawn – who is still my clinical supervisor at that time – that it isn't too late for me to do my PhD.

What is my compass point – my sense of directionality - in this map? Towards 'material dignity through creativity at work' (Being 'myself', being able to 'sell' my best qualities, within the social world)

How am I embodied in this map? Moving at a fast pace. Over-eating. Finding it difficult to wind down on a night-time. Over-frequent checking of phone, emails, social media etc. Flare-ups of jaw pain when I feel incompetent and lack the necessary skills, which will pass when I restore a sense of mastery. My body is there to serve me, like Frank's (1995) *disciplined body*, and if it breaks down I go to the doctor to get it repaired.

What kind of researcher am I? A change process researcher. I have found a scientific tradition that I belong to and can ally with. Established protocols can be followed to generate and test hypotheses about therapeutic change. My theories evolve incrementally with little or no reference to higher principles.

What kind of therapist am I? I have an explicit model of change which is continually being tested against new data. Because this model evolves incrementally the client experiences more continuity and purposefulness week by week. Because I hold a model of change the client implicitly understands that therapeutic change is our agenda – rather than other therapeutic ideals such as learning, catharsis, healing or resolution.

In what context does the functionality of this map break down? When my clients, colleagues, and loved ones need something else from me other than a drive towards progress and productivity. For example when the people around me need me to share an experience; when they need my time, and for that time to be intrinsically meaningful.

When I think about the dream of the driverless car that I woke from on the morning that Dad died, I think about fate. We were travelling together, but neither of us was behind the wheel. And for a time our fate was sealed – in the days and weeks following his death I grieved bitterly for the relationship that we would now never go on to have; that my feelings towards him in our final years together had been ambivalent, with adult love and gratitude tainted by child-like grievance and teenager-like embarrassment. I don't know if he would have grieved in a similar way if I had died and he had lived. However in the months following his death, finally listening to his Twins piece and coming through in my dreams, it became apparent that whilst we stood on either side of the curtain, nonetheless we were still communicating. After I had thrown myself into organising the funeral, delivering his eulogy on the day, I resolved to myself that the next eighteen months would be my Rocky montage – just like in the movies – I would do everything I could to become a Father Provider as a tribute to my own Dad. I saw this in external terms: delivering my thesis, getting a job, paying the bills. However this was internally about becoming a more skilful navigator in life. I would finally throw off the hoodoo that Dad and I shared, symbolised by our cack-handedness, our lack of dexterity; I would bend against that fate. Thus I became a cartographer – of my own life, and as modelled for my clients.

When encountering polar positioning, e.g. black and white thinking, in my work with my clients, I encourage a search for a synthesis between those positions, or for the continua upon which

the positions sit. In this thesis I appear to be working through a resolution between my own binary positions. This resolution may be mapped thus:

Can I identify a motif to serve as a 'shorthand' reference for this map? Gliding, steering my trajectory. As I was putting together this chapter, one of my non-participant clients spoke to me about gliding – literally jumping off a hillside with a glider and taking to flight. He explained to me that the buzz was in it being a battle against gravity – you know that gravity will always win, but you can try your best to ride along the currents with skilfulness and grace. It spoke directly to me in my own recurring dreams of flight. I imagined a kind of theoretical compromise between the determinism (fatalism) of gravity and the free will of the glide. We can't change the basic facts of our existence – gravity, time, impermanence etc. - but we can influence our trajectory.



In what context is this map functional? Now that I have some stability in my career and can begin to make contact again with what really matters. Now that I am in private practice, and am inviting my clients to collaborate, so that we might journey together.

What bridging event first permits me to make contact with this map? Doing a training course in Acceptance and Commitment Therapy in which the idea of psychological flexibility starts to properly sink in.

What is my compass point – my sense of directionality - in this map? Towards 'a lightness of being' (There is always a more energetic, more liberating, and more creative way of being/doing, and I can know this intuitively like a sea bird – with its bird brain - gliding along currents of wind).



How am I embodied in this map? I experience a physical lightness, such as a dancer might feel when they're 'in flow'. My jaw pain softens. My restlessness subsides and I take a moment to breathe. I feel gratitude for my physical health.

What kind of researcher am I? A pragmatist who treats methods as tools rather than as allegiances. Interested in research that promotes change: change in how therapy is done, change for the benefit of the client, change in the social fabric in which therapy sits.

What kind of therapist am I? A pluralist who puts options in front of my clients and invites them to co-design the therapeutic work with me. A modeller of the psychological ideas that have had the most profound impact for me personally, and for whom this modelling is superordinate to any therapeutic strategies or interventions I might deploy.

In what context does the functionality of this map break down? Impossible to answer at the time of writing as the answer would emerge in a state of disillusionment I have yet to make contact with.

The development of this thesis – as tracked longitudinally to this point – provided me with a rootedness and a constancy that I did not have at the beginning of this process. I find I can still be creative and cavalier, enthusiastic and naïve, but I now have a capacity - a degree of subjective competence - that I did not have before to continually re-orient myself.

8.8 Conclusion

I observed at the beginning of this thesis that the question I first explicitly began to ask in 2015 has been a consistent thread running throughout the research project: in psychotherapeutic working with clients who presented with embodied distress, what does change look like and how is change facilitated? The thesis as presented here in its distilled form offers the following answer: that change is realised through the conception and performance of alternative cognitive maps, in which embodied experience, sense of self, and the conditions in which we relate to the world are re-framed. I have also highlighted the personal transformations that have been taking place within me during the period of my PhD study, in which I as the therapist and the researcher re-framed my own experience through the production of this thesis. In the coming, final chapter I ask a question pertinent of all research: *So What?* What are the implications of this research beyond my personal experience and my private practice? If as conceptualised in chapters one and two the research makes a contribution to an ongoing dialogue in psychotherapy practitioner research, what is the quality of that contribution? I consider how this research may make an impact in counselling practice and in practitioner research, and the

cultural contexts in which this research sits. I will also consider directions for future inquiry. I conclude the thesis by exploring a final big question: *What if?*



Chapter Nine: So What?

When I was beginning my MA dissertation project, one of my trainers at the University, Bonnie Meekums, who herself had produced an autoethnographic thesis, stressed the importance of our research passing the *So What* test. An autoethnography may be evocative and aesthetic as well as analytic and critical, but as with all pieces of research an autoethnography should make a meaningful contribution to knowledge. Similar arguments can be made about case study research – if a case study produces knowledge in a highly localised context then what is the meaningful contribution to knowledge made through it?

The question of what a meaningful contribution looks like is by no means settled. Ought case studies or ethnographic research generate ideas that have applicability beyond the local contexts described? Or is it that the insights into a particular group may influence policies that are particular to those local groups? Perhaps knowledge products should not be gauged according to their utility, but rather by their capacity to enhance and enrich knowledge for knowledge's own sake?

I considered and engaged with these questions at some length in chapter two in advocating a 'naturalistic generalisation' concept of knowledge. It follows that the *So What* test of this piece of work depends not just upon the author but upon the readers. In this chapter I identify what I believe are the features of this project that make it meaningful, impactful, and significant beyond a simple striving to get a PhD qualification. However the proof of the *So What* test ultimately depends on those who 'receive' the products of this research – how well it meets with and articulates experience beyond my own bubble.

9.1 Congruence with existing theory

From the point of view of clinicians, this thesis offers a template for how our clients presenting with embodied distress may realise a greater capacity for metacognition, which alongside the overlapping concepts of mentalization and reflective function, is regarded as a transtheoretical mechanism of change. The thesis also builds more particularly upon dialogical approaches to change, working with I-positions. The hypothesis advanced in this thesis is that each I-position originates within its own cognitive map: I-positions are always and inescapably inhabiting their own contextual worlds. Whilst as a therapist I continue to find it useful in much client work to explicitly name and characterise different I-positions, the natural extension of this work is to chart the relational worlds that these I-positions inhabit.

What is not being offered is another manualised therapeutic approach. In chapter one I described the two leading manualised approaches for work with clients presenting with embodied distress: of Allen and Woolfolk (2006) on the one hand and Luyten et al. (2012) on the other. The present thesis does not in any way challenge the interventions or the framings of interventions advanced within those two protocols. Rather, my thesis offers an alternative frame of reference which is more congruent with third wave cognitive behavioural approaches such as Acceptance and Commitment Therapy, as well as with contemporary narrative-dialogical approaches. There is however a further observation to make about the application of manualised approaches. Applied rigidly by the therapist they may model for the client a similar rigidity: the implicit idea that there is a 'correct' frame of reference, or a correct way of doing things. What is axiomatic in this thesis is that at the core of the client's pathology is psychological rigidity and thus their sense of fatedness to play out the same patterns forevermore. I venture that a cognitive mapping approach implicitly models psychological flexibility and thus transcendence of present circumstances as an ongoing process rather than a singular event.

I note the congruence of the present thesis with Luyten et al.'s (2017) 'two-polarities' model of personality development which rests upon three systems, as mechanisms of change. The first of the three systems is centred upon the capacity of the therapist to model for their client a different way of thinking about their problems – this for Luyten et al. rests mostly on the level of the modality that the therapist practises. Crucially Luyten et al. argue that less important than

what that modality is, is that the framework for interpretation can contain and offer insight into what the client brings. I would argue that the first of these three systems includes not just the therapist's formal modality but also their own personal styles of cognition which they bring to the therapeutic situation. In the second system, the client develops their capacity to mentalize. Whilst mentalization is under-represented in the present thesis, nonetheless what is evidenced is the enhanced capacity for metacognition. Finally the third system is based upon 'social learning beyond therapy' and is performative in nature – the client realising change in their relational worlds outside of therapy, which appears to fit well with the concept of 'bridging' that I have described in the previous chapter. The thesis that I advance here I therefore consider to offer evidence and concepts which are complementary to the two-polarities model.

I note also a compatibility with Mick Cooper's contemporary writings on directionality which he proposed may be the unitary shape of change observed across the modalities. In a recent blog post Cooper observed the absence of a stable overriding source of value underpinning human motivation:

So the directional framework says that we do things for reasons (i.e., we have directions in life), and we can trace those reasons up and up and up to higher and higher orders of directions. [...] The thing is, we can go up and up and up to highest-order directions like pleasure but then, when we ask, 'What is the meaning of pleasure?' we're stuck really. There just isn't any answer. Or 'Why actualisation of potential?' or 'Why spirituality?' They're there, but there's no real way of going above them to something higher order. One option might be to say that these directions contribute to a wider social direction, like global harmony or planetary healing but still, then, so what? What does that lead up to. Essentially, there's nothing 'fixed' up there.

(Cooper, 2019b)

With reference back to my own thesis, value is not fixed, as Cooper recognises, but rather is embedded within the maps we have found to organise our lives. What Cooper also articulates here is also that where there is value, there is also directionality – healing or growth is a journey to somewhere – and the micro decisions that we take in each and every day may work in the same direction as that value or contrary to it.

What is significant about both Cooper's thoughts on directionality, and Luyten et al.'s two-polarities model, is that they are transtheoretical – the modalities that we practise may be considered meta-mechanisms of change in that they provide a framework of meaning through which change is realised but in these models there are unitary mechanisms which transcend

modalities and provide theoretical bases for more pluralistic approaches to practice such as are evidenced in my own clinical work.

9.2 Practitioner research and the visibility of the therapist

Aside from what I consider to be the consequences of this thesis for practice is the commentary this thesis makes on how practitioner research could be done, and especially on the visibility of the therapist - the practitioner researcher - within it. As was observed in chapter one, even within contemporary published psychotherapy case studies the therapist is often if not usually under-represented or invisible in the accounts. The therapist is often alluded to within those accounts as somehow above the fray, taking a God's-eye view of the situation, usually to interpret the case data presented according to their own theoretical frame. What I have offered in the thesis which is novel is my visibility as the therapist in the fray, and also as a researcher tracking my own development longitudinally throughout the period of data collection and beyond. In addition I have represented the voices of each of my clients, both in the real time experiences of the therapy, and latterly as they were invited to comment on their own experiences of the work both at the case review and at the three-month follow-up. Other voices that have directly contributed to the emergence of theory in this study are the voices of Jane, John and Dawn my research supervisors, and Steve my clinical supervisor.

However the research I've presented is not simply an attempt to innovate in the presentation of case study evidence. The correspondence of the autoethnographic strand allows my research to more fully model the therapist as fellow traveller. I don't doubt that other practitioner-researchers could have taken up a similar design and done it better e.g. to provide richer accounts of the intersubjective events shared between client and therapist, or indeed of the discoveries that we therapists make about ourselves and how these transform our 'presence' in the consulting room. However what I believe this thesis offers is a precedent that those others might take up. I have not in any sense been faithful to the vision of researcher independence as envisaged in positivistic or post-positivistic approaches to psychotherapy research. Rather than seeking to bracket off my subjectivity for the purposes of the purity of the emergent analysis and theory, in this project I have 'managed' my subjectivity through transparency. And my attitude here has been that there is more to subjectivity than an inconvenient epistemological hurdle to negotiate. Rather in this thesis I have demonstrated the personal and multi-layered

contexts that underpinned the emergence of formal theory. Subjectivity is modelled here positively as a research instrument.

Nonetheless we might still be left wondering: so I offered a ‘thesis beneath a thesis’ – so what? Why does the human story matter? Why would we, for example, be interested in the human story of a scientist investigating the role of microbiota in pancreatic disease, or of an astronomer processing radio-telescope data to test theories on dark matter, or a conservationist evaluating the success of a wildlife corridor in the South-West of England? It would, I imagine, be very interesting to read the ‘thesis beneath the thesis’ of a medical doctor, a lawyer, an architect, or an archaeologist, and not just because we need to be transparent about our prejudices to improve the quality of our science. There is a limit to that line of argument and taken to an absolute degree it would not withstand the counter-charge that we were merely descending into navel-gazing. Rather, the real value of the human story is not simply to supplement the *what* of the science, or even the *how*, but to illuminate the *why* of science. What are the deeply held human values embedded within our sciences? Why does this matter in the end? So What? I think again of Cooper’s account of directionality: that as a society of human beings we cannot help but continue to discover our highest directions in this life, and that that quest is without any natural conclusion. I have revealed something of my own personal directionality here in this thesis – directionality as cloaked in my unique personhood – but I believe it will be recognisable to others, in reference to their own internalised directions.

9.3 Impact

Given then that I envisage this thesis now going back out into the collective dialogue – making its own incremental contribution within that dialogue – it would be helpful to identify more particularly its entry-points into that dialogue. Here therefore we might consider the question of research impact.

In the opening pages of this thesis I identified the landmark conference presentations to which I brought my thesis as it stood at that present time. These experiences were the most tangible experiences of what I have described as a dialogical approach to knowledge. I have found that I belong to various communities including the British Association for Counselling and Psychotherapy (BACP), the Society for Psychotherapy Research (SPR), and wider cross-

disciplinary networks of qualitative researchers. I have discovered that I can take my thesis into these arenas, make a valid and meaningful contribution, and that my various hypotheses continue to evolve within those dialogues. In 2020 I will present my thesis to the 3rd International Conference on Pluralistic Counselling and Psychotherapy in Dublin, as well as returning to the BACP Research Conference, this time held in Bristol, to make the case more explicitly for subjectivity and the self as research instrument in theory building. However upon completion of my thesis my supervisors and I have identified a suite of journal articles to propagate the headline findings of this project. These publications will include:

- An account of the multicase study, the member-checking processes, and the emergence of the model of change from it, which we will pitch to *Pragmatic Case Studies in Psychotherapy*
- A theoretical exploration of the three states of change: identification, bridging and cognitive mapping, supported by data from the study, which may be suitable for the *Journal for Integrative Psychotherapy*
- An account of the use of self as research instrument as well as introducing the use of mini-studies to assist in the analytic process, which may be of interest to *Qualitative Health Research*
- And an exploratory article on the social determinants underpinning psychosomatic health, and the embeddedness of psychosomatic experience within wider cognitive maps of self and world, which could be pitched to *Aeon*, an online magazine with a large, general-interest circulation, celebrating ideas and culture.

I'm mindful that my thesis is a beginning, not an end, and that the key theoretical threads which emerge from the project will be ones that I carry forward and that continue to transform within different practice and research contexts.

My PhD research will also benefit my students. I have delivered interim findings of my PhD research in seminars delivered to students at the University of Leeds and Leeds Beckett University, as well as CPD classes offered to groups of local IAPT practitioners and colleagues at the charity where I conducted the research. In August 2019 I began work as a full time lecturer at Leeds Beckett University and on the back of my PhD research I bring theoretical contributions around working with psychosomatics and embodied distress, of transtheoretical patterns of change, of dialogism and multivocality, and of cognitive mapping, all included in the course

materials. Furthermore I encourage in my own students their own reflexivity as practitioner researchers informally asking questions about their own practice.

For the benefit of my clients too, my PhD research planted seeds which continue to germinate. At the time of writing these words the data collection window closed over a year ago. The same strategies and techniques described in this thesis are still present in my practice but they have become more integrated; offered in a subtler, more skilful way. In my present practice I consciously model alternative ways for my clients to think about their problems – taking the ‘material’ they present to me from their own lives and offering it back to them in a form that I believe can be helpful. Another way of saying this is that the same cognitive transformations that have been helpful to me over the previous years I offer back to my clients cloaked in the content of their own experience. With reference more directly to the content of my thesis, I am now more careful about offering up a binary choice between two alternative I-positions, one of which is evidently preferred over the other. Rather I help my clients to model their own psychological flexibility, and to discover themselves as navigators with the capacity to consciously migrate between cognitive maps into more open, lighter, and creative ways of being.

9.4 A cultural context

As previously observed, the purpose of this research was never to produce a manualised approach to therapeutic working, nor do I envisage it ever developing into one. The ethos underpinning this piece of research is microcosmic of a wider cultural debate that is taking place within psychotherapy research and in particular the influence of the Evidence-Based Practice paradigm. In my capacity as a member of the UK Council of the *Society for Psychotherapy Research (SPR)* I contributed to the SPR’s response to the 2018 NICE Guideline on Treatment for Depression in Adults. One of our primary scientific objections to the production of the Guideline was that the panel’s system for ranking different evidence sources excluded all case study evidence and qualitative research. The Guideline thus was drawn up based on evidence from randomised controlled trials and meta-analyses. These approaches are rigorous and carry huge statistical weight in evidencing the effectiveness of different forms of therapy, however they also systematically strip away the subjectivity of the therapists and their clients, whose theories were co-constructed through their dialogue; and the rich contextual data supporting accounts of

therapeutic change. When policies are created such as the NICE Guideline, they emphasise modalities: in the present iteration Cognitive Behavioural Therapy is still presented as a preferred option to other forms of counselling and psychotherapy in the treatment of depression. These approaches to managing the evidence do not contain well at all the appreciable transtheoretical mechanisms of change, such as those which have been highlighted here. In the present treatment of evidence vital factors such as the personal qualities and integrity of the therapist, their depth of experience, the coherence of their framework etc. are overlooked in favour of generalised attributions made on the basis of modality. By producing manualised therapies we fall into the same trap. Rather the cultural position that I have occupied in this thesis is that higher quality therapy is transtheoretical in nature and to some extent rests in the person of the therapist. As such a radical overhaul of clinical commissioning is required. In the SPR International Conference in Amsterdam in 2018 John McLeod offered a radical suggestion: the production of an alternative Guideline for clinical commissioning of therapies based exclusively on qualitative research. Such a guideline would have subjectivity running all the way through it, but as a meta-synthesis of voices, out of which new constructions of knowledge would emerge, could have the potential to carry as much evidential weight as the NICE Guideline itself does. My belief is that research produced with a consciousness of its place within an ongoing dialogue within our professional communities would have the consequence of drawing therapists and clients into a dialogue that presently they are excluded from.

9.5 Quality appraisal

At the same time as considering the congruence of the present thesis with existing theory and current research and cultural contexts, it is also fitting that we consider the extents to which the current study met existing standards of good practice in qualitative inquiry and more particularly in autoethnography. In this section and in the coming section on limitations I consider the indicators of quality in this study but also highlight important lessons learned that may improve the design and execution of future research which may take up the methodological precedents set in this study.

To appraise the study on the basis of good practice in qualitative inquiry I have decided to select Levitt et al.'s (2017 and 2019) recommendations for methodological integrity. As I have understood during the years of my study and conferences attendances during the period, the

Levitt et al. recommendations are treated as the current industry standard for qualitative research in psychology. I also appreciate their simplicity and clarity. In tandem with these recommendations I also consider Le Roux's (2017) five criteria for rigour in the production of autoethnographic research, as there are substantial theoretical overlaps between these two sets of guidelines.

Levitt et al.'s framing of methodological integrity centre upon two parent concepts: *fidelity* and *utility*. Fidelity is realised through the researcher's immersion and intimate connection with the topic under investigation, a methodology that best fits the nature of the inquiry, adequate data, management of perspectives, the importance of capturing the difference (or uniqueness) of research subjects and theories that are 'true' to the data. Somewhat complementary to Levitt et al.'s framing of fidelity, Le Roux (2017) ventures that autoethnographic research should capture subjectivity, through genuine subjective engagement with the topic; self-reflexivity, through the scrutinising of the researcher's own performed self; and credibility, as achieved through a transparent and trustworthy research process.

Utility in Levitt et al.'s (2017 and 2019) recommendations is the question of how effective the study design and methods were in answering the research questions, the study's success in meeting its own goals, coherence between findings, and that findings may serve as catalysts for insight and make a meaningful contribution to knowledge. Le Roux (2017) also argued that autoethnographies should make a contribution to knowledge, but furthermore that autoethnographic studies should offer genuine resonance for the reader. This latter criterion reinvokes for me the ideal of a dialogical approach to knowledge production and also theories of experiential knowledge as an epistemological principle of case study research as explored in chapter 2, section 2.1.2.

By virtue of the production of a thesis beneath a thesis I believe that I do demonstrate a high degree of immersion and intimate connection with this topic. As well as being the researcher, I was the therapist striving to facilitate change for my clients, and also the idea of change – especially in the narrative-dialogical form described here – manifest through my personal life, and windows into my sub-conscious processes. However there are limits to my degree of immersion as the researcher – primarily I am aware of the limits of the extent to which I was able to generate good data on my experience of the intersubjective processes between the participant clients and myself. I share some of these in chapter seven on dialogism in the therapeutic relationship however other therapists, perhaps with more experience in the relational dimension of the therapeutic work might have offered deeper and richer data from

their immersion in this aspect of the work. At the time of data collection I was still a relatively inexperienced therapist and my attunement to the subtleties of the therapeutic relationship is something that continues to develop during the years of my practice. I note here that the area in which I suggest a slight blind-spot pertains to my performance as a therapist and therefore by extension to my capacity to generate meaningful data as a researcher. However this slight under-attention to the therapeutic relationship may be also partly owed to the nature of my sample. As observed in our qualitative synthesis (Hills et al., 2020; see appendix 1.4) mechanisms of change which pertained to the therapeutic relationship were only evidenced in longer-term therapies, above 24 sessions. Three out of the four therapies described in this multi-case study were made up of ten sessions or less. It is possible that by sheer chance if I had begun work with clients and that work was of a longer term nature that richer relational themes and experiences of intersubjectivity would have been evidenced.

Whilst Levitt et al. (2017 and 2019) call for a methodology that best fits with the nature of the inquiry, Le Roux (2017) also argued for a transparent and trustworthy research process. I have related these two criteria because transparency about the evolution of my methodology – not simply the production of mini-studies but moreover the significant rupturing of my project when my Dad died and my subsequent turn to autoethnography, is a thread that runs through the heart of this thesis. The methodology I began with was not the methodology I ended up with, and evolved as my understanding of the meaning of my research project evolved. I have addressed previously that I do not believe the current project is an example of ‘method slurring’ (Holloway and Todres, 2013) but rather that evolutions in my methodology were made consciously and with justification. Two key principles guided the evolution of my methodology which only began to come into my awareness as I was well into the period of data collection. The first of these principles is the idea of research methods as scaffolds: that whilst research methods are helpful if deployed consciously, as tools to assist in the theory building process, the findings of research should normally exceed the limitations of the methods, because they emerge from the self as research instrument and perception is not limited by the conditions of a certain method. From this stems the second principle of transparency about the subjective origins of theory generation. From these two principles emerged the two obvious methodological innovations of this project: the use of mini-studies to ask questions of the data and develop new theories, and the use of autoethnography to deliver the thesis beneath a thesis. Therefore where I ended up methodologically I do believe to have been completely congruent with the aim and purpose of this research.

However there were limitations to the methods I used during the period of data collection. Primarily in hindsight I realise that I had an overly passive approach to coding the data from the audio recordings following each session. By coding from an innovative moments perspective – focused on highlighting indices of the client speaking from different I-positions or reflecting on change – I was missing subtleties that might have been caught if I had been less passive: could I see instances of metacognition for example, or any evidence of how the client was using their therapy? Innovative Moments coding should technically lend itself to the revealing microphenomena – as innovations in therapeutic process - but in practice I found that my relatively passive approach emphasised explicit meanings in the data and thus limited the capacity of my approach to coding to draw attention to the implicit. In reference to the principle of research methods being used as scaffolding, perhaps I allowed my understanding of coding for innovative moments to become too deterministic. Another significant limitation to the methods I used was my failure to bring other voices into the mini-study on qualitative (hermeneutic) analysis of causality and effectiveness claims (chapter six). A dialogue featuring myself and two of my supervisors was relatively closed, the discussion between us generated relatively generic observations and as such was not in keeping with the principle of a dialogical production of knowledge which I have tried to champion here.

Another aspect of fidelity according to Levitt et al. (2017 and 2019) was about the provision of adequate data. The thesis as reported here does include a large volume of selected passages of therapeutic exchanges and clients' commentaries on their therapies – both as analysed through the mini-studies but also as included to supplement commentary throughout the chapters. I have also included other sources of data – most notably passages from my therapeutic notes, reflective diarying, and dreams – both within the main body of the thesis and also in the appendices. The reader is thus able to see how I triangulated between different tiers of data in accounting for the emergent models of change. One aspect that the reader may find disappointing is the absence of visual maps in a thesis on cognitive maps. It is of course important to recognise that the thesis of cognitive maps only emerged latterly, following the closure of data collection. However there is a case here that I under-emphasised creativity in work with the four participant client – for example in exercises that might have involved the production of visual timelines, genograms, or indeed mind-maps. Such data would have offered another degree of triangulation in the development of the thesis, and as such my failure to initiate such exercises during the period of data collection may be considered a missed opportunity both therapeutically but also in terms of the quality of the research. As with the earlier observations about the sensitivity to dynamics in the therapeutic relationship, my under-

emphasis on creative methods during the period of data collection may also reflect my relative inexperience as a therapist at that time.

Whilst Levitt et al. (2017 and 2019) stress the importance of the management of perspective and the importance of capturing the difference of research subjects, I believe I had a mixed success in achieving this ideal. I was conscious from the beginning of the data collection period of the importance of remaining 'true' to my clients' own words and language and have faithfully represented their idiosyncratic constructions through my reporting of the multi-case study in chapters three through seven. These subjective meanings have been preserved and reported well. However and as previously observed, one shortcoming here was at the point of producing the case reports. I produced the case reports in a relatively 'objective' fashion – attempting to process the data from work with that client through the prism of relatively objectifying principles of change. The consultation on the case reports didn't yield very fluent responses from the clients and it is possible that in the case of the fifth participant who withdrew the case reports may also have been experienced as alienating. This was because I tried to engage with them as co-researchers and layman scientists without regard for their own uses of language and frames of reference. By a similar token, where Levitt et al. (2017 and 2019) call for findings that are 'true' to the data, my findings might have been truer had I hardwired more elements of co-production into my research design from the beginning of the project. Whilst my participants – especially *Michael* and *Jennifer* – actively engaged with my modelling of theories such as I-positions and of metacognition, as evidenced in earlier chapters, I now believe that in the spirit of co-production I could have done more to make these theories more explicit with the participants and thus that they would have felt a greater degree of degree of investment in where I eventually ended up theoretically.

This consideration may also suggest at some limitation in the principle of 'coherence between findings' which fell under the banner of Utility in the Levitt et al. recommendations. As explained in chapter eight, towards the end of section 8.5, I believe the emergent mechanisms of change, described here as *identification*, *bridging* and *mapping*, will be readily recognisable to therapists working across different modalities, and as such that the thesis makes a tangible and incremental contribution within an ongoing dialogue about the nature of change in psychotherapy. However if I'd have been able to take my participants with me throughout those latter stages of theory generation – through a more explicit dialogue with them about theory – the potential outputs of the research could serve as far greater catalysts for insight. As previously explained, I do believe the methodological innovations of this project – particularly

my treatment of methods as scaffolds and of transparency in the subjective processes underpinning theory-generation – mean that the methodology ventured here has been highly appropriate for addressing the original questions posed through the study. It is the autoethnographic account of a therapist developing their own models of change which I believe offers true novelty and thus meets with Le Roux's (2017) requirement of resonance for the reader.

Finally Le Roux (2017) highlighted the importance of the researcher scrutinising their own performed self. Whilst in some respects the accounts of my various difficulties and periods of fear and doubt throughout the process do reflect my own self-scrutiny in the 'real time' of the therapeutic process, there was in other respects an under-attention to the identity I brought to the research. As previously discussed in the Introduction, my contemporary interest in change reflects my life history – my interest in social change, spiritual ideas and self-help books from my teenage years onwards. I haven't considered in any great depth how my participants clients 'met' that historical version of me in the counter-transference. Indeed it wasn't until John's stinging critiques of my case reports towards the data collection period that I realised that I had been pre-disposed towards a 'helicopter view' of therapeutic process given my interest in longitudinal change. This under-attention to my historical identity is therefore a limitation of the present thesis.

9.5.1 What would I have done differently?

In consideration then of all the points made, I can briefly outline how I would have conducted this study differently had I had my time again, or indeed how I would recommend other researchers to take these methodological precedents forward in future projects. I would hardwire the autoethnographic strand from the beginning of the project as a source of essential data. My approach to coding of the data would be less passive – I envisage working with explicit formulations of change that I would check in with following each session, and consider passages from the latest audio recording against existing formulations, and re-formulation where appropriate in the light of the new data. In the production of the mini-studies I would seek consultation with therapist and researcher colleagues and perhaps also with informed laymen, perhaps even former clients. In the spirit of the research jury approaches advocated by Elliott (2002) and Bohart et al. (2011) I would present to them my processed data – as fully and as transparently as I could in protecting my participants' anonymity - and I would audio record our

deliberations on the data with reference to the selected research method. The objective would not be to reproduce a rigorous and systematic exercise in the research method per se, but to offer a transparent account of how theories emerge through dialogue. I would also stress the collaborative nature of the therapy and research participation, encouraging my clients to generate their own layman's interpretations of my theories, which I would explicitly aim to share with them in each review session, as well as during the case report consultation. As previously observed the case report would not be produced after the end of the therapy sessions, but instead would be co-created by myself and the client perhaps over the final third of our sessions. Rather than the report being produced in relatively technical, objective language, I would seek to produce a report that more faithfully represented the client's own narrative about the meaning that therapy had had in their life. Finally as the researcher I would take more care to consider the subtleties of the therapeutic relationship – particularly transference and counter-transference but also the presence of my 'historical self' in the research process. More attention to these subtle processes may well yield richer, more impactful data better reflecting the clinical reality of contemporary psychotherapy.

9.6 A revisiting of the core ethical dimensions of the project

One overriding ethical theme emerges retrospectively which may inform future research projects which take up these methodological precedents and it has already been strongly alluded to in the previous section. Where the current research has required special ethical attention are in the areas of imbalance of power and the agency of participant clients. I have described various mechanisms introduced into the research design and developed during the process in order to protect client agency and to protect against the inevitable imbalance of power in the therapist-client relationship. I believe that the issues raised through this project may have been more adequately contained within the methods and ethos associated with the co-production of research: that is 'professional' researchers working alongside participants at every stage of the process from the original conception of research aims and design, all the way through data collection, theory generation and the reporting and dissemination of findings (Social Care Institute for Excellence, 2015). I can offer some thoughts here as to the key ethical moments from the PhD project and how the methods and ethos of co-production might have more effectively contained these issues:

As previously observed probably the most significant ethical event of the project was my receiving the request from the fifth participant in the second half of 2019 to withdraw from the study – this being almost a year after the cut-off date for participant withdrawal, and following production of the first draft of the thesis. Whilst to the ‘letter of the law’ I might have been in my rights to refuse their request, in the reality of the situation, in my commitment to non-maleficence as a BACP accredited therapist, there really was no dilemma – I had to accede to the participant’s request. They did not provide any reasons for their withdrawal – nor were they required to – and as such they were able to retain some degree of agency in the situation. I realised retrospectively that a short-coming of my approach to generating the case reports was that they were produced after the therapy was finished and received by the client as a *fait accompli* – as recipient they had a right of reply but this placed them in a relatively passive situation. Whilst I will probably never know the reasons why the fifth participant had a change of heart and decided to withdraw, my impression is that if the resultant document – the documentary evidence of our time together – had been co-produced, this might have been a protective factor against the client’s change of heart. As proposed in the previous section, a co-produced case report would be:

- 1) Co-authored, and would begin to be co-authored several sessions before the end of the therapy itself. As therapist I might have initiated the process by asking the client what they think we should be writing about in the case-report. We would be able to produce draft versions which we might then be able to discuss, such that the resultant document emerged out of a ‘negotiation’ between us.
- 2) The document would be structured and written from the client’s own frame of reference, reflecting their own narratives about the meaning that therapy had had in their lives.

I observed previously how, especially for *Lou* and for *Jennifer*, the case reports had had a crystallising effect. A further benefit of producing a document from within the client’s own frame of reference would be to enhance its meaning for the client as a kind of transitional object (Winnicott, 1953) – part of the therapy itself.

Issues of experimenter expectancy, and of the client’s possible inclination to provide desirable results for the therapist, were explored in the mini-study at the end of chapter six. We saw a compelling instance of the client’s awareness of her responses feeding into a research project where Jennifer made a comment about me getting a ‘gold star’ (see section 6.7.3). Whilst Jennifer was also able to identify situations in which the therapy had not been helpful, for

example with respect to a homework I had set her, nonetheless a core question that seemed to emerge at moments like this was: who does this research belong to? And, perhaps even more tellingly, who does this therapy belong to? Therapy that is truly collaborative and research that is truly co-produced should be experienced as 'owned' by the participant themselves. In response to Jennifer's praise for me as the therapist, I might have modelled collaboration through the corrective thought that we would both deserved a gold star in that instance.

Elsewhere *Myrtle* was able to put her subtle stamp on the research process by offering beautiful reflections from her cancer journey – at the case report consultation and three-month follow-up events – some of which I've been able to include as data in this thesis. When Myrtle wrote about the importance of still being a person, rather than just a generic cancer patient, or elsewhere about what she had learned about the nature of her fibromyalgia, it was as though she was consciously communicating, via the medium of the research project, to other people living with fibromyalgia or cancer. It was as though she was saying: 'this is what it was like for me, whatever happens to me, perhaps this can speak to your experience too?'. There was as such potentially a legacy motivation for Myrtle too – she would be able to leave a personal imprint on the work beyond our time together – this may have been lent extra significance following her cancer diagnosis.

If co-production had been explicitly part of my agenda from the inception of the project I might have been able to reflect explicitly with my client on how they would like to use their participation in the research project, much in the same way as I would encourage them to say how they would like to use their therapy.

9.7 A proposal for further work on the data

I have provided an account in this thesis of how a therapist's ideas about therapeutic change can emerge in personal experience and sometimes originally through dreams and sub-conscious processes. What I have charted less tangibly is my own development as a therapist as influenced by my participation in the research project, and thus envisage a fascinating re-analysis of the data. What did my therapy look like at the beginning of the process? What did my therapy look like at the end? And what were the processes that got me there? Likewise what was my identity as a researcher at the beginning of the process? And what was it by the end?

And what were the processes that got me there? These are fascinating questions which would require me to return to all the data I collected.

I would listen back through the audio recordings and listen out for my 'performance' as a therapist. That would be easier to do now in hindsight as I look back on work I did two years ago. Just as I looked for indices of change in the I-positions my clients performed I could produce fresh analyses on the indices of changes in my performance (indices that I was barely aware of at that time). These indices could be cross-referenced against my therapeutic notes, my reflective diarying, experiences of CPD training and activities and the revisiting the recordings of my supervision sessions made during this period. I could consider which elements of my journey were the ones that made a difference. Was it for example to weekly listening back to and analyses of my audio recordings? Was it the powerful supervision I had with Steve during the period? Was it what I learned from the clients themselves?

The question of what kind of researcher I developed into could be addressed in parallel. I imagine the possibilities of producing a documentary analysis of the emergence of a researcher through PhD study from a variety of interesting and diverse data sources, including:

- My reflective diarying
- Notes from my supervision session (which were collected through Grad)
- Emails to my supervisors and other colleagues
- My conference presentations, their titles and abstracts, the PowerPoint slides etc.
- Versions of pieces of research I was working on, for example articles that were published and earlier version of the qualitative synthesis

Much as with the fantasy of Ouroboros, described in chapter 2, section 2.5 the possibilities to revisit the same data from different vantage points, and thus for different theses to emerge, could yield interesting findings for discussion within the professional community of therapists and researchers. Whilst the thesis as reported here offers a case study on how practitioner research and the emergence of a theoretical map of change might be done visibly and at reflexive depth, the re-analysis here may offer a valuable case study on how a therapist's practice may evolve through their participation in formal research.

9.8 Directions for future enquiry

In chapter two I identified two research designs that I envisaged and had to choose between at the beginning of my PhD study in 2016. On the one hand I envisaged what I described as an ‘ethnographic action research project’ in which I would have led an ongoing group supervision meeting in which therapists interested in working with clients who presented somatically would generate insights into change and ‘what works’ in these practice situations. On the other hand I envisaged a multi-case study in which I would develop theories at depth through collaborative work with my own clients using my self as a research instrument to develop keener insights. I decided to go for the latter of these designs.

It may be that I return to the first of those original designs in a postdoctoral research project. During the course of my research I received training in Participatory Action Research (PAR) and it is a methodological approach that is particularly exciting in furthering practitioner research. A PAR project represents the voices of all participants –clients, therapists, supervisors, researchers and other stakeholders – directly, not just at the point of analysis but from the beginning of a project – in designing its aims, methods and its intended impacts. Participatory Action Research, like ethnography and case study research, is highly contextualised and thus critics argue that its theoretical contributions beyond those local contexts are limited. However I venture that much like with case study research, PAR may offer up theory for ‘naturalistic generalisation’ – that is, to be taken up and applied by fellow practitioners and other actors in their own local contexts according to fit and utility. As speculated in chapter two a PAR project that faithfully reproduced the voices of multiple stakeholders would carry a lot of weight and impact in its dissemination.

A further question is what an envisaged PAR project would seek to investigate. I have already alluded to an interesting question that stems directly from the fourth template of analysis in this project. Further research might seek to uncover the cognitive maps that clients take into therapy e.g. their own internalised views of what therapy ought to be about, how they should perform in the therapeutic situation, what they are there to achieve, and so on. Such research could consider how these different maps were co-created between client and therapist, whether the quality of these different maps influenced therapeutic success or the depth of working, and whether longitudinal changes in *how* the client used their therapy, or related to their therapist, corresponded to changes in the client’s lived experience (which might be considered a form of

transference cure). Another line of questioning may be about the extent to which cognitive maps have an archetypal quality – how much are they idiosyncratic to the person and how much can common patterns be observed between people? I observe for example that my own idiosyncratic symbolism of the river will have many features in common with the symbolic river as it appears in the fantasies of others. If cognitive maps are shared – perhaps appropriated by individuals in application to their own local circumstances – then who has sovereignty, the person or the maps that they live by? Phrased differently: do we selves project meaning onto the world, or do these different platforms of meaning animate and colonise selfhood in a form of ‘top-down’ influence? I think at this point of Foucault’s *Regimes of Truth*.

There is also a growing interest in psychotherapy research in the role of the client’s everyday experience – in the 167 hours of the week that the client is typically not in the consulting room – over change processes observed (Jackson, 2018). Meira et al. (2017) took up methods associated with Gonçalves and Ribeiro’s narrative-dialogical concepts to study psychological change in everyday life. They found that psychological change in people not currently in therapy corresponded to a greater degree of complexity in their reflexivity, and their capacity for metacognition. Further research in this area might utilise methods from ethnography: photo elicitation and assignments, video diaries, transect walks – in which participant and researcher walk together through a place of ethnographic interest, and the participant drawing maps of their social spaces. This line of thought may be considered to link directly to my argument in this thesis that change is performed ‘out there’ in the client’s relational worlds. A reframing of therapy - as performing a decentralised role as one ingredient of change in a client’s life - may offer a more realistic view of the purposes of psychotherapy and our methods may in the future evolve to match these purposes more effectively.

However a further research possibility is to relocate my interest in psychosomatics within the emergent theory on the social determinants of health. During the years of my PhD study, the cultural meaning of what I identified as medically unexplained symptoms has continued to evolve with the lines between organic and functional illnesses becoming increasingly blurred; reflected in my preference for the term ‘embodied distress’. Given the neuropsychological evidence about functional overlay (Wilson, 2019) and the role of the central nervous system in the modulation of *all* somatic symptoms and sensations, there would be limited rationale for a further project that sought to study psychosomatics as distinct from non-psychosomatic health conditions. The emerging theory around the social determinants of health – the influence of a person’s relational and social life over all aspects of a person’s mental and physical health –

offers an exciting theoretical bridge. In his landmark work *The Health Gap*, Marmot (2015) comprehensively reviewed evidence demonstrating that key indicators of health such as heart disease, obesity, depression, and life expectancy are significantly determined by our position in social hierarchies and the social environments we live in. Wilkinson and Pickett (2011; 2018) have advanced understanding on the social determinants of health further through curiosity into the psychological mechanisms that may be at work in yielding these psychosomatic health disparities. The behavioural theories being developed to explain these influences may be seen to have a dialogical quality to them. Oyserman et al. (2014) and Hoff and Stiglitz (2016) advance theory about persons having multiple identities that are activated in different social environments, and crucially that these different identities are associated with different health behaviours. There are 'underlying rationalities' and mechanisms underpinning 'social causation': people made 'bad' choices for reasons including instability and scarcity (Larsen, 2015; Vancea and Utzet, 2017). What would be particularly interesting from a practitioner researcher point of view would be to consider how counsellors and psychotherapists have encountered these multiple identities and their associated health behaviours, and seek to discover what change looked like in these circumstances and how change was facilitated. I would hypothesise that a person's health behaviours are determined within the cognitive maps that they are performing in these different social environments. The impacts of such a piece of research may stretch beyond psychotherapeutic practice, into recommendations for social and structural policy. In this way I imagine not just the continued contribution of my own voice as a practitioner-researcher within a community of psychological therapists, but moreover the contribution that we psychological therapists can make into much wider debates about social and environmental change.

9.9 What If?

My final supervision meeting was with Dawn, who in December 2019 contacted me via video conferencing from her sweltering office in Perth, Western Australia. In that discussion our attention turned in particular towards this final chapter. As a response to the punchy challenge presented by my *So What*, Dawn offered her own wondering – *What if?* What if I'd have had a different set of participants? What if I had have undertaken a much cleaner research design – a more conventional multicase study? What if I had done the ethnographic action research project after all? What if I'd never secured the research scholarship? What if I'd never even

trained to become a counsellor? The question was left wide open, we said our goodbyes and signed off, and I let this idea percolate for some time. What began to emerge was an image of the river: the way all rivers begin as tiny tributaries – the home pools in which the salmon lay their eggs. Each of these tiny tributaries join to larger streams and rivers, all the time flowing down hill, and that each of these rivers will in turn join one singular river which drains out into the sea. My whole life I've made choices which appear to have taken me down certain streams – it might be considered that if I'd had made a different choice at some point that everything would have turned out very differently. And yet there was a certain gravity steering my own choices. I remembered being a teenager and rifling through the mind, body, spirit sections of my local bookstores – driven by some mysterious force that was only ever on the edge of my awareness. I write these words twenty years later with many vital choices already made and, like the river, my life feels to have its own momentum and a weightiness it didn't feel to have when I was a teenager drifting in and out of those bookstores.

On Sunday, 22nd December 2019 as I was putting the final touches to my PhD thesis news spread across social media of the death of psychologist and spiritual teacher Ram Dass – born Richard Alpert - who had been a towering figure in what might be described as the New Age movement, since the 1960s. Ram Dass' publications share common themes around conscious living, conscious ageing and conscious dying. When I heard the news about his death I recalled a quote for which he is famous and which for him captured the essence of what might be thought of as our spiritual journey through life: *'When all's said and done, we are all just walking each other home'*¹⁰. I reflected on this quote in relation to my own musings about the salmon swimming back upstream to their home rivers, and that embedded in any map of self and world is purpose, or directionality (Cooper, 2019a), however implicit this might be. We might speculate as to what it means to walk home. It might suggest authentic living – being our truest self. It could be about a sense of destiny or even fate. It could mean in the end that we feel carried by something (or someone) greater than ourselves. It could mean returning to an original state of Oneness; which Freud (2002) described somewhat disparagingly as the 'Oceanic feeling', equivalent to an infantile desire to return to unity with one's mother. But it seems to me that to get caught up in how we ought to interpret the idea is to miss the greater meaning. It is as though Ram Dass imagined a transcendent sense of directionality beyond the individual chapters of our lives, or indeed the maps that we live by. That whatever the different costumes

¹⁰ I can't find the original source of this quote but it is likely to have been uttered in many different contexts including in the spoken word as well as print throughout his career. Ram Dass co-authored a book of this title which was published in 2018.

we put on, whatever the different roles we inhabit, we may discern a motion towards home. Moreover this journey is made together, and we support one another on that journey. I consider the role of counsellor as fellow traveller: that we support our clients on their own journeys, whilst our own are incomplete.

Here I have advanced the discovery and performance of cognitive maps as platforms for therapeutic change. In these final remarks my attention turns back towards what I have described as 'bridging' – the moments of consciousness in any one's life where we perceive an opportunity to enter into a qualitatively different state of being; to deviate from a well-worn groove, and thus to transcend the present circumstances. In therapy these are the innovative moments; either those that occur in session or in the seven days between sessions. Whilst the present inquiry ends here, a fascinating question emerges: *What if* these bridging events – which might be seen to run through our life's story like a string of pearls – had common qualities, such that they pointed in a common direction? What might these common qualities reveal to us about the nature of our own homecomings? Could this 'long view' be useful therapeutically beyond a conventional perspective of transition between one self-narrative and another? The thesis ends as it began: with questions that I hold as a therapist and as a fellow traveller; to investigate both pragmatically and scientifically, but also to test against my own lived experience and within the continuous dialogue of which I am a part. In this study I hope I have adequately modelled this approach and that my findings, as derived through this approach, have utility for colleagues and contemporaries, both in their local contexts and in the light of their own experience.

Reference list

- Abbass, A. 2005. Somatization: Diagnosing it sooner through emotion-focused interviewing. *The Journal of Family Practice*. **54**(3), pp.215-224
- Abel, A., Henley, W., Hayes, A., and Kuyken, W. 2016. Sudden Gains in Cognitive-Behavior Therapy for Treatment-Resistant Depression: Processes of Change. *Journal of Consultant Clinical Psychology*. **84**(8), pp.726-737
- Allen, J.G., Fonagy, P. and Bateman, A.W. 2008. *Mentalizing in Clinical Practice*. Washington DC : American Psychiatric Publishing
- Allen, L.A. and Woolfolk, R. 2006. Affective Cognitive Behavioral Therapy: A new treatment for somatization. *Behavioural Psychology*. **14**(3), pp.549-566
- Anderson, L. 2006. Analytic Autoethnography. *Journal of Contemporary Ethnography*. **35**(4), pp.373-395
- Arntz, A. 2019. [Post-print]. A plea for more attention to mental representations. *Journal of Behavior Therapy and Experimental Psychiatry*.
- Bager-Charleson, S. 2014. *Doing Practice-Based Research in Therapy: A reflexive approach*. London : Sage Publications
- Bager-Charleson, S. and Kasap, Z. 2017. Embodied situatedness and emotional entanglement in research— An autoethnographic hybrid inquiry into the experience of doing data analysis. *Counselling and Psychotherapy Research*. **17**(3), pp. 190–200
- Bakhtin, M.M. 1981. *The Dialogic Imagination: Four Essays*. Austin : University of Texas Press
- Balabanovic, J. And Hayton, P. 2019. [Post-print]. Engaging patients with "medically unexplained symptoms" in psychological therapy: An integrative and transdiagnostic approach. *Psychology and Psychotherapy: Theory, Research and Practice*
- Balkin, R.S. and Kliet, D.M. 2017. *Counseling Research: A scholar-practitioner approach*. Alexandria : American Counseling Association
- Bandura, A. 1998. Health promotion from the perspective of social cognitive theory, *Psychology and Health*. **13**(4), pp.623-649
- Bandura, A. 2007. Reflections on an Agentic Theory of Human Behavior. *Tidsskrift for Norsk Psykologforening*. **10**, pp.995-1004
- Batista, J., Silva, J., Freitas, S., Alves, D., Machado, A., Sousa, I., Fernández-Navarro, P., Magalhães, C. and Gonçalves, M.M. 2019. Relational schemas as mediators of innovative moments in symptom improvement in major depression. *Psychotherapy Research*. **29**(1), pp.58-69

- Baumeister, R. F. 1994. The crystallization of discontent in the process of major life change. In: Heatherton, T.F. and Weinberger, J. eds. *Can personality change?* Washington, DC: American Psychological Association, pp.281-297
- Benítez, J.L., Abalscal, A., Garrido, M. and Escudero, V. 2019. [Post-print]. Building an expanded therapeutic analysis: a task-analysis with families trapped in parental-adolescent conflict. *Family Process*
- Benoot, C., Hannes, K. and Bilsen, J. 2016. The use of purposive sampling in a qualitative evidence synthesis: A worked example on sexual adjustment to cancer trajectory. *BMC Medical Research Methodology*. **16**(article 21)
- Berne, E. 1964. *Games People Play: The psychology of human relationships*. London : Penguin
- Bocknek, G. 1976. A developmental approach to counseling adults. *The Counseling Psychologist*. **6**(1), pp. 37-40
- Bohart, A.C. and Tallman, K. 2010. Clients: The neglected common factor in psychotherapy. In: Duncan, B. L., Miller, S. D., Wampold, B. E., and Hubble, M. A. eds. *The heart and soul of change: Delivering what works in therapy*. 2nd ed. Washington, DC : American Psychological Association, pp.83-111
- Bohart, A.C., Tallman, K.L., Byock, G. and Mackrill, T. 2011. The “Research Jury” Method: The Application of the Jury Trial Model to Evaluating the Validity of Descriptive and Causal Statements about Psychotherapy Process and Outcome. *Pragmatic Case Studies in Psychotherapy*. **7**(1), pp. 101-144
- Bonn, E. 2009. Turbulent Contextualism: Bearing Complexity Toward Change, *International Journal of Psychoanalytic Self Psychology*. **5**(1), pp.1-18
- Boston Change Process Study Group. 2010. *Change in Psychotherapy: A unifying paradigm*. New York : Norton Professional Books
- Bowlby, J. 1971. *Attachment*. Harmondsworth : Penguin Books
- Brenner, I. 2006. Termination of Psychoanalysis and September II. *Psychoanalytic Quarterly*. **75**(3), pp.753-781
- Bromberg, W. 1979. Functional overlay: An illegitimate diagnosis? *The Western Journal of Medicine*. **130**(6), pp.561-565
- Bronstein, C. 2011. On psychosomatics: The search for meaning. *International Journal of Psycho-Analysis*. **92**(1), pp.173–195
- Brown, R.J. 2004. Psychological Mechanisms of Medically Unexplained Symptoms: An Integrative Conceptual Model. *Psychological Bulletin*. **130**(5), pp.793-812
- Carey, T.A. 2011. Exposure and reorganization: The what and how of effective psychotherapy. *Clinical Psychology Review*. **31**(2), pp.236-48

- Cashdan, S. 1973. *Interactional Psychotherapy: Stages and strategies in behavioural change*. New York and London : Grune & Stratton
- Chevalier, J. and Gheerbrant, A. 1996. *The Penguin Dictionary of Symbols*. London : Penguin Books
- Clarkson, P. 1989. *Gestalt Counselling in Action*. London : Sage Publications
- Colognori, D., Herzig-Anderson, K., Reigada, L., Leiby, A., & Masia Warner, C. 2014. Cognitive behavioral therapy. In R.D. Anbar (Ed.), *Functional symptoms in pediatric disease: A clinical guide*. New York: Springer
- Cooper, A., Abbass, A. and Town, J. 2017. Implementing a Psychotherapy Service for Medically Unexplained Symptoms in a Primary Care Setting. *Journal of Clinical Medicine*. **6**(12), pp. 109-141
- Cooper. M. 2019a. *Integrating Counselling & Psychotherapy Directionality, Synergy and Social Change*. London : Sage Publications
- Cooper, M. 2019b. What does it mean to say that life is meaningless? A directional account. 19 July. *Mick Cooper Training & Consultancy*. [Online]. [Accessed: 23 July 2019]. Available from: <https://mick-cooper.squarespace.com/new-blog/2019/7/19/what-does-it-mean-to-say-that-life-is-meaningless-a-directional-account>
- Cooper, M. and Dryden, W. eds. 2016. *The handbook of pluralistic counselling and psychotherapy*. London : Sage Publications
- Corrigall, J., Payne, H.L. and Wilkinson, H. eds. 2006. *About a Body*. London and New York : Routledge
- Creed, F. 2016. Exploding myths about medically unexplained symptoms. *Journal of Psychosomatic Research*. **85**, pp91-93
- Crombez, G., Beirens, K., Van Damme, S., Eccleston, C., and Fontaine, J. 2009. The Unbearable Lightness of Somatisation: A systematic review of the concept of somatisation in empirical studies of pain. **145**(1-2), pp.31-35
- Crombez, G., Eccleston, C., Van Damme, S., Vlaeyen, J.W. and Karoly, P. 2012. Fear-Avoidance Model of Chronic Pain: The Next Generation. *Clinical Journal of Pain*. **28**(6), pp.475-483
- Dallos, R. and Draper, R. 2015. *An introduction to family therapy: Systemic theory and practice*. Maidenhead : Open University Press
- Deary, V., Chalder, T. and Sharp, M. 2007. The Cognitive Behavioural Model of Medically Unexplained Symptoms: a theoretical and empirical review. *Clinical Psychology Review*. **27**(7), pp. 781-797
- Densham, S., Williams, D., Johnson, A. and Turner-Cobb, J.M. 2016. Enhanced psychological flexibility and improved quality of life in chronic fatigue syndrome/myalgic encephalomyelitis. *Journal of Psychosomatic Research*. **88**, pp. 42-7
- DiCarlo, J.J., Zoccolan, D. and Rust, N.C. 2012. How does the brain solve visual object recognition? *Neuron*. **73**(3), pp. 415–434

- Dimaggio, G., Carcione, A., Salvatore, G., Semerari, R. and Nicoló, G. 2010. A rational model for maximizing the effects of therapeutic relationship regulation in personality disorders with poor metacognition and over-regulation of affects. *Psychology and Psychotherapy: Theory, Research and Practice*. **83**(4), pp. 363–384
- Dimaggio, G., Procacci, M., Nicoló, G., Popolo, R., Semerari, A., Carcione, A. and Lysaker, P.H. 2007. Poor metacognition in narcissistic and avoidant personality disorders: Four psychotherapy patients analysed using the Metacognition Assessment Scale. *Clinical Psychology and Psychotherapy*. **14** (5), pp. 386–401
- Dimaggio, G. and Stiles, W.B. 2007. Psychotherapy in Light of Internal Multiplicity *Journal of Clinical Psychology: In session*. **63**(2), pp.119–127
- Dimaggio, G., Valeri, S., Salvatore, G., Popolo, R., Montano, A. and Ottavi, P. 2013. Adopting Metacognitive Interpersonal Therapy to Treat Narcissistic Personality Disorder with Somatization. *Journal of Contemporary Psychotherapy*. **44**(2), [no pagination]
- Donmoyer, G. 2009. Generalisability and the Single-Case Study. In: Gomm, R., Hammersley, M. and Foster, P. eds. *Case Study Method: Key Issues, Key Texts*. London : Sage Publications, pp.45-68
- Doran, N.J. 2014. Experiencing wellness within illness: Exploring a mindfulness-based approach to chronic back pain. *Qualitative Health Research*. **24**(6), pp. 749-760
- Dragioti, E., Dimoliatis, I., Fountoulakis, K.N., Evangelou, E. 2015. A systematic appraisal of allegiance effect in randomized controlled trials of psychotherapy. *Annals of General Psychiatry*. **14**(article 25)
- Duncan, B.L. and Miller, S.D. 2000. The Client's Theory of Change: Consulting the Client in the Integrative Process. *Journal of Psychotherapy Integration*. **10**(2), pp.169-187
- Edwards, T.M., Stern, A., Clarke, D.D., Ivbijaro, G. & Kasney, L.M. (2010). The treatment of patients with medically unexplained symptoms in primary care: a review of the literature. *Mental Health in Family Medicine*. **7**(4), pp. 209–21
- Elliott, R. 2002. Hermeneutic Single-Case Efficacy Design. *Psychotherapy Research*. **12**(1), pp. 1-21
- Elliott, R. 2010. Psychotherapy change process research: Realizing the promise. *Psychotherapy Research*. **20**(2), pp.123-135
- Elliott, R. 2012. Qualitative Methods for Studying Psychotherapy Change Processes. In: Harper, D. and Thompson, A. R. *Qualitative Research Methods in Mental Health and Psychotherapy*. Hoboken : Wiley-Blackwell, pp.69-81
- Fernández-Navarro, P., Ribeiro, A.P., Soylemez, K.K. and Gonçalves, M.M. 2019. [Post-print]. Innovative Moments as Developmental Change Levels: A Case Study on Meaning Integration in the Treatment of Depression. *Journal of Constructivist Psychology*
- Figueiredo, J.M. and Frank, J.D. 1982. Subjective incompetence, the clinical hallmark of demoralization. *Comprehensive Psychiatry*. **23**(4), pp.353-363

- Figueiredo, J.M. and Griffith, J.L. 2016. Chronic Pain, Chronic Demoralization and the Role of Psychotherapy. *Journal of Contemporary Psychotherapy*. **46**(3), pp.167–177
- Fink, P. 2017. Syndromes of bodily distress or functional somatic syndromes - Where are we heading. Lecture on the occasion of receiving the Alison Creed award 2017. *Journal of Psychosomatic Research* **97**, pp.127–130
- Fink, P. and Schröder, A. 2010. One single diagnosis, bodily distress syndrome, succeeded to capture 10 diagnostic categories of functional somatic syndromes and somatoform disorders. *Journal of Psychosomatic Research* **68**(5), pp. 415–426
- Forrester, J. 1996. If p, then what? Thinking in cases. *History of the Human Sciences*. **9**(3), pp.1-25
- Frank, A. 1995. *The Wounded Storyteller: Bodies, Illness and Ethics*. Chicago : The University of Chicago Press
- Fraser, J.S. 2018. *Unifying Effective Psychotherapies: Tracing the process of change*. Washington DC : American Psychological Association
- Freedman, J. and Combs, G. 1996. *Narrative Therapy: The social construction of preferred realities*. New York : WW Norton and Company
- Freshwater, D. and Rolfe, G. 2001. Critical Reflexivity: A politically and ethically engaged research method for nursing. *Journal of Research in Nursing*. **6**(1), pp.526-537
- Freud, S. 1926. Inhibitions, Symptoms and Anxiety. In: *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume 20 (1925-1926)*. London : The Hogarth Press, pp. 75-176
- Freud, S. 1954. *The origins of psychoanalysis: Letters to Wilhelm Fliess, drafts and notes 1887–1902*. New York : Basic Books
- Freud, S. 2002. *Civilisation and its Discontents*. London : Penguin
- Gask, L., Dowrick, C., Salmon, P., Peters, S. and Morris, R. 2011. Reattribution reconsidered: Narrative review and reflections on an educational intervention for medically unexplained symptoms in primary care settings. *Journal of Psychosomatic Research* **71**(5), pp.325-34
- Gloria: Three Approaches to Psychotherapy*. 1965. [Film]. Everett L. Shostrom. Dir. USA : Psychedfilms
- Gonçalves, M.M., Matos, M. and Santos, A. 2009a. Narrative Therapy and the Nature of “Innovative Moments” in the Construction of Change. *Journal of Constructivist Psychology*. **22**(1), pp.1—23
- Gonçalves, M.M., Mendes, I., Ribeiro, A.P., Angus, L.E. and Greenberg, L.S. 2010. Innovative Moments and Change in Emotion-Focused Therapy: The Case of Lisa. *Journal of Constructivist Psychology*. **23**(4), pp. 267-294

- Gonçalves, M.M. and Ribeiro, A.P. 2017. Three narrative-based coding systems: Innovative moments, ambivalence and ambivalence resolution. 14 September. *Society for Psychotherapy Research* webinar. [Online]. [Accessed 14 September 2017]. Webinar no longer live
- Gonçalves, M.M., Ribeiro, A.P., Matos, M., Santos, A. and Mendes, I. 2009b. The Innovative Moments Coding System: A new coding procedure for tracking changes in psychotherapy. In: Salvatore, S., Valsiner, J., Strout, S. and Clegg, J. *Yearbook of Ideographic Science*, vol. 2. Charlotte : Information Age Publishing
- Gonçalves, M.M., Ribeiro, A.P., Mendes, I., Matos, M. and Santos, S. 2011. Tracking novelties in psychotherapy process research: The innovative moments coding system. *Psychotherapy Research*. **21**(5), pp. 497-509
- Gonçalves, M.M., Ribeiro, A.P., Silva, J.R., Mendes, I. and Sousa, I. 2016. Narrative innovations predict symptom improvement: Studying innovative moments in narrative therapy of depression. *Psychotherapy Research*. **26**(4), pp. 425–435
- Graham, C.D., Gillanders, D., Stuart, S. & Gouick, J. 2015. An Acceptance and Commitment Therapy (ACT)–Based Intervention for an Adult Experiencing Post Stroke Anxiety and Medically Unexplained Symptoms. *Clinical Case Studies*. **14**(2), pp.83-97
- Graham, C.D., Stuart, S.R., O'Hara, D.J. & Kemp, S. 2017. Using Acceptance and Commitment Therapy to Improve Outcomes in Functional Movement Disorders: A Case Study. *Clinical Case Studies*. **16**(5), pp. 401–416
- Green, D. 2016. Making the case for using personalised outcome measures to track progress in psychotherapy. *European Journal of Psychotherapy and Counselling*. **18**(1), pp. 39-57
- Greenberg, L.S. 2007. A guide to conducting a task analysis of psychotherapeutic change. *Psychotherapy Research*. **17**(1), pp.15-30
- Gubb, K. 2013. Psychosomatics Today: A Review of Contemporary Theory and Practice. *Psychoanalytic Review*. **100**(1), pp.103-42
- Halfon, S., Cavdar, A., Paoloni, G., Andreassi, S., Giuliani, A., Orsucci, F. and de Felice, G. 2019. Monitoring Nonlinear Dynamics of Change in a Single Case of Psychodynamic Play Therapy. *Nonlinear Dynamics Psychology and Life Sciences*. **23**(1), pp.113-135
- Hartunga, T. and Steinbrecher, M. 2017. From somatic pain to psychic pain: The body in the psychoanalytic field. *International Journal of Psychoanalysis*. **99**(1), pp.159-180
- Hayes, A.M., Laurenceau, J., Feldman, G., Strauss, J.L. and Cardaciotto, L. 2007. Change is not always linear: The study of nonlinear and discontinuous patterns of change in psychotherapy. *Clinical Psychology Review*. **27**(6), pp.715-723
- Hayes, S.C. 2004. Acceptance and Commitment Therapy, Relational Frame Theory, and the Third Wave of Behavioral and Cognitive Therapies. *Behavior Therapy*. **35**(4), pp.639-665

- Hayes, S.C. and Lillis, J. 2012. *Acceptance and Commitment Therapy*. Washington DC : American Psychological Association
- Hayes, S.C., Strosahl, K.D., and Wilson, K.G. 1999. *Acceptance and Commitment Therapy: An experiential approach to behaviour change*. New York and London : The Guilford Press
- Heaton, Kenneth W. 2012. Somatic expressions of grief and psychosomatic illness in the works of William Shakespeare and his coevals. *Journal of Psychosomatic Research*. **73**(4), pp. 301-306
- Hermans, H.J. 1996. Voicing the Self: From Information Processing to Dialogical Interchange. *Psychological Bulletin*. **119**(1), pp.31-50
- Hermans, H.J., Kempen, H.J., and Van Loon, R.J. 1992. The Dialogical Self: Beyond individualism and rationalism. *American Psychologist*. **47**(1), pp.23-33
- Hills, J. 2018. The Psychosomatics of distress: Case study insights into lived experience and therapeutic change. *Self and Society*. **46**(2), pp. 58-65
- Hills, J., Cahill, J., Lees, J. and Freshwater, D. 2018a. Indices of change: Analysing the indexical properties of data from psychotherapy case work to discern patterns of therapeutic change over time. In: Costa, A.P., Reis, L.P., Souza, F.N.D., and Moreira, A. eds. 2018. *Computer Supported Qualitative Research*. Advances in Intelligent Systems and Computing. Berlin: Springer Verlag, pp.418-424
- Hills, J., Cahill, J., Lees, J., Freshwater, D. and Krivzov, J. 2020. [currently under peer review]. Mechanisms of change in psychotherapy with physical symptom presentations: a qualitative synthesis of case study evidence
- Hills, J., Lees, J. Freshwater, D. and Cahill, J. 2018b. Psychosoma in Crisis: An autoethnographic study of medically unexplained symptoms and their diverse contexts. *British Journal of Guidance and Counselling*. **46**(2), pp.135-147
- Hinshelwood, R.D. 2013. *Research on the couch: Single-case studies, subjectivity and psychoanalytic knowledge*. London and New York : Routledge
- Hoff, K. and Stiglitz, J.E. 2016. Striving for balance in economics: Towards a theory of the social determination of behaviour. *Journal of Economic Behavior and Organization*. **126**(B), pp.25–57
- Holloway, I. and Todres, L. 2003. The status of method: flexibility, consistency and coherence. *Qualitative Research*. **3**(3), pp. 345-357
- IAPT (Improved Access to Psychological Therapies). 2014. Medically Unexplained Symptoms / Functional Symptoms: Positive Practice Guide. *IAPT Medically Unexplained Symptoms Evaluation Task and Finish Group (2012-13)*. The Department of Health. Available from: <https://www.uea.ac.uk/documents/246046/11919343/medically-unexplained-symptoms-positive-practice-guide-.pdf/55aea215-100e-4925-a968-65d6e89ad9b3>

- Iwakabe, S., and Conceição, N. 2015. Metatherapeutic Processing as a Change-Based Therapeutic Immediacy Task: Building an Initial Process Model Using a Task-Analytic Research Strategy. *Journal of Psychotherapy Integration*. **23**(3), pp.230-247
- Jackson, C. 2018. It Aint What You Do... *Therapy Today*. **29**(4), pp.8-12
- Jenkins, P. 2019. First do no harm. Second, do no direct, qualitative research with psychotherapy clients... *Contemporary Psychotherapy*. **10**(2), Available from: <http://www.contemporarypsychotherapy.org/vol-10-no-2-winter-2019/first-do-no-harm-second-do-no-direct-qualitative-research-with-psychotherapy-clients/>
- Johnstone, L. and Watson, J. 2017. Just Listen to their Stories. *Therapy Today*. **28**(3), pp.30-33
- Jones, E. 1993. *Family Systems Therapy: Developments in the Milan-Systemic therapies*. Chichester : Wiley
- Kannan, D., Henretty, J.R., Piazza-Bonin, E., Levitt, H., Coleman, R.A., Bickerest-Townsend, M. and Mathews, S.S. 2011. The Resolution of Anger in Psychotherapy: A Task Analysis. *The Humanistic Psychologist*. **39**(2), pp.169-181
- Kaplan, M.J. 2016. Clinical considerations regarding regression in psychotherapy with patients with conversion disorder. *Psychodynamic Psychiatry*. **44**(3), pp.367-84
- Karasu, T.B. 1979. Psychotherapy of the psychosomatic patient. *American Journal of Psychotherapy*. **33**(3), pp.354-364
- Karpman, S. B. 1968. Fairy tales and script drama analysis. *Transactional Analysis Bulletin*. **7**(26), pp. 39–43
- Kashdan, T.B. 2010. Psychological Flexibility as a Fundamental Aspect of Health. *Clinical Psychology Review*. **30**(7), pp. 865–878
- Kazdin, A.E. 2007. Mediators and Mechanisms of Change in Psychotherapy Research. *Annual Review of Clinical Psychology*. **3**(1), pp.1-27
- Kazdin, A.E. 2009. Understanding how and why psychotherapy leads to change. *Psychotherapy Research*. **19**(4), pp. 418-428
- Kessinger, S.W. 1959. The Indispensable Man. In: Kessinger, S.W. 2012. The Indispensable Man. 15 June. *Blowing away my life*. [Online]. [Accessed: 3rd January 2020]. Available from: <https://blowingawaymylife.wordpress.com/2012/06/15/the-indispensable-man/>
- Kim, J. 2018. Can good posture help mental health? 12 June. *Psychology Today*. [Online]. [Accessed 11th June 2019]. Available from: <https://www.psychologytoday.com/gb/blog/culture-shrink/201806/can-good-posture-help-mental-health>
- Kirmayer, L.J., Groleau, D., Looper, K.J., and Dao, M.D. 2004. Explaining medically unexplained symptoms. *Canadian Journal of Psychiatry*. **49**(10), pp.663-72.
- Kirmayer, L.J. and Sartorius, N. 2007. Cultural Models and Somatic Syndromes. *Psychosomatic Medicine*. **69**(9), pp 832-840

- Kirsch, I., Wampold, B., and Kelley, J. M. 2016. Controlling for the placebo effect in psychotherapy: Noble quest or tilting at windmills? *Psychology of Consciousness: Theory, Research, and Practice*. **3**(2), pp. 121-131
- Kleinstäuber, M., Witthöft, M. and Hiller, W. 2011. Efficacy of short-term psychotherapy for multiple medically unexplained physical symptoms: A meta-analysis. *Clinical Psychology Review*. **31**(1), pp. 146–160
- Koelen, J.A., Houtveen, J. H., Abbass, A., Luyten, P., Eurelings-Bontekoe, E.H.M., Van Broeckhuysen-Kloth, S.A.M., Buhring, M.E.F. and Geenen, R. 2014. Effectiveness of psychotherapy for severe somatoform disorder: meta-analysis. *The British Journal of Psychiatry*. **204**(1), pp.12-19
- Konopka, A., Niemeyer, R.A. and Jacobs-Lentz, J. 2018. Composing the Self: Toward the Dialogical Reconstruction of Self-Identity, *Journal of Constructivist Psychology*. **31**(3), pp.308-320
- Kornelsen, J., Atkins, C., Brownell, K. and Woollard, R. 2015. The Meaning of Patient Experiences of Medically Unexplained Physical Symptoms. *Qualitative Health Research*, **26**(3), pp. 367-376
- Kozłowska, K. and Khan, R. 2011. A developmental, body-oriented intervention for children and adolescents with medically unexplained chronic pain. *Clinical Child Psychology and Psychiatry*. **16**(4), pp. 575–598
- Kozłowska, K. 2016. The Body Comes to Family Therapy: Utilising Research to Formulate Treatment Interventions with Somatising Children and their Families. *Australian and New Zealand Journal of Family Therapy*. **37**(1), pp.6–29
- Kozłowska, K., Chudleigh, C., Elliott, B., & Landini, A. 2016. The body comes to family therapy: Treatment of a school-aged boy with hyperventilation-induced non-epileptic seizures. *Clinical Child Psychology and Psychiatry*. **21**(4), pp.669–685
- Krebs, P., Norcross, J.C., Nicholson, J.M. and Prochaska, J.O. 2018. Stages of change and psychotherapy outcomes: A review and meta-analysis. *Journal of Clinical Psychology*. **74**(11), pp.1964-1979
- Kroenke, K. 2007. Efficacy of Treatment for Somatoform Disorders: A Review of Randomized Controlled Trials. *Psychosomatic Medicine*. **69**(9), pp 881-888
- Kroenke, K. and Spitzer, R.L. 2002. The PHQ-9: A new depression diagnostic and severity measure. *Psychiatric Annals*. **32**(9), pp.509-515
- Lamb, J., Bower, P., Rogers, A.; Dowrick, C. and Gask, L. 2011. Access to mental health in primary care: A qualitative meta-synthesis of evidence from the experience of people from ‘hard to reach’ groups. *Health*. **16**(1) pp.76–104
- Landa, S. and Duschinsky, R. 2013. Crittenden’s dynamic-maturational model of attachment and adaptation. *Review of General Psychology*. **17**(3), pp. 326-228

- Larsen, M.H. 2015. Nutritional advice from George Orwell. Exploring the social mechanisms behind the overconsumption of unhealthy foods by people with low socio-economic status. *Appetite*. **91**, pp.150–156
- Launer, J. 2009. Medically Unexplained Stories. *Postgraduate Medical Journal*. **85**, pp.503-504
- Le Roux, C.S. 2017. Exploring rigour in autoethnographic research. *International Journal of Social Research Methodology*. **20**(2), pp.195-207
- Levin, P. 1998. Devolution: The Link between Script Instructions and Physical Illness. *Transactional Analysis Journal*. **28**(2), pp.100-110
- Levitt, H.M., Morrill, Z. and Collins, K.M. 2019. Considering methodological integrity in counselling and psychotherapy research. *Counselling and Psychotherapy Research*. **00**, pp.1–7
- Levitt, H. M., Motulsky, S. L., Wertz, F. J., Morrow, S. L., and Ponterotto, J. G. 2017. Recommendations for designing and reviewing qualitative research in psychology: Promoting methodological integrity. *Qualitative Psychology*. **4**(1), pp.2-22
- Lieberson, S. 2000. Small N's and Big Conclusions. In: Gomm, R., Hammersley, M. and Foster, P. *Case Study Method: Key Issues, Key Texts*. London : Sage Publications, pp.208-222
- Liersch, U. and Maher-Edwards, L. 2017. Chronic Pain and Counselling Psychology: Application of the existential phenomenological four-dimension model in working with clients with chronic pain. *Journal of Psychotherapy and Counselling Psychology*. **2**(2), pp.31-37
- Lincoln, Y.S. and Guba, E.G. 2009. The Only Generalisation is: There is No Generalisation. In: Gomm, R., Hammersley, M. and Foster, P. *Case Study Method: Key Issues, Key Texts*. London : Sage Publications, pp.27-44
- Liu, J., Gill, N.S, Teodorczuk, A., Li, Z. and Sun, J. 2019. The efficacy of cognitive behavioural therapy in somatoform disorders and medically unexplained physical symptoms: A meta-analysis of randomized controlled trials. *Journal of Affective Disorders*. **245**, pp. 98-112
- Lloyd, C.E.M., Duncan, C. & Cooper, M. 2019. Goal measures for psychotherapy: A systematic review of self-report, idiographic instruments. *Clinical Psychology Science and Practice*. **26**(3), pp. 1-16
- Luca, M. 2012. Therapeutic activities and psychological interventions by cognitive behavioural and psychodynamic therapists working with medically unexplained symptoms: A qualitative study. *Counselling and Psychotherapy Research*. **8**(2), pp.118-127
- Luyten, P., Lowyck, B. and Blatt, S.J. 2017. Mechanisms of Change Through the Lens of Two-Polarities Models of Personality Development: State of the Art and New Directions. *Psychoanalytic Inquiry*. **37**(3), pp. 179-190
- Luyten, P., Van Houdenhove, B., Lemma, A., Target, M. and Fonagy, P. 2012. A mentalization-based approach to the understanding and treatment of functional somatic disorders. *Psychoanalytic Psychotherapy*. **26**(2), pp.121–140

- Marks-Tarlow, T. 2011. Merging and Emerging: A Nonlinear Portrait of Intersubjectivity During Psychotherapy. *Psychoanalytic Dialogues*. **21**(1), pp.110–127
- Marmot, M. 2015. *The Health Gap: The challenge of an unequal world*. London : Bloomsbury Publishing
- Masuda, A. and Tully, E.C. 2012. The role of mindfulness and psychological flexibility in somatization, depression, anxiety, and general psychological distress of a non-clinical college sample. *Journal of Evidence-Based Complementary and Alternative Medicine*. **17**(1), pp.66-71
- McCormack, D. and Chalder, T. 2018. Horses for courses: choosing an evidence-based psychological therapy for your patient. *BJPsych Advances*. **24**(6), pp.402-411
- McCracken. L.M. and Velleman, S.C. 2010. Psychological flexibility in adults with chronic pain: A study of acceptance, mindfulness, and values-based action in primary care. *Pain*. **148**(1), pp.141-7
- McDougall, J. 1989. *Theatres of the Body: A Psychoanalytic Approach to Psychosomatic Illness*. New York : W.W. Norton & Company
- McLeod, J. 2010. *Case Study Research*. London : Sage Publications
- McLeod, J. 2013. Increasing the rigour of case study evidence in therapy research. *Pragmatic Case Studies in Psychotherapy*. **9**(4), pp.382-402
- McLeod, J. 2017. Science and psychotherapy: Developing research-based knowledge that enhances the effectiveness of practice. *Transactional Analysis Journal*. **47**(2), pp.82-101
- McLeod, J. 2018. *Pluralistic Therapy*. Oxford : Routledge
- McLeod, J. and McLeod, J. 2016. Assessment and formulation in pluralistic counselling and psychotherapy. In: Cooper, M. and Dryden, W. eds. *The handbook of pluralistic counselling and psychotherapy*. London : Sage Publications, pp.15-27
- McMillan, D., Gilbody, S. and Richards, D. 2010. Defining successful treatment outcome in depression using the PHQ-9: A comparison of methods. *Journal of Affective Disorders*. **127**(1-3), pp.122-9
- McNaughton, D.T., Hush, J.M., Beath, A.P., Dear, B.F. and Jones, M.P. 2018. No moderating impact of a medically unexplained etiology on the relationship between psychological profile and chronic pain. *Journal of Psychosomatic Research*. **115**, pp.87-93
- Meekums, B. 2008. Embodied narratives in becoming a counselling trainer: an autoethnographic study. *British Journal of Guidance and Counselling*. **36**(3), pp.287-301
- Meganck, R., Inslegers, R., Krivzov, J. and Notaerts, L. 2017. Beyond Clinical Case Studies in Psychoanalysis: A review of psychoanalytic empirical single-case studies published in ISI-ranked journals. *Frontiers in Psychology*. **8**(Article 1749)
- Meira, L., Salgado, J., Sousa, I., Ribeiro, A.P. and Gonçalves, M.M. 2017. Psychological Change in Everyday Life: An Exploratory Study. *Journal of Constructivist Psychology*. **31**(3), pp.252-272

- Meystre, C., Pascual-Leone, A., de Roten, Y., Despland, J. and Kramer, U. 2015. What interventions facilitate client progress through the assimilation model? A task analysis of interventions in the psychodynamic treatment of depression, *Psychotherapy Research*. **25**(4), pp.484-502
- Miller, R.B. 2011. Panels of Psychological Inquiry for Transforming Anecdotal Data into Clinical Facts and Validated Judgments: Introduction to a Pilot Test with the Case of "Anna". *Pragmatic Case Studies in Psychotherapy*. **7**(1), pp. 6-36
- Miller, S., Hubble, M. and Duncan, B. 2007. Supershinks: What is the secret of their success? *Psychotherapy in Australia*. **14**(4), pp.14-22
- Monarchy, Season 3, Episode 2, The Glorious Revolution*. 2006. Channel 4. 20 November, 21:00
- Monk, G., Winslade, J., Crocket, K. and Epston, D. 1997. *Narrative Therapy in Practice: the archaeology of hope*. San Francisco : Jossey-Bass
- Mosher, J.K. and Stiles, W.B. 2009. Clients' assimilation of experiences of their therapist. *Psychotherapy Theory, Research, Practice, Training*. **46**(4), pp.432-447
- Moustakas, C. 1992. *Heuristic Research: Design, methodology and applications*. London : Sage Publications
- Muncey, T. 2010. *Creating Autoethnographies*. London : Sage Publications
- Murphy, J., Rowell, L., McQuaid, A., Timulak, L., O'Flynn, R. and McElvaney, J. 2017. Developing a model of working with worry in emotion-focused therapy: A discovery-phase task analytic study. *Counselling and Psychotherapy Research*. **17**(1), pp. 56-70
- Nasim, R., Shimshi, S., Ziv-Beiman, S., Peri, T., Fernández-Navarro, P., Oliveira, J. T., and Gonçalves, M. M. 2018. [Post-print]. Exploring Innovative Moments in a Brief Integrative Psychotherapy Case Study. *Journal of Psychotherapy Integration*
- Nathan, P.E., Stuart, S.P., and Dolan, S.L. 2000. Research on psychotherapy efficacy and effectiveness: Between Scylla and Charybdis? *Psychological Bulletin*. **126**(6), pp.964-981
- O'Sullivan, S. 2015. *It's All in your Head: True stories of imaginary illness*. London : Penguin
- O'Toole, F. 2014. Modern Ireland in 100 artworks: 1922 – Ulysses, by James Joyce. 24 December. *The Irish Times*. [Online]. [Accessed 12 October 2019]. Available from: <https://www.irishtimes.com/culture/modern-ireland-in-100-artworks-1922-ulysses-by-james-joyce-1.2044029>
- Oyserman, D., Smith, G.C., and Elmore, K. 2014. Identity-Based Motivation: Implications for Health and Health Disparities. *Journal of Social Issues*. **70**(2), pp. 206--225
- Patel, K. 2016. Chronic Pain and the Self. *Therapy Today*. **27**(5), pp. 11-14
- Payne, H.L. 2015. The Body speaks its Mind: The BodyMind Approach for Patients with Medically Unexplained Symptoms in Primary Care in England. *The Arts in Psychotherapy*. **42**, pp. 19-27
- Payne, H.L. 2017. Moving on: the BodyMind Approach for medically unexplained symptoms. *Journal of public mental health*. **16**(2), pp.63-71

- Peirce, C.S. 1903. *A Syllabus of Certain Topics of Logic*. Boston : Alfred Mudge & Son
- Petrocelli, J.V. 2002. Processes and Stages of Change: Counseling With the Transtheoretical Model of Change. *Journal of Counseling and Development*. **80**(1), pp. 22-30
- Prochaska, J.O. and Norcross, J.C. 2001. Stages of Change. *Psychotherapy: Theory, Research and Practice*. **38**(4), pp.443-448
- Quinn, M. C., Schofield, M. J., & Middleton, W. 2012. Successful psychotherapy for psychogenic seizures in men. *Psychotherapy Research*. **22**(6), pp. 682-698
- Råbu, M., McLeod, J., Haavind, H., Stange Bernhardt, I., Nissen-Lie, H. and Moltu, C. 2019. [Post-print]. How psychotherapists make use of their experiences from being a client: Lessons from a collective autoethnography. *Counselling Psychology Quarterly*
- Ribeiro, A.P., Braga, C., Stiles, W.B., Teixeira, P. Gonçalves, M.M. and Ribeiro, E. 2016a. Therapist interventions and client ambivalence in two cases of narrative therapy for depression, *Psychotherapy Research*. **26**(6), pp.681-693
- Ribeiro, A.P. and Gonçalves, M.M. 2010. Commentary: Innovation and Stability within the Dialogical Self: The Centrality of Ambivalence. *Culture and Psychology*. **16**(1), pp. 116-126
- Ribeiro, A.P., Gonçalves, M.M., Silva, J.R., Brás, A. and Sousa, I. 2016b. Ambivalence in Narrative Therapy: A Comparison Between Recovered and Unchanged Cases. *Clinical Psychology and Psychotherapy*. **23**(2), pp. 166–175
- Ribeiro, E., Gonçalves, M.M. and Santos, B. 2018. [Post-print]. How Reconceptualization of the Self Is Negotiated in Psychotherapy: An Exploratory Study of the Therapeutic Collaboration. *Journal of Humanistic Psychology*
- Ribeiro, E., Ribeiro, A.P., Gonçalves, M.M., Horvath, A.O. and Stiles, W.B. 2013. How collaboration in therapy becomes therapeutic: The therapeutic collaboration coding system. *Psychology and Psychotherapy: Theory, Research and Practice*. **86**(3), pp.294–314
- Rice, L.N. and Greenberg, L.S. eds. 1984. *Patterns of Change: Intensive analysis of psychotherapy process*. New York and London : The Guilford Press
- Robinson, E., Titov, N., Andrews, G., McIntyre, K., Schwencke, G. and Solley, K. 2010. Internet treatment for Generalized Anxiety Disorder: A randomized controlled trial comparing clinician vs technician assistance. *PLOS ONE*. **5**(6), [no pagination]
- Rogers, C.R. 1961. *On Becoming a Person: A therapist's view of psychotherapy*. Boston : Houghton Mifflin Company
- Ross, S.M. and Proctor, S. 1973. Frequency and duration of hierarchy item exposure in a systematic desensitization analogue. *Behaviour Research and Therapy*. **11**(3), pp. 303-312
- Roth, W.M. 2012. *First Person Methods: Towards an Empirical Phenomenology of Experience*. Leiden : Sense Publishers

- Rowe, W. 2014. Positionality. In Coghlan, D. and Brydon-Miller, M. (eds). *Sage Encyclopaedia of Action Research*. London : Sage Publications, pp.627-628
- Scott, W., Hann, K.E.J., and McCracken, L.M. 2016. A Comprehensive Examination of Changes in Psychological Flexibility Following Acceptance and Commitment Therapy for Chronic Pain. *Journal of Contemporary Psychotherapy*. **46**(3), pp.139–148
- Sedgwick, D. 1994. *The Wounded Healer: Countertransference from a Jungian perspective*. Florence : Taylor & Frances/Routledge
- Seligman, S. 2014. Paying Attention and Feeling Puzzled: The Analytic Mindset as an Agent of Therapeutic Change. *Psychoanalytic Dialogues*. **24**(6), pp.648-662
- Skjerve, J., Reichelt, S. and McLeod, J. 2016. Topic change processes in psychotherapy: a case study approach, *Qualitative Research in Psychology*. **13**(4), pp.271-288
- Social Care Institute for Excellence. 2015. *Co-production in social care: what it is and how to do it – At a glance*. [online]. [Accessed 26 May 2020]. Available from: <https://www.scie.org.uk/publications/guides/guide51/at-a-glance/>
- Spitzer, R.L., Kroenke, K., Williams, J.B.W. and Löwe, B. 2006. A brief measure for assessing generalised anxiety disorder: GAD-7. *Archives of Internal Medicine*. **166**(10), pp.1092-1097
- Stake, R.E. 1978. The Case Study Method in Social Inquiry. *Educational Researcher*. **7**(2), pp.5-8
- Stake, R.E. 2006. *Multiple Case Study Analysis*. New York : Guilford Press
- Stiles, W. B. 2001. Assimilation of problematic experiences. *Psychotherapy*. **38**(4), pp. 462–465
- Stiles, W.B. 2007. Theory-building case studies of counselling and psychotherapy, *Counselling and Psychotherapy Research*. **7**(2), pp.122-127
- Stiles, W.B. 2009. Logical Operations in Theory-Building Case Studies. *Pragmatic Case Studies in Psychotherapy*. **5**(3), pp. 9-22
- Stiles, W.B. 2011. Coming to Terms. *Psychotherapy Research*. **21**(4), pp.367-384
- Stiles, W.B., Galalda, I.S. and Ribeiro, E. 2016. Exceeding the therapeutic zone of proximal development as clinical error. *Psychotherapy*. **53**(3), pp.268 –272
- Stiles, W.B., Morrison, L.A., Haw, S.K., Harper, H., Shapiro, D.A. and Firth-Cozens, J. 1991. Longitudinal Study of Assimilation in Exploratory Psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*. **28**(2), pp.195-206
- Stuthridge, J. 2017. Falling apart and getting it together: the dialectics of disintegration and integration in script-change and self-development. *Transactional Analysis*. **47**(1), pp.19-31
- Sullivan, P. 2012. *Qualitative Data Analysis Using a Dialogical Approach*. London : Sage
- Thakur, E. R, Holmes, H. J, Lockhart, N. A., Carty, J. N., Ziadni, M. S., Doherty, H. K., Lackner, J. M., Schubiner, H. & Lumley M. A. 2017. Emotional awareness and expression training improves irritable bowel syndrome: A randomized controlled trial. *Neurogastroenterology*. **29**(12), [no pagination]

- Theodoratou-Bekou, M., Ou, A., Andriopoulou, P. and Wood, B. 2012. Stress-related asthma and family therapy: Case study. *Annals of General Psychiatry*. 11(1), [no pagination]
- Thoreau, H.D. 2008. *Walden: Civil Disobedience and Other Writings*. New York : WW Norton and Company
- Timmer, B., Bleichhardt, G. and Rief, W. 2006. Importance of Psychotherapy motivation in patients with somatization syndrome. *Psychotherapy Research*. 16(3), pp.348-356
- Tikkanen, S., Stiles, W.N. and Leiman, M. 2013. Achieving an empathic stance: Dialogical sequence analysis of a change episode. *Psychotherapy Research*. 23(2), pp.178-189
- Tolman, E.C. 1948. Cognitive maps in rats and men. *The Psychological Review*. 55(4), pp.189-208
- Toren, M. and Luca, M. 2017. The persecutory character of irritable bowel syndrome: A grounded theory of the lived experience of IBS sufferers. *Journal of Psychotherapy and Counselling Psychology Reflections*. 2(2), pp.39-51
- Totton, N. 2003. *Body Psychotherapy: an introduction*. Maidenhead : Open University Press
- Totton, N. 2014. *Embodied Relating: The Ground of Psychotherapy*. London : Routledge
- Town, J.M., Lomax, V., Abbass, A.A. and Hardy, G. 2017. The role of emotion in psychotherapeutic change for medically unexplained symptoms. *Psychotherapy Research*. 29(1), pp.86-98
- Trainor, A.A. and Graue, E. 2014. Evaluating Rigor in Qualitative Methodology and Research Dissemination. *Remedial and Special Education*. 35(5), pp. 267 –274
- Trop, J.L., Burke, M.L. and Trop, G.S. 2013. Psychoanalytic Theory and Psychotherapy: A Dynamic Systems View of Change. *Clinical Social Work Journal*. 41(1), pp 34–42
- Truijens, F., Desmet, M., De Coster, E., Uyttenhove, H., Deeren, B. and Meganck, R. 2019. [Post-print]. When quantitative measures become a qualitative storybook: A phenomenological case analysis of validity and performativity of questionnaire administration in psychotherapy research. *Qualitative Research in Psychology*.
- Vancea, M. and Utzet, M. 2017. How unemployment and precarious employment affect the health of young people: A scoping study on social determinants. *Scandinavian Journal of Public Health*. 45(1), pp.73–84
- Van Hennik, R. and Hillewaere, B. 2017. Practice Based Evidence Based Practice. Navigating based on coordinated improvisation, collaborative learning and multi-methods research in Feedback Informed Systemic Therapy. *Journal of Family Therapy*. 39(3), pp.288–309
- Wampold, B.E. 2015. How important are the common factors in psychotherapy? An update. *World Psychiatry*. 14(3), pp.270–27
- Wells, A. and Purdon, C. 1999. Metacognition and cognitive-behaviour therapy: a special issue. *Clinical Psychology and Psychotherapy*. 6(2), pp.71–72
- West, R. 2005. Time for a change: putting the Transtheoretical (Stages of Change) Model to rest. *Addiction*. 100(8), pp.1036-1038

- White, M. 2007. *Maps of Narrative Practice*. New York : Norton Professional Books
- Wiech K., Ploner, M. and Tracey, I. 2008. Neurocognitive aspects of pain perception. *Trends in Cognitive Sciences*. **12**(8), pp.306-13
- Wilkinson, R. G. and Pickett, K. 2011. *The Spirit Level: Why Greater Equality Makes Societies Stronger*. New York: Bloomsbury
- Wilkinson, R.G. and Pickett, K. 2018. *The Inner Level: How More Equal Societies Reduce Stress, Restore Sanity and Improve Everyone's Well-Being*. London : Allen Lane
- Wilson, C. 2019. The illnesses caused by a disconnect between brain and mind. *New Scientist*. 3 April. [online]. [accessed 13 April 2019]. Available from:
<https://www.newscientist.com/article/mg24232240-100-the-illnesses-caused-by-a-disconnect-between-brain-and-mind/>
- Winnicott, D. W. 1953. Transitional objects and transitional phenomena; a study of the first not-me possession. *The International Journal of Psychoanalysis*. **34**, pp.89–97
- Winnicott, D.W. 1965. *The maturational processes and the facilitating environment: Studies in the theory of emotional development*. New York : International Universities Press
- Winnicott, D.W. 1966. Psycho-somatic Illness in its positive and negative aspects. *International Journal of Psychoanalysis*. **47**(4), pp.510-6
- Wolman, T. and Thompson, T.L. 1996. Psychoanalytic Approach to the Psychosomatic Interface. In: Neressian, E. 1996. *Textbook of Psychoanalysis*. Washington DC : American Psychiatric Press pp. 391-418
- Yalom, I.D. 1980. *Existential Psychotherapy*. New York : Basic Books
- Yesudian, S. 1976. *Yoga Week by Week*. London : George Allen & Unwin Ltd.
- Young, J.E., Klosko, J.S. and Weishaar, M.E. 2003. *Schema therapy: a practitioner's guide*. New York: Guilford Press

Bibliography

- Abbass, A. 2005. Somatization: Diagnosing it sooner through emotion-focused interviewing. *The Journal of Family Practice*. **54**(3), pp.215-224
- Abel, A., Henley, W., Hayes, A., and Kuyken, W. 2016. Sudden Gains in Cognitive-Behavior Therapy for Treatment-Resistant Depression: Processes of Change. *Journal of Consultant Clinical Psychology*. **84**(8), pp.726-737
- Allen, J.G., Fonagy, P. and Bateman, A.W. 2008. *Mentalizing in Clinical Practice*. Washington DC : American Psychiatric Publishing
- Allen, L.A. and Woolfolk, R. 2006. Affective Cognitive Behavioral Therapy: A new treatment for somatization. *Behavioural Psychology*. **14**(3), pp.549-566
- Anderson, L. 2006. Analytic Autoethnography. *Journal of Contemporary Ethnography*. **35**(4), pp.373-395
- Arntz, A. 2019. [Post-print]. A plea for more attention to mental representations. *Journal of Behavior Therapy and Experimental Psychiatry*.
- Bager-Charleson, S. 2014. *Doing Practice-Based Research in Therapy: A reflexive approach*. London : Sage Publications
- Bager-Charleson, S. and Kasap, Z. 2017. Embodied situatedness and emotional entanglement in research— An autoethnographic hybrid inquiry into the experience of doing data analysis. *Counselling and Psychotherapy Research*. **17**(3), pp. 190–200
- Bakhtin, M.M. 1981. *The Dialogic Imagination: Four Essays*. Austin : University of Texas Press
- Balabanovic, J. And Hayton, P. 2019. [Post-print]. Engaging patients with "medically unexplained symptoms" in psychological therapy: An integrative and transdiagnostic approach. *Psychology and Psychotherapy: Theory, Research and Practice*
- Balkin, R.S. and Kliet, D.M. 2017. *Counseling Research: A scholar-practitioner approach*. Alexandria : American Counseling Association
- Bandura, A. 1998. Health promotion from the perspective of social cognitive theory, *Psychology and Health*. **13**(4), pp.623-649
- Bandura, A. 2007. Reflections on an Agentic Theory of Human Behavior. *Tidsskrift for Norsk Psykologforening*. **10**, pp.995-1004
- Batista, J., Silva, J., Freitas, S., Alves, D., Machado, A., Sousa, I., Fernández-Navarro, P., Magalhães, C. and Gonçalves, M.M. 2019. Relational schemas as mediators of innovative moments in symptom improvement in major depression. *Psychotherapy Research*. **29**(1), pp.58-69
- Benítez, J.L., Abalscal, A., Garrido, M. and Escudero, V. 2019. [Post-print]. Building an expanded therapeutic analysis: a task-analysis with families trapped in parental-adolescent conflict. *Family Process*

- Benoot, C., Hannes, K. and Bilsen, J. 2016. The use of purposive sampling in a qualitative evidence synthesis: A worked example on sexual adjustment to cancer trajectory. *BMC Medical Research Methodology*. **16**(article 21)
- Berne, E. 1964. *Games People Play: The psychology of human relationships*. London : Penguin
- Bocknek, G. 1976. A developmental approach to counseling adults. *The Counseling Psychologist*. **6**(1), pp. 37-40
- Bohart, A.C., Tallman, K.L, Byock, G. and Mackrill, T. 2011. The “Research Jury” Method: The Application of the Jury Trial Model to Evaluating the Validity of Descriptive and Causal Statements about Psychotherapy Process and Outcome. *Pragmatic Case Studies in Psychotherapy*. **7**(1), pp. 101-144
- Bonn, E. 2009. Turbulent Contextualism: Bearing Complexity Toward Change, *International Journal of Psychoanalytic Self Psychology*. **5**(1), pp.1-18
- Boston Change Process Study Group. 2010. *Change in Psychotherapy: A unifying paradigm*. New York : Norton Professional Books
- Bowlby, J. 1971. *Attachment*. Harmondsworth : Penguin Books
- Brenner, I. 2006. Termination of Psychoanalysis and September II. *Psychoanalytic Quarterly*. **75**(3), pp.753-781
- Bromberg, W. 1979. Functional overlay: An illegitimate diagnosis? *The Western Journal of Medicine*. **130**(6), pp.561-565
- Bronstein, C. 2011. On psychosomatics: The search for meaning. *International Journal of Psycho-Analysis*. **92**(1), pp.173–195
- Brown, R.J. 2004. Psychological Mechanisms of Medically Unexplained Symptoms: An Integrative Conceptual Model. *Psychological Bulletin*. **130**(5), pp.793-812
- Caldwell, L. and Joyce, A. eds. 2011 *Reading Winnicott*. Hove : Routledge
- Carey, T.A. 2011. Exposure and reorganization: The what and how of effective psychotherapy. *Clinical Psychology Review*. **31**(2), pp.236-48
- Cashdan, S. 1973. *Interactional Psychotherapy: Stages and strategies in behavioural change*. New York and London : Grune & Stratton
- Chevalier, J. and Gheerbrant, A. 1996. *The Penguin Dictionary of Symbols*. London : Penguin Books
- Clarkson, P. 1989. *Gestalt Counselling in Action*. London : Sage Publications
- Colognori, D., Herzig-Anderson, K., Reigada, L., Leiby, A., & Masia Warner, C. 2014. Cognitive behavioral therapy. In R.D. Anbar (Ed.), *Functional symptoms in pediatric disease: A clinical guide*. New York: Springer
- Cooper, A., Abbass, A. and Town, J. 2017. Implementing a Psychotherapy Service for Medically Unexplained Symptoms in a Primary Care Setting. *Journal of Clinical Medicine*. **6**(12), pp. 109-141

- Cooper, M. 2019a. *Integrating Counselling & Psychotherapy Directionality, Synergy and Social Change*. London : Sage Publications
- Cooper, M. 2019b. What does it mean to say that life is meaningless? A directional account. 19 July. *Mick Cooper Training & Consultancy*. [Online]. [Accessed: 23 July 2019]. Available from: <https://mick-cooper.squarespace.com/new-blog/2019/7/19/what-does-it-mean-to-say-that-life-is-meaningless-a-directional-account>
- Cooper, M. and Dryden, W. eds. 2016. *The handbook of pluralistic counselling and psychotherapy*. London : Sage Publications
- Corrigan, J., Payne, H.L. and Wilkinson, H. eds. 2006. *About a Body*. London and New York : Routledge
- Costa, A.P., Reis, L.P., Souza, F.N.D., and Moreira, A. eds. 2018. *Computer Supported Qualitative Research*. Advances in Intelligent Systems and Computing. Berlin: Springer Verlag
- Creed, F. 2016. Exploding myths about medically unexplained symptoms. *Journal of Psychosomatic Research*. **85**, pp91-93
- Crombez, G., Beirens, K., Van Damme, S., Eccleston, C., and Fontaine, J. 2009. The Unbearable Lightness of Somatisation: A systematic review of the concept of somatisation in empirical studies of pain. **145**(1-2), pp.31-35
- Crombez, G., Eccleston, C., Van Damme, S., Vlaeyen, J.W. and Karoly, P. 2012. Fear-Avoidance Model of Chronic Pain: The Next Generation. *Clinical Journal of Pain*. **28**(6), pp.475-483
- Dallos, R. and Draper, R. 2015. *An introduction to family therapy: Systemic theory and practice*. Maidenhead : Open University Press
- Deary, V., Chalder, T. and Sharp, M. 2007. The Cognitive Behavioural Model of Medically Unexplained Symptoms: a theoretical and empirical review. *Clinical Psychology Review*. **27**(7), pp. 781-797
- Densham, S., Williams, D., Johnson, A. and Turner-Cobb, J.M. 2016. Enhanced psychological flexibility and improved quality of life in chronic fatigue syndrome/myalgic encephalomyelitis. *Journal of Psychosomatic Research*. **88**, pp. 42-7
- DiCarlo, J.J., Zoccolan, D. and Rust, N.C. 2012. How does the brain solve visual object recognition? *Neuron*. **73**(3), pp. 415–434
- Dacey-Jennings, C. 2017. I Attend Therefore I Am. 10 July. *Aeon*. [Online]. [Accessed 29th March 2019]. Available from: <https://aeon.co/essays/what-is-the-self-if-not-that-which-pays-attention>
- Dimaggio, G., Carcione, A., Salvatore, G., Semerari, R. and Nicoló, G. 2010. A rational model for maximizing the effects of therapeutic relationship regulation in personality disorders with poor metacognition and over-regulation of affects. *Psychology and Psychotherapy: Theory, Research and Practice*. **83**(4), pp. 363–384
- Dimaggio, G., Procacci, M., Nicoló, G., Popolo, R., Semerari, A., Carcione, A. and Lysaker, P.H. 2007. Poor metacognition in narcissistic and avoidant personality disorders: Four psychotherapy patients

- analysed using the Metacognition Assessment Scale. *Clinical Psychology and Psychotherapy*. **14** (5), pp. 386–401
- Dimaggio, G. and Stiles, W.B. 2007. Psychotherapy in Light of Internal Multiplicity *Journal of Clinical Psychology: In session*. **63**(2), pp.119–127
- Dimaggio, G., Valeri, S., Salvatore, G., Popolo, R., Montano, A. and Ottavi, P. 2013. Adopting Metacognitive Interpersonal Therapy to Treat Narcissistic Personality Disorder with Somatization. *Journal of Contemporary Psychotherapy*. **44**(2), [no pagination]
- Donmoyer, G. 2009. Generalisability and the Single-Case Study. In: Gomm, R., Hammersley, M. and Foster, P. eds. *Case Study Method: Key Issues, Key Texts*. London : Sage Publications, pp.45-68
- Doran, N.J. 2014. Experiencing wellness within illness: Exploring a mindfulness-based approach to chronic back pain. *Qualitative Health Research*. **24**(6), pp. 749-760
- Dragioti, E., Dimoliatis, I., Fountoulakis, K.N., Evangelou, E. 2015. A systematic appraisal of allegiance effect in randomized controlled trials of psychotherapy. *Annals of General Psychiatry*. **14**(article 25)
- Duncan, B.L. and Miller, S.D. 2000. The Client's Theory of Change: Consulting the Client in the Integrative Process. *Journal of Psychotherapy Integration*. **10**(2), pp.169-187
- Duncan, B. L., Miller, S. D., Wampold, B. E., and Hubble, M. A. 2010. eds. *The heart and soul of change: Delivering what works in therapy*. 2nd ed. Washington, DC : American Psychological Association
- Edwards, T.M., Stern, A., Clarke, D.D., Ivbijaro, G. & Kasney, L.M. (2010). The treatment of patients with medically unexplained symptoms in primary care: a review of the literature. *Mental Health in Family Medicine*. **7**(4), pp. 209–21
- Elliott, R. 2002. Hermeneutic Single-Case Efficacy Design. *Psychotherapy Research*. **12**(1), pp. 1-21
- Elliott, R. 2010. Psychotherapy change process research: Realizing the promise. *Psychotherapy Research*. **20**(2), pp.123-135
- Fernández-Navarro, P., Ribeiro, A.P., Soylemez, K.K. and Gonçalves, M.M. 2019. [Post-print]. Innovative Moments as Developmental Change Levels: A Case Study on Meaning Integration in the Treatment of Depression. *Journal of Constructivist Psychology*
- Figueiredo, J.M. and Frank, J.D. 1982. Subjective incompetence, the clinical hallmark of demoralization. *Comprehensive Psychiatry*. **23**(4), pp.353-363
- Figueiredo, J.M. and Griffith, J.L. 2016. Chronic Pain, Chronic Demoralization and the Role of Psychotherapy. *Journal of Contemporary Psychotherapy*. **46**(3), pp.167–177
- Fink, P. 2017. Syndromes of bodily distress or functional somatic syndromes - Where are we heading. Lecture on the occasion of receiving the Alison Creed award 2017. *Journal of Psychosomatic Research* **97**, pp.127–130

- Fink, P. and Schröder, A. 2010. One single diagnosis, bodily distress syndrome, succeeded to capture 10 diagnostic categories of functional somatic syndromes and somatoform disorders. *Journal of Psychosomatic Research* **68**(5), pp. 415–426
- Forrester, J. 1996. If p, then what? Thinking in cases. *History of the Human Sciences*. **9**(3), pp.1-25
- Frank, A. 1995. *The Wounded Storyteller: Bodies, Illness and Ethics*. Chicago : The University of Chicago Press
- Fraser, J.S. 2018. *Unifying Effective Psychotherapies: Tracing the process of change*. Washington DC : American Psychological Association
- Freedman, J. and Combs, G. 1996. *Narrative Therapy: The social construction of preferred realities*. New York : WW Norton and Company
- Freshwater, D. and Rolfe, G. 2001. Critical Reflexivity: A politically and ethically engaged research method for nursing. *Journal of Research in Nursing*. **6**(1), pp.526-537
- Freud, S. 1926. Inhibitions, Symptoms and Anxiety. In: *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume 20 (1925-1926)*. London : The Hogarth Press, pp. 75-176
- Freud, S. 1954. *The origins of psychoanalysis: Letters to Wilhelm Fliess, drafts and notes 1887–1902*. New York : Basic Books
- Freud, S. 2002. *Civilisation and its Discontents*. London : Penguin
- Gask, L., Dowrick, C., Salmon, P., Peters, S. and Morris, R. 2011. Reattribution reconsidered: Narrative review and reflections on an educational intervention for medically unexplained symptoms in primary care settings. *Journal of Psychosomatic Research* **71**(5), pp.325-34
- Gloria: Three Approaches to Psychotherapy*. 1965. [Film]. Everett L. Shostrom. Dir. USA : Psychedfilms
- Gomm, R., Hammersley, M. and Foster, P. 2009. eds. *Case Study Method: Key Issues, Key Texts*. London : Sage Publications
- Gonçalves, M.M., Matos, M. and Santos, A. 2009a. Narrative Therapy and the Nature Of “Innovative Moments” in the Construction of Change. *Journal of Constructivist Psychology*. **22**(1), pp.1—23
- Gonçalves, M.M., Mendes, I., Ribeiro, A.P., Angus, L.E. and Greenberg, L.S. 2010. Innovative Moments and Change in Emotion-Focused Therapy: The Case of Lisa. *Journal of Constructivist Psychology*. **23**(4), pp. 267-294
- Gonçalves, M.M. and Ribeiro, A.P. 2017. Three narrative-based coding systems: Innovative moments, ambivalence and ambivalence resolution. 14 September. *Society for Psychotherapy Research* webinar. [Online]. [Accessed 14 September 2017]. Webinar no longer live
- Gonçalves, M.M., Ribeiro, A.P., Matos, M., Santos, A. and Mendes, I. 2009b. The Innovative Moments Coding System: A new coding procedure for tracking changes in psychotherapy. In: Salvatore, S., Valsiner, J., Strout, S. and Clegg, J. *Yearbook of Ideographic Science, vol. 2*. Charlotte : Information Age Publishing

- Gonçalves, M.M., Ribeiro, A.P., Mendes, I., Matos, M. and Santos, S. 2011. Tracking novelties in psychotherapy process research: The innovative moments coding system. *Psychotherapy Research*. **21**(5), pp. 497-509
- Gonçalves, M.M., Ribeiro, A.P., Silva, J.R., Mendes, I. and Sousa, I. 2016. Narrative innovations predict symptom improvement: Studying innovative moments in narrative therapy of depression. *Psychotherapy Research*. **26**(4), pp. 425–435
- Green, D. 2016. Making the case for using personalised outcome measures to track progress in psychotherapy. *European Journal of Psychotherapy and Counselling*. **18**(1), pp. 39-57
- Greenberg, L.S. 2007. A guide to conducting a task analysis of psychotherapeutic change. *Psychotherapy Research*. **17**(1), pp.15-30
- Gubb, K. 2013. Psychosomatics Today: A Review of Contemporary Theory and Practice. *Psychoanalytic Review*. **100**(1), pp.103-42
- Halfon, S., Cavdar, A., Paoloni, G., Andreassi, S., Giuliani, A., Orsucci, F. and de Felice, G. 2019. Monitoring Nonlinear Dynamics of Change in a Single Case of Psychodynamic Play Therapy. *Nonlinear Dynamics Psychology and Life Sciences*. **23**(1), pp.113-135
- Harper, D. and Thompson, A. R. 2012. *Qualitative Research Methods in Mental Health and Psychotherapy*. Hoboken : Wiley-Blackwell
- Hartunga, T. and Steinbrecher, M. 2017. From somatic pain to psychic pain: The body in the psychoanalytic field. *International Journal of Psychoanalysis*. **99**(1), pp.159-180
- Hayes, A.M., Laurenceau, J., Feldman, G., Strauss, J.L. and Cardaciotto, L. 2007. Change is not always linear: The study of nonlinear and discontinuous patterns of change in psychotherapy. *Clinical Psychology Review*. **27**(6), pp.715-723
- Hayes, S.C. 2004. Acceptance and Commitment Therapy, Relational Frame Theory, and the Third Wave of Behavioral and Cognitive Therapies. *Behavior Therapy*. **35**(4), pp.639-665
- Hayes, S.C. and Lillis, J. 2012. *Acceptance and Commitment Therapy*. Washington DC : American Psychological Association
- Hayes, S.C., Strosahl, K.D., and Wilson, K.G. 1999. *Acceptance and Commitment Therapy: An experiential approach to behaviour change*. New York and London : The Guilford Press
- Heatherton, T.F. and Weinberger, J. 1994. eds. *Can personality change?* Washington, DC: American Psychological Association
- Heaton, Kenneth W. 2012. Somatic expressions of grief and psychosomatic illness in the works of William Shakespeare and his coevals. *Journal of Psychosomatic Research*. **73**(4), pp. 301-306
- Hermans, H.J. 1996. Voicing the Self: From Information Processing to Dialogical Interchange. *Psychological Bulletin*. **119**(1), pp.31-50
- Hermans, H.J., Kempen, H.J., and Van Loon, R.J. 1992. The Dialogical Self: Beyond individualism and rationalism. *American Psychologist*. **47**(1), pp.23-33

- Hills, J. 2018. The Psychosomatics of distress: Case study insights into lived experience and therapeutic change. *Self and Society*. **46**(2), pp. 58-65
- Hills, J., Cahill, J., Lees, J., Freshwater, D. and Krivzov, J. 2020. [currently under peer review].
Mechanisms of change in psychotherapy with physical symptom presentations: a qualitative synthesis of case study evidence
- Hills, J., Lees, J. Freshwater, D. and Cahill, J. 2018b. Psychosoma in Crisis: An autoethnographic study of medically unexplained symptoms and their diverse contexts. *British Journal of Guidance and Counselling*. **46**(2), pp.135-147
- Hinshelwood, R.D. 2013. *Research on the couch: Single-case studies, subjectivity and psychoanalytic knowledge*. London and New York : Routledge
- Hoff, K. and Stiglitz, J.E. 2016. Striving for balance in economics: Towards a theory of the social determination of behaviour. *Journal of Economic Behavior and Organization*. **126**(B), pp.25–57
- Holloway, I. and Todres, L. 2003. The status of method: flexibility, consistency and coherence. *Qualitative Research*. **3**(3), pp. 345-357
- Improved Access to Psychological Therapies [IAPT]. 2014. Medically Unexplained Symptoms / Functional Symptoms: Positive Practice Guide. *IAPT Medically Unexplained Symptoms Evaluation Task and Finish Group (2012-13)*. The Department of Health. Available from:
<https://www.uea.ac.uk/documents/246046/11919343/medically-unexplained-symptoms-positive-practice-guide-.pdf/55aea215-100e-4925-a968-65d6e89ad9b3>
- Jackson, C. 2018. It Aint What You Do... *Therapy Today*. **29**(4), pp.8-12
- Jenkins, P. 2019. First do no harm. Second, do no direct, qualitative research with psychotherapy clients... *Contemporary Psychotherapy*. **10**(2), Available from:
<http://www.contemporarypsychotherapy.org/vol-10-no-2-winter-2019/first-do-no-harm-second-do-no-direct-qualitative-research-with-psychotherapy-clients/>
- Johnstone, L. and Watson, J. 2017. Just Listen to their Stories. *Therapy Today*. **28**(3), pp.30-33
- Jones, E. 1993. *Family Systems Therapy: Developments in the Milan-Systemic therapies*. Chichester : Wiley
- Jung, C.G. 1968. *The Collected Works of C.G. Jung*, Volume 9, Part 1. 2nd ed. London : Routledge Hall
- Kannan, D., Henretty, J.R., Piazza-Bonin, E., Levitt, H., Coleman, R.A., Bickerest-Townsend, M. and Mathews, S.S. 2011. The Resolution of Anger in Psychotherapy: A Task Analysis. *The Humanistic Psychologist*. **39**(2), pp.169-181
- Kaplan, M.J. 2014. A psychodynamic perspective on treatment of patients with conversion and other somatoform disorders. *Psychodynamic Psychiatry*. **42**(4), pp. 593-615
- Kaplan, M.J. 2016. Clinical considerations regarding regression in psychotherapy with patients with conversion disorder. *Psychodynamic Psychiatry*. **44**(3), pp.367-84

- Karasu, T.B. 1979. Psychotherapy of the psychosomatic patient. *American Journal of Psychotherapy*. **33**(3), pp.354-364
- Karpman, S. B. 1968. Fairy tales and script drama analysis. *Transactional Analysis Bulletin*. **7**(26), pp. 39–43
- Kashdan, T.B. 2010. Psychological Flexibility as a Fundamental Aspect of Health. *Clinical Psychology Review*. **30**(7), pp. 865–878
- Kazdin, A.E. 2007. Mediators and Mechanisms of Change in Psychotherapy Research. *Annual Review of Clinical Psychology*. **3**(1), pp.1-27
- Kazdin, A.E. 2009. Understanding how and why psychotherapy leads to change. *Psychotherapy Research*. **19**(4), pp. 418-428
- Kessinger, S.W. 1959. The Indispensable Man. In: Kessinger, S.W. 2012.The Indispensable Man. 15 June. *Blowing away my life*. [Online]. [Accessed: 3rd January 2020]. Available from: <https://blowingawaymylife.wordpress.com/2012/06/15/the-indispensable-man/>
- Kim, J. 2018. Can good posture help mental health? 12 June 2018. *Psychology Today*. [Online]. [Accessed 11th June 2019]. Available from: <https://www.psychologytoday.com/gb/blog/culture-shrink/201806/can-good-posture-help-mental-health>
- Kirmayer, L.J., Groleau, D., Looper, K.J., and Dao, M.D. 2004. Explaining medically unexplained symptoms. *Canadian Journal of Psychiatry*. **49**(10), pp.663-72.
- Kirmayer, L.J. and Sartorius, N. 2007. Cultural Models and Somatic Syndromes. *Psychosomatic Medicine*. **69**(9), pp 832-840
- Kirsch, I., Wampold, B., and Kelley, J. M. 2016. Controlling for the placebo effect in psychotherapy: Noble quest or tilting at windmills? *Psychology of Consciousness: Theory, Research, and Practice*. **3**(2), pp. 121-131
- Kleinstäuber, M., Witthöft, M. and Hiller, W. 2011. Efficacy of short-term psychotherapy for multiple medically unexplained physical symptoms: A meta-analysis. *Clinical Psychology Review*. **31**(1), pp. 146–160
- Koelen, J.A., Houtveen, J. H., Abbass, A., Luyten, P., Eurelings-Bontekoe, E.H.M., Van Broeckhuysen-Kloth, S.A.M., Buhning, M.E.F. and Geenen, R. 2014. Effectiveness of psychotherapy for severe somatoform disorder: meta-analysis. *The British Journal of Psychiatry*. **204**(1), pp.12-19
- Konopka, A., Niemeyer, R.A. and Jacobs-Lentz, J. 2018. Composing the Self: Toward the Dialogical Reconstruction of Self-Identity, *Journal of Constructivist Psychology*. **31**(3), pp.308-320
- Kornelsen, J., Atkins, C., Brownell, K. and Woollard, R. 2015. The Meaning of Patient Experiences of Medically Unexplained Physical Symptoms. *Qualitative Health Research*, **26**(3), pp. 367-376
- Kozłowska, K. 2016. The Body Comes to Family Therapy: Utilising Research to Formulate Treatment Interventions with Somatising Children and their Families. *Australian and New Zealand Journal of Family Therapy*. **37**(1), pp.6–29

- Kozłowska, K., Chudleigh, C., Elliott, B., & Landini, A. 2016. The body comes to family therapy: Treatment of a school-aged boy with hyperventilation-induced non-epileptic seizures. *Clinical Child Psychology and Psychiatry*. **21**(4), pp.669–685
- Kozłowska, K. and Khan, R. 2011. A developmental, body-oriented intervention for children and adolescents with medically unexplained chronic pain. *Clinical Child Psychology and Psychiatry*. **16**(4), pp. 575–598
- Krebs, P., Norcross, J.C., Nicholson, J.M. and Prochaska, J.O. 2018. Stages of change and psychotherapy outcomes: A review and meta-analysis. *Journal of Clinical Psychology*. **74**(11), pp.1964-1979
- Kroenke, K. 2007. Efficacy of Treatment for Somatoform Disorders: A Review of Randomized Controlled Trials. *Psychosomatic Medicine*. **69**(9), pp 881-888
- Kroenke, K. and Spitzer, R.L. 2002. The PHQ-9: A new depression diagnostic and severity measure. *Psychiatric Annals*. **32**(9), pp.509-515
- Lamb, J., Bower, P., Rogers, A.; Dowrick, C. and Gask, L. 2011. Access to mental health in primary care: A qualitative meta-synthesis of evidence from the experience of people from 'hard to reach' groups. *Health*. **16**(1) pp.76–104
- Landa, S. and Duschinsky, R. 2013. Crittenden's dynamic-maturational model of attachment and adaptation. *Review of General Psychology*. **17**(3), pp. 326-228
- Larsen, M.H. 2015. Nutritional advice from George Orwell. Exploring the social mechanisms behind the overconsumption of unhealthy foods by people with low socio-economic status. *Appetite*. **91**, pp.150–156
- Launer, J. 2009. Medically Unexplained Stories. *Postgraduate Medical Journal*. **85**, pp.503-504
- Le Roux, C.S. 2017. Exploring rigour in autoethnographic research. *International Journal of Social Research Methodology*. **20**(2), pp.195-207
- Levin, P. 1998. Devolution: The Link between Script Instructions and Physical Illness. *Transactional Analysis Journal*. **28**(2), pp.100-110
- Levitt, H.M., Morrill, Z. and Collins, K.M. 2019. Considering methodological integrity in counselling and psychotherapy research. *Counselling and Psychotherapy Research*. **00**, pp.1–7
- Levitt, H. M., Motulsky, S. L., Wertz, F. J., Morrow, S. L., and Ponterotto, J. G. 2017. Recommendations for designing and reviewing qualitative research in psychology: Promoting methodological integrity. *Qualitative Psychology*. **4**(1), pp.2-22
- Liersch, U. and Maher-Edwards, L. 2017. Chronic Pain and Counselling Psychology: Application of the existential phenomenological four-dimension model in working with clients with chronic pain. *Journal of Psychotherapy and Counselling Psychology*. **2**(2), pp.31-37
- Liu, J., Gill, N.S, Teodorczuk, A., Li, Z. and Sun, J. 2019. The efficacy of cognitive behavioural therapy in somatoform disorders and medically unexplained physical symptoms: A meta-analysis of randomized controlled trials. *Journal of Affective Disorders*. **245**, pp. 98-112

- Lloyd, C.E.M., Duncan, C. & Cooper, M. 2019. Goal measures for psychotherapy: A systematic review of self-report, idiographic instruments. *Clinical Psychology Science and Practice*. **26**(3), pp. 1-16
- Luca, M. 2012. Therapeutic activities and psychological interventions by cognitive behavioural and psychodynamic therapists working with medically unexplained symptoms: A qualitative study. *Counselling and Psychotherapy Research*. **8**(2), pp.118-127
- Luyten, P., Lowyck, B. and Blatt, S.J. 2017. Mechanisms of Change through the Lens of Two-Polarities Models of Personality Development: State of the Art and New Directions. *Psychoanalytic Inquiry*. **37**(3), pp. 179-190
- Luyten, P., Van Houdenhove, B., Lemma, A., Target, M. and Fonagy, P. 2012. A mentalization-based approach to the understanding and treatment of functional somatic disorders. *Psychoanalytic Psychotherapy*. **26**(2), pp.121–140
- Marks-Tarlow, T. 2011. Merging and Emerging: A Nonlinear Portrait of Intersubjectivity during Psychotherapy. *Psychoanalytic Dialogues*. **21**(1), pp.110–127
- Marmot, M. 2015. *The Health Gap: The challenge of an unequal world*. London : Bloomsbury Publishing
- Masuda, A. and Tully, E.C. 2012. The role of mindfulness and psychological flexibility in somatization, depression, anxiety, and general psychological distress of a non-clinical college sample. *Journal of Evidence-Based Complementary and Alternative Medicine*. **17**(1), pp.66-71
- McCormack, D. and Chalder, T. 2018. Horses for courses: choosing an evidence-based psychological therapy for your patient. *BJPsych Advances*. **24**(6), pp.402-411
- McCracken. L.M. and Velleman, S.C. 2010. Psychological flexibility in adults with chronic pain: A study of acceptance, mindfulness, and values-based action in primary care. *Pain*. **148**(1), pp.141-7
- McDougall, J. 1989. *Theatres of the Body: A Psychoanalytic Approach to Psychosomatic Illness*. New York : W.W. Norton & Company
- McLeod, J. 1997. *Narrative and Psychotherapy*. London : Sage Publications
- McLeod, J. 2010. *Case Study Research*. London : Sage Publications
- McLeod, J. 2013. Increasing the rigour of case study evidence in therapy research. *Pragmatic Case Studies in Psychotherapy*. **9**(4), pp.382-402
- McLeod, J. 2017. Science and psychotherapy: Developing research-based knowledge that enhances the effectiveness of practice. *Transactional Analysis Journal*. **47**(2), pp.82-101
- McLeod, J. 2018. *Pluralistic Therapy*. Oxford : Routledge
- McMillan, D., Gilbody, S. and Richards, D. 2010. Defining successful treatment outcome in depression using the PHQ-9: A comparison of methods. *Journal of Affective Disorders*. **127**(1-3), pp.122-9
- McNaughton, D.T., Hush, J.M., Beath, A.P., Dear, B.F. and Jones, M.P. 2018. No moderating impact of a medically unexplained etiology on the relationship between psychological profile and chronic pain. *Journal of Psychosomatic Research*. **115**, pp.87-93

- Meekums, B. 2008. Embodied narratives in becoming a counselling trainer: an autoethnographic study. *British Journal of Guidance and Counselling*. **36**(3), pp.287-301
- Meganck, R., Inslegers, R., Krivzov, J. and Notaerts, L. 2017. Beyond Clinical Case Studies in Psychoanalysis: A review of psychoanalytic empirical single-case studies published in ISI-ranked journals. *Frontiers in Psychology*. **8**(Article 1749)
- Meira, L., Salgado, J., Sousa, I., Ribeiro, A.P. and Gonçalves, M.M. 2017. Psychological Change in Everyday Life: An Exploratory Study. *Journal of Constructivist Psychology*. **31**(3), pp.252-272
- Meystre, C., Pascual-Leone, A., de Roten, Y., Despland, J. and Kramer, U. 2015. What interventions facilitate client progress through the assimilation model? A task analysis of interventions in the psychodynamic treatment of depression, *Psychotherapy Research*. **25**(4), pp.484-502
- Miller, R.B. 2011. Panels of Psychological Inquiry for Transforming Anecdotal Data into Clinical Facts and Validated Judgments: Introduction to a Pilot Test with the Case of "Anna". *Pragmatic Case Studies in Psychotherapy*. **7**(1), pp. 6-36
- Miller, S., Hubble, M. and Duncan, B. 2007. Supershinks: What is the secret of their success? *Psychotherapy in Australia*. **14**(4), pp.14-22
- Mojgani, A. 2019. 'Where is it that we are?' A poet conjures a journey along the waters of the afterlife. [Online]. [Accessed 15 July 2019]. Available from: <https://aeon.co/videos/where-is-it-that-we-are-a-poet-conjures-a-journey-along-the-waters-of-the-afterlife>
- Monarchy, Season 3, Episode 2, The Glorious Revolution*. 2006. Channel 4. 20 November, 21:00
- Monk, G., Winslade, J., Crocket, K. and Epston, D. 1997. *Narrative Therapy in Practice: the archaeology of hope*. San Francisco : Jossey-Bass
- Mosher, J.K. and Stiles, W.B. 2009. Clients' assimilation of experiences of their therapist. *Psychotherapy Theory, Research, Practice, Training*. **46**(4), pp.432-447
- Moustakas, C. 1992. *Heuristic Research: Design, methodology and applications*. London : Sage Publications
- Muncey, T. 2010. *Creating Autoethnographies*. London : Sage Publications
- Murphy, J., Rowell, L., McQuaid, A., Timulak, L., O'Flynn, R. and McElvaney, J. 2017. Developing a model of working with worry in emotion-focused therapy: A discovery-phase task analytic study. *Counselling and Psychotherapy Research*. **17**(1), pp. 56-70
- Nasim, R., Shimshi, S., Ziv-Beiman, S., Peri, T., Fernández-Navarro, P., Oliveira, J. T., and Gonçalves, M. M. 2018. [Post-print]. Exploring Innovative Moments in a Brief Integrative Psychotherapy Case Study. *Journal of Psychotherapy Integration*
- Nathan, P.E., Stuart, S.P., and Dolan, S.L. 2000. Research on psychotherapy efficacy and effectiveness: Between Scylla and Charybdis? *Psychological Bulletin*. **126**(6), pp.964-981
- Neressian, E. 1996. *Textbook of Psychoanalysis*. Washington DC : American Psychiatric Press
- O'Sullivan, S. 2015. *It's All in your Head: True stories of imaginary illness*. London : Penguin

- O'Toole, F. 2014. Modern Ireland in 100 artworks: 1922 – Ulysses, by James Joyce. 24 December. *The Irish Times*. [Online]. [Accessed 12 October 2019]. Available from:
<https://www.irishtimes.com/culture/modern-ireland-in-100-artworks-1922-ulysses-by-james-joyce-1.2044029>
- Oyserman, D., Smith, G.C., and Elmore, K. 2014. Identity-Based Motivation: Implications for Health and Health Disparities. *Journal of Social Issues*. **70**(2), pp. 206--225
- Patel, K. 2016. Chronic Pain and the Self. *Therapy Today*. **27**(5), pp. 11-14
- Pawson, R. and Tilley, N. 1997. *Realistic Evaluation*. London : Sage Publications
- Payne, H.L. 2015. The Body speaks its Mind: The BodyMind Approach for Patients with Medically Unexplained Symptoms in Primary Care in England. *The Arts in Psychotherapy*. **42**, pp. 19-27
- Payne, H.L. 2017. Moving on: the BodyMind Approach for medically unexplained symptoms. *Journal of public mental health*. **16**(2), pp.63-71
- Peirce, C.S. 1903. *A Syllabus of Certain Topics of Logic*. Boston : Alfred Mudge & Son
- Petrocelli, J.V. 2002. Processes and Stages of Change: Counseling With the Transtheoretical Model of Change. *Journal of Counseling and Development*. **80**(1), pp. 22-30
- Pirsig, R. 1999. *Zen and the art of motorcycle maintenance: An inquiry into values*. 25th anniversary ed. New York : Morrow
- Prochaska, J.O. and Norcross, J.C. 2001. Stages of Change. *Psychotherapy: Theory, Research and Practice*. **38**(4), pp.443-448
- Quinn, M. C., Schofield, M. J., & Middleton, W. 2012. Successful psychotherapy for psychogenic seizures in men. *Psychotherapy Research*. **22**(6), pp. 682-698
- Răbu, M., McLeod, J., Haavind, H., Stange Bernhardt, I., Nissen-Lie, H. and Moltu, C. 2019. [Post-print]. How psychotherapists make use of their experiences from being a client: Lessons from a collective autoethnography. *Counselling Psychology Quarterly*
- Ribeiro, A.P., Braga, C., Stiles, W.B., Teixeira, P. Gonçalves, M.M. and Ribeiro, E. 2016. Therapist interventions and client ambivalence in two cases of narrative therapy for depression, *Psychotherapy Research*. **26**(6), pp.681-693
- Ribeiro, A.P. and Gonçalves, M.M. 2010. Commentary: Innovation and Stability within the Dialogical Self: The Centrality of Ambivalence. *Culture and Psychology*. **16**(1), pp. 116-126
- Ribeiro, A.P., Gonçalves, M.M., Silva, J.R., Brás, A. and Sousa, I. 2016b. Ambivalence in Narrative Therapy: A Comparison Between Recovered and Unchanged Cases. *Clinical Psychology and Psychotherapy*. **23**(2), pp. 166–175
- Ribeiro, E., Gonçalves, M.M. and Santos, B. 2018. [Post-print]. How Reconceptualization of the Self Is Negotiated in Psychotherapy: An Exploratory Study of the Therapeutic Collaboration. *Journal of Humanistic Psychology*

- Ribeiro, E., Ribeiro, A.P., Gonçalves, M.M., Horvath, A.O. and Stiles, W.B. 2013. How collaboration in therapy becomes therapeutic: The therapeutic collaboration coding system. *Psychology and Psychotherapy: Theory, Research and Practice*. **86**(3), pp.294–314
- Rice, L.N. and Greenberg, L.S. eds. 1984. *Patterns of Change: Intensive analysis of psychotherapy process*. New York and London : The Guilford Press
- Robinson, E., Titov, N., Andrews, G., McIntyre, K., Schwencke, G. and Solley, K. 2010. Internet treatment for Generalized Anxiety Disorder: A randomized controlled trial comparing clinician vs technician assistance. *PLOS ONE*. **5**(6), [no pagination]
- Rogers, C.R. 1961. *On Becoming a Person: A therapist's view of psychotherapy*. Boston : Houghton Mifflin Company
- Ross, S.M. and Proctor, S. 1973. Frequency and duration of hierarchy item exposure in a systematic desensitization analogue. *Behaviour Research and Therapy*. **11**(3), pp. 303-312
- Rossen, C.B., Buus, N., Stenager E. & Stenager, E. 2017. Identity work and illness careers of patients with medically unexplained symptoms. *Health*. **23**(5), pp. 551-567
- Roth, W.M. 2012. *First Person Methods: Towards an Empirical Phenomenology of Experience*. Leiden : Sense Publishers
- Rowe, W. 2014. Positionality. In Coghlan, D. and Brydon-Miller, M. (eds). *Sage Encyclopaedia of Action Research*. London : Sage Publications, pp.627-628
- Salvatore, S., Valsiner, J., Strout, S. and Clegg, J. 2009. *Yearbook of Ideographic Science, vol. 2*. Charlotte : Information Age Publishing
- Scott, W., Hann, K.E.J., and McCracken, L.M. 2016. A Comprehensive Examination of Changes in Psychological Flexibility Following Acceptance and Commitment Therapy for Chronic Pain. *Journal of Contemporary Psychotherapy*. **46**(3), pp.139–148
- Sedgwick, D. 1994. *The Wounded Healer: Countertransference from a Jungian perspective*. Florence : Taylor & Frances/Routledge
- Seligman, S. 2014. Paying Attention and Feeling Puzzled: The Analytic Mindset as an Agent of Therapeutic Change. *Psychoanalytic Dialogues*. **24**(6), pp.648-662
- Skjerve, J., Reichelt, S. and McLeod, J. 2016. Topic change processes in psychotherapy: a case study approach, *Qualitative Research in Psychology*. **13**(4), pp.271-288
- Social Care Institute for Excellence. 2015. *Co-production in social care: what it is and how to do it – At a glance*. [online]. [Accessed 26 May 2020]. Available from: <https://www.scie.org.uk/publications/guides/guide51/at-a-glance/>
- Spitzer, R.L., Kroenke, K., Williams, J.B.W. and Löwe, B. 2006. A brief measure for assessing generalised anxiety disorder: GAD-7. *Archives of Internal Medicine*. **166**(10), pp.1092-1097
- Stake, R.E. 1978. The Case Study Method in Social Inquiry. *Educational Researcher*. **7**(2), pp.5-8
- Stake, R.E. 2006. *Multiple Case Study Analysis*. New York : Guilford Press

- Stiles, W. B. 2001. Assimilation of problematic experiences. *Psychotherapy*. **38**(4), pp. 462–465
- Stiles, W.B. 2007. Theory-building case studies of counselling and psychotherapy, *Counselling and Psychotherapy Research*. **7**(2), pp.122-127
- Stiles, W.B. 2009. Logical Operations in Theory-Building Case Studies. *Pragmatic Case Studies in Psychotherapy*. **5**(3), pp. 9-22
- Stiles, W.B. 2011. Coming to Terms. *Psychotherapy Research*. **21**(4), pp.367-384
- Stiles, W.B., Gabalda, I.S. and Ribeiro, E. 2016. Exceeding the therapeutic zone of proximal development as clinical error. *Psychotherapy*. **53**(3), pp.268 –272
- Stiles, W.B., Morrison, L.A., Haw, S.K., Harper, H., Shapiro, D.A. and Firth-Cozens, J. 1991. Longitudinal Study of Assimilation in Exploratory Psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*. **28**(2), pp.195-206
- Stuthridge, J. 2017. Falling apart and getting it together: the dialectics of disintegration and integration in script-change and self-development. *Transactional Analysis*. **47**(1), pp.19-31
- Sullivan, P. 2012. *Qualitative Data Analysis Using a Dialogical Approach*. London : Sage
- Thakur, E. R, Holmes, H. J, Lockhart, N. A., Carty, J. N., Ziadni, M. S., Doherty, H. K., Lackner, J. M., Schubiner, H. & Lumley M. A. 2017. Emotional awareness and expression training improves irritable bowel syndrome: A randomized controlled trial. *Neurogastroenterology*. **29**(12), [no pagination]
- Theodoratou-Bekou, M., Ou, A., Andriopoulou, P. and Wood, B. 2012. Stress-related asthma and family therapy: Case study. *Annals of General Psychiatry*. **11**(1), [no pagination]
- Thoreau, H.D. 2008. *Walden: Civil Disobedience and Other Writings*. New York : WW Norton and Company
- Timmer, B., Bleichhardt, G. and Rief, W. 2006. Importance of Psychotherapy motivation in patients with somatization syndrome. *Psychotherapy Research*. **16**(3), pp.348-356
- Tikkanen, S., Stiles, W.N. and Leiman, M. 2013. Achieving an empathic stance: Dialogical sequence analysis of a change episode. *Psychotherapy Research*. **23**(2), pp.178-189
- Tolman, E.C. 1948. Cognitive maps in rats and men. *The Psychological Review*. **55**(4), pp.189-208
- Toren, M. and Luca, M. 2017. The persecutory character of irritable bowel syndrome: A grounded theory of the lived experience of IBS sufferers. *Journal of Psychotherapy and Counselling Psychology Reflections*. **2**(2), pp.39-51
- Totton, N. 2003. *Body Psychotherapy: an introduction*. Maidenhead : Open University Press
- Totton, N. 2014. *Embodied Relating: The Ground of Psychotherapy*. London : Routledge
- Town, J.M., Lomax, V., Abbass, A.A. and Hardy, G. 2017. The role of emotion in psychotherapeutic change for medically unexplained symptoms. *Psychotherapy Research*. **29**(1), pp.86-98
- Trainor, A.A. and Graue, E. 2014. Evaluating Rigor in Qualitative Methodology and Research Dissemination. *Remedial and Special Education*. **35**(5), pp. 267 –274

- Trop, J.L., Burke, M.L. and Trop, G.S. 2013. Psychoanalytic Theory and Psychotherapy: A Dynamic Systems View of Change. *Clinical Social Work Journal*. **41**(1), pp 34–42
- Truijens, F., Desmet, M., De Coster, E., Uyttenhove, H., Deeren, B. and Meganck, R. 2019. [Post-print]. When quantitative measures become a qualitative storybook: A phenomenological case analysis of validity and performativity of questionnaire administration in psychotherapy research. *Qualitative Research in Psychology*.
- Vancea, M. and Utzet, M. 2017. How unemployment and precarious employment affect the health of young people: A scoping study on social determinants. *Scandinavian Journal of Public Health*. **45**(1), pp.73–84
- Van Hennik, R. and Hillewaere, B. 2017. Practice Based Evidence Based Practice. Navigating based on coordinated improvisation, collaborative learning and multi-methods research in Feedback Informed Systemic Therapy. *Journal of Family Therapy*. **39**(3), pp.288–309
- Vorne, A. 2011. Conversion symptom as condensation of childhood traumata. *The Scandinavian Psychoanalytic Review*. **34**(1), pp. 13-22
- Wampold, B.E. 2015. How important are the common factors in psychotherapy? An update. *World Psychiatry*. **14**(3), pp.270–27
- Wells, A. and Purdon, C. 1999. Metacognition and cognitive-behaviour therapy: a special issue. *Clinical Psychology and Psychotherapy*. **6**(2), pp.71–72
- West, R. 2005. Time for a change: putting the Transtheoretical (Stages of Change) Model to rest. *Addiction*. **100**(8), pp.1036-1038
- White, M. 2007. *Maps of Narrative Practice*. New York : Norton Professional Books
- Wiech K., Ploner, M. and Tracey, I. 2008. Neurocognitive aspects of pain perception. *Trends in Cognitive Sciences*. **12**(8), pp.306-13
- Wilkinson, R. G. and Pickett, K. 2011. *The Spirit Level: Why Greater Equality Makes Societies Stronger*. New York: Bloomsbury
- Wilkinson, R.G. and Pickett, K. 2018. *The Inner Level: How More Equal Societies Reduce Stress, Restore Sanity and Improve Everyone's Well-Being*. London : Allen Lane
- Wilson, C. 2019. The illnesses caused by a disconnect between brain and mind. *New Scientist*. 3 April. [online]. [accessed 13 April 2019]. Available from: <https://www.newscientist.com/article/mg24232240-100-the-illnesses-caused-by-a-disconnect-between-brain-and-mind/>
- Winnicott, D. W. 1953. Transitional objects and transitional phenomena; a study of the first not-me possession. *The International Journal of Psychoanalysis*. **34**, pp.89–97
- Winnicott, D.W. 1956. Mind and its relation to the psyche-soma. *Psychoanalytic Quarterly*. **25**, pp.127-127

- Winnicott, D.W. 1965. *The maturational processes and the facilitating environment: Studies in the theory of emotional development*. New York : International Universities Press
- Winnicott, D.W. 1966. Psycho-somatic illness in its positive and negative aspects. *International Journal of Psychoanalysis*. **47**(4), pp.510-6
- Yalom, I.D. 1980. *Existential Psychotherapy*. New York : Basic Books
- Yesudian, S. 1976. *Yoga Week by Week*. London : George Allen & Unwin Ltd.
- Young, J.E., Klosko, J.S. and Weishaar, M.E. 2003. *Schema therapy: a practitioner's guide*. New York: Guilford Press

Appendix 1: Inclusion of Published Studies

Appendix 1.1: Psychosoma in Crisis

Hills, J., Lees, J. Freshwater, D. and Cahill, J. 2018. Psychosoma in Crisis: An autoethnographic study of medically unexplained symptoms and their diverse contexts. *British Journal of Guidance and Counselling*. 46(2), pp.135-147



British Journal of Guidance & Counselling



ISSN: 0306-9885 (Print) 1469-3534 (Online) Journal homepage: <https://www.tandfonline.com/loi/cbjg20>

Psychosoma in crisis: an autoethnographic study of medically unexplained symptoms and their diverse contexts

John Hills, John Lees, Dawn Freshwater & Jane Cahill

To cite this article: John Hills, John Lees, Dawn Freshwater & Jane Cahill (2018) Psychosoma in crisis: an autoethnographic study of medically unexplained symptoms and their diverse contexts, *British Journal of Guidance & Counselling*, 46:2, 135-147, DOI: [10.1080/03069885.2016.1172201](https://doi.org/10.1080/03069885.2016.1172201)

To link to this article: <https://doi.org/10.1080/03069885.2016.1172201>



Published online: 13 Apr 2016.



Submit your article to this journal [↗](#)



Article views: 330



View related articles [↗](#)



View Crossmark data [↗](#)



Citing articles: 3 View citing articles [↗](#)

Full Terms & Conditions of access and use can be found at
<https://www.tandfonline.com/action/journalInformation?journalCode=cbjg20>



Psychosoma in crisis: an autoethnographic study of medically unexplained symptoms and their diverse contexts

John Hills, John Lees, Dawn Freshwater and Jane Cahill

School of Healthcare, Baines Wing, The University of Leeds, Leeds, UK

ABSTRACT

In this study, we examine autoethnographic data from three critical incidents as experienced by the first author demonstrating the importance of context in understanding medically unexplained symptoms, their incidence and underlying patterns. We make the case

ARTICLE HISTORY

KEYWORDS for ethnographies

as a crucial research strand in discerning the finer experience; aspects that might be missed medically unexplained where people are directed along protocolised pathways of care. The symptoms; trauma; patient article describes care as fragmented and depersonalising, leading to narratives; depersonalisation; disembodied exchanges, as reflected in other autoethnographic studies, autoethnography particularly those that highlight the complex relationship and controversies surrounding diagnostic uncertainty. We observe that psychological therapists, given the quality of the therapeutic relationship and sustained attention to the person's experience, are well placed to assist in the necessary processes of re-contextualisation and reembodiment.

Introduction

Medically unexplained symptoms (MUS) account for up to one in five of all GP consultations and 30% of these are subsequently found to have an associated psychiatric disorder – usually depression or anxiety (RCGP, 2014). It is generally understood that medically unexplained and somatic symptoms can be triggered or exacerbated by emotional distress, which the person can experience directly or indirectly. A 2010 study found up to 10% of all NHS spending was incurred by somatising patients, and the total cost including sickness absences to be over £14 billion per annum (Birmingham, Cohen, Hague, & Parsonage, 2010). Common examples of physical symptoms that may arise or are exacerbated during times of emotional distress include eczema, alopecia, fibromyalgia or irritable bowel syndrome.

Contemporary literature suggests a stigma associated with pain and other symptoms where there is a diagnostic uncertainty (e.g. Anderson, Jason, Hlavaty, Porter, & Cudia, 2012; Gask, Dowrick, Salmon, Peters, & Morriss, 2011; Wilbers, 2015). This can lead to suspicion and breakdowns in the relationships between the sufferer and health practitioners, their carers, family members and other interested parties such as employers. The sufferer may feel that nobody understands them leading to, and perpetuating existing, feelings of alienation.

Controversy and confusion surround terms such as ‘psychosomatic’ and ‘psychogenic’ – with existing evidence suggesting that these terms still imply that symptoms are ‘all in the mind’ and thus that ‘there’s nothing wrong with you’ (Leone, Wessely, Huibers, Knottnerus, & Kant, 2011; Ricciardi & Edwards, 2014). Many people dread such a diagnosis because the implication is that their symptoms

CONTACT John Lees  j.lees@leeds.ac.uk

© 2016 Informa UK Limited, trading as Taylor & Francis Group

will no longer be taken seriously (Hinton & Kirk, 2016; Mobini, 2015). Some strongly resist and fiercely reject the idea of a psychological element to their symptoms/experience and may even believe their symptoms indicate that something is seriously wrong but is being missed.

The current study is a continuation of previous research into the topic by the First Author (FA), a trained psychological therapist, having himself suffered from chronic pain for 16 years. This culminated, in 2014, in an autoethnographic study into chronic pain, and what appeared to be its psychosomatic qualities. As in all ethnographic study, particular attention is drawn to the contexts in which events acquired meaning, and it was discovered that these contexts had significant therapeutic value. This article will explore three critical incidents typical of the data derived from the study and we will use these to highlight the importance of context. In doing so, we make the wider case for ethnography as a crucial research strand for advancements in the ways psychological therapists work with somatisation and MUS.

MUS and the counselling and psychotherapy profession

The substantive literature on MUS comes from medical discourses. Yet there is a continued reluctance in the counselling and psychotherapy (therapy) profession to engage with this literature, with strong antagonisms sometimes expressed by counselling and psychotherapy (therapy) practitioners towards the medical model (Lees, 2011). This, arguably, began with the work of Carl Rogers in the early 1950s when he used the term ‘clients’ rather than

'patients'. The challenges to the medical model have increased in recent years in response to the increasing influence of evidence-based practice and managed care on the profession with its emphasis on medical model principles (Lees, 2016). This development has, for several years, been rebutted by some therapists: therapy is 'not a branch of medicine nor an activity ancillary to medicine. Most forms of therapy do not focus exclusively on the relief of symptoms, but emphasise creating and exploring a relationship' (Alliance, 2009). Attitudes, leading to a disinterest in medically orientated literature, are problematic since this literature contains many valuable insights. In contrast to such antagonisms, the article unashamedly draws on medically orientated literature and aims to break down the conceptual barriers separating these disciplines. Moreover, we believe it is essential to maintain a congruence between the approach taken in the current study, that is holistic and integrative, and the problematising of the psyche-soma split.

One primary criticism levelled against medical thinking is that it fails to take into account social, political and economic factors; that is to say, it is reductive. Yet there is a substantial body of literature which includes client stories which stands between medically orientated and psychotherapeutic literature and this 'intermediate' literature includes contextual factors (Fisher & Lees, 2015). Indeed this study will cite several examples of this literature. It will also adopt ethnographic methods which are explicitly concerned with examining conceptual factors.

Ethnography and patient narratives

There is a clear case to be made for ethnography and patient narratives in the field of health-care research. Andersen and Risør (2014) observed that even where qualitative research is undertaken, for example in research into why a patient may delay seeking health care, the themes that are extracted are often 'one-way' and have the quality of 'thin description' (in contrast to 'thick description' in Geertz, 1973) that limit the capacity of the research to provide genuine and useful insight into the lived experience of the patient. The authors observed that where themes are identified, such as the patient not wanting to bother their GP or to appear as a hypochondriac, or where a woman delays health-care seeking because she 'did not put herself first' there is little or no investigation into the social and historical contexts of why a patient might have these attitudes.

A substantial body of autoethnographic literature demonstrates its value as a methodological approach (good examples include Neville-Jan 2003 and Etorre, 2005) in providing insights into the lived experience of symptoms. Wilbers, whose (2015) autoethnography explored the

impacts and meanings of her mother's chronic pain and treatment, made the case for patient narratives so that practitioners may more fully appreciate and even anticipate the patient experience, and argued that this may have tangible implications for, say, whether or not to prescribe medication. Following spinal cord injury that resulted in permanent paralysis, Clifton (2014) wrote that 'narrative storying' can help the patient work through the grief of losing the use of their limbs and indeed the life that they had before the injury, but believed there was not enough literature available about the processes of adapting to life-changing injuries and illnesses that would have helped him as a patient going through it. Barry (2006) argued that a problem with randomised controlled trial methodologies was that they measured the easily measurable and typically excluded subtle, but complex, inputs and outputs. Furthermore, she argued that these same methodologies typically excluded or only gave passing consideration to the contexts in which pathologies appeared, citing evidence from psychoneuroimmunology that a person's prognoses could be heavily determined by their beliefs about health and disease. Barry noted that 'the use of anthropological forms or evidence may be more helpful in providing a measure of how therapies are working on the real patient in the real world, not on the statistically average patient' (Barry, 2006, p. 2655). In this article, our intention is to add to the literature on the patient's lived experience by providing a narrative, 'thick description' (Geertz, 1973) of an experience of MUS and the biopsychosocial contexts in which they are situated. As an autoethnographic study, the investigation is based on lived experience as the primary data source. An ethnographer records 'scratch notes' as they listen and observe so as to aid memory during later analysis (Suzuki, Auhlualia, Mattis, & Quizon, 2005). During the formal period of research in 2014, an app on a phone was used to record any impressions about experience, physical or otherwise, that felt pertinent to the study of chronic pain and several times a week this raw data were explored for meaning through purposeful diarying. During and after observation, ethnographers ask questions about the meaning of behaviour and events (Gerrish & Lacey, 2010). The raw data are the 'tip of iceberg' – the visible 10% of the berg indicating an invisible 90% submerged in the depths – and the diary considered what might be indicated by the particular data that had been recorded. Very often links from present experience would be established to historical events, memories and dream material. The app took on the character of a seismograph as the FA was able to record each 'tremor' in real-time. The practice of recording experience in this way facilitated the development of an embodied awareness which enabled the psychosocial triggers and patterns underpinning the flare-ups of his physical symptoms to be understood more directly – a habit cultivated during the formal research period which Roth (2012) describes as 'perceptual tuning'. We will consider

later the implications for practice of the findings of this research and how as practitioners we can assist sufferers of MUS to develop their own embodied awareness, make sense of their condition and manage the psychosocial impacts, for example, on identity and relationships.

The following sections describe three critical incidents from the FA's autoethnographic research regarding chronic pain. Each incident is described in the form of thick description which includes the psychosocial context of the experience. It is then followed by a brief reflection to link the experience to the extant literature. In the first incident, the FA's lived experience of his pregnant wife's ultrasound scan and his symptoms unexpectedly flaring up 'sets the scene' in terms of establishing contextual reference points in the present day. The second incident is a historic event – a traumatic bereavement experience at the age of 18 seems to have been the origin of his chronic symptoms. The final incident, an anxiety attack on a bus, captures the experience of depersonalisation – an 'out of body experience' that will help us to demonstrate the dynamics of disassociation, its links to 'conservation withdrawal' mechanisms that perform a comparable function to the fight or flight reflex. Each narrative stresses the physical elements of the experience, and indeed grounds experience in the physical frame of reference. Our purpose is to challenge the dualistic concept of mental distress vis-à-vis physical distress that still prevails in conventional medicine (Edwards, Stern, Clarke, Ivbijaro, & Kasney, 2010) and which is now infiltrating the therapy profession as a result of the influence of government-sponsored therapy in the form of the IAPT scheme. One problem with this scheme is that complex and multi-faceted problems are presented as being treatable by psychological therapists who do not have an understanding of the broader context (see Lees, 2016). Placing somatic experience at the centre of the narrative is appropriate in a discussion of psychological phenomena today in view of the recognition, in recent years, of the somatic aspects of psychological problems. This idea has been around for a long time (Steiner, 1920) but has, more recently, been acknowledged by a considerable number of scientific researchers who have identified the relationship between trauma and the autonomic nervous system (Quillman, 2013), the body's systems in general (allostatic load) (McEwan, 2000), the endocrine system (Meany, 2001) and the immune system (Ramo-Fernandez, Schneider, Wilker, & Kolassa, 2015). Whilst an autoethnographic case study is unique, the study aims to have relevance beyond a single case by resonating with the experiences of others who present with MUS, and the experiences of the practitioners who try to help them. As Roth (2012) observed, the purpose of first-person research is to critically investigate phenomena in such a way as to articulate experience in terms of 'concrete universals' (Roth, 2012, p. 17). A central perspective of the study, which we will return to later, is considering the practical consequences that stem from a person's lived experience of

having a body vis-à-vis being a body. In this account, we will take the latter view and chart a personal journey, undergone by the FA of re-embodiment in thought and emotion.

Data: critical incidents

Critical incident one: an unexpected surge of myofascial pain

A June day in 2014. I am sitting in the driver's seat with my feet operating the pedals, my hands on the steering wheel, shifting the gears where necessary. The roads are busy outside the frame of the vehicle though I manage to synchronise our motion with the rest of the traffic smoothly. I'm gripping the wheel a little tighter than necessary, my shoulders a little hunched. My wife is sat in the passenger seat, her seatbelt positioned so as to avoid her 'bump' – not noticeable yet to those who don't know – and yet cushioned within a spherical layer of amniotic fluid, and anchored by life giving cords, are two tiny little embryos, less than 10 cm in length each. The prevailing idea that takes form in my mind is of having to drive safely, I increase our distance from the other vehicles, protecting our precious cargo from the threat of any sudden jerks or collisions. I'm 32 and yet feel quite naive, as though I don't really know what I'm doing, as though I were assuming the responsibility of a far better man than myself, a man far more 'together' than I feel. Parking up and emerging from the car our physical mode shifts now – I lift up my chest and shoulders, and although nerves would propel me along at a much faster pace, I consciously match my wife's footsteps, because this is my role at this moment. As we enter the General Infirmary and traverse its long, utilitarian corridors, we feel anxious. It has been four weeks now since we last 'heard' from our twins – in all that period where they are not being scanned, where their heartbeats are not being measured, anything could have happened, they could be struggling in there, or worse, and we wouldn't have any idea about it. We take our seats in the waiting room with other mothers, the occasional awkward looking dad and restless older children. I place my hands self-consciously on my thighs and as we exchange words I feel a little exposed, because the others in the room can hear what we are saying. The radiologist calls us in – a Malaysian nurse with a warm smile and a confident professionalism about her. The room is dark, the jelly is cold on my wife's tummy, we are all very polite and make nervous jokes. The ultrasound images come into focus on the screen above the bed as a figure appearing out of a blizzard. The nurse announces 'twin one' but we have already seen him – his head, his nose, his arms, his legs and his little heart visibly beating away. My eyes fill with tears and I look to my wife who is the same. The nurse takes many measures of our son's physiology, those crucial indexes of his health and development. Then she introduces us to 'twin two'

and there she appears, wriggling and kicking, testing out her muscles – our daughter, so alive and so real. We emerge from the dark room grinning and I feel a little guilty, not knowing what kind of a day the other families in the waiting room were having. As we make our way back through and out of the hospital our pace is different now – the clock has been reset and everything is fine. I feel a familiar pain begin to creep across my face, starting at the base of my jaw bone – a raw feeling, a burning and a sore tightness. As we excitedly exchange reflections on what we learned today, I feel the pain increasing and wonder why of all times the pain would be surging now. The tipping point must have been my experience of the scan – was it the twins' clean bill of health, the relief that I must have felt; was it perhaps the heralding of a different phase of anxiety – they're healthy so now I have the luxury of worrying about my responsibilities as father and provider, am I really big enough and strong enough for this task?

The next critical incident articulates the original psychosocial context in which the MUS first emerged.

Critical incident two: a trauma after a sudden death

A Friday evening in June, in the year 2000. I'm 18 years old, and I have just come through the door of our terraced house in West Yorkshire. The grownups are away – they've gone on a road trip. The house suggests silently the jobs I was meant to be doing; plants that need watering, a pile of washing by the sink. The A-level exams are still in process but I seem not to be taking these very seriously. Today I've been working in a factory, packing boxes – I couldn't pass up on the chance at some extra cash. I feel excited as the weekend is just beginning. Soon people start arriving, and the whole tone of the house changes – the volume increases, the music brings its own atmosphere, joints are being rolled and smoked, the smoke infuses throughout the living room and the kitchen. I have only recently discovered ecstasy, and I take two now – swallowing the chalky, bitter tasting pills down in one go with a swig of water, feeling slightly nauseated in the process. There is a knock on the door and I go straight for it, but I see before I get there that there is a policeman on the outside. I panic and call out 'it's the police' and quickly everyone scarpers to hide anything incriminating. I feel a wave of panic come over me – that naughty boy feeling of butterflies when you know you're in a lot of trouble. However, the policeman is not interested in the drugs. How exactly he broke the news is now something of a hole in my memory but I learn that there has been a road accident. Two members of our family are dead and another is critically ill in hospital. What I do remember is feeling like I am losing my balance; staggering back into the living room, crying without restraint. Then I head back through the front door and cry some more

out in the road. The policeman, even I can tell, is finding this assignment extremely difficult and doesn't quite know what to say or do. The next few hours are a blur – phone calls made to the hospital for news and to others who might be able to help. I remember the familiar physical sensations of the ecstasy starting to take effect – a warm tingling in my extremities and a lightness that passes throughout my body, pleasure in every inhale and exhale. And I feel guilty for having this completely inappropriate physical experience amidst this disaster scene.

The morning after the physical experience is typical of any 'come down' from an ecstasy trip as I experienced them – slight nausea; slight headache; heavy eyes; concentration that slips and slips almost like a fever; and crucially a sore jaw. The sore jaw is a typical experience amongst ecstasy users – during the high, one typically grinds their teeth and tenses their jaw muscles for hours on end. Usually, the soreness dissipates over the day or so; I am the only one as far as I know whose jaw pain became chronic after a period of ecstasy use. The jaw pain is a permanent feature in my life – some days are harder than others but the intensity of the pain seems to depend very much on what is currently happening; my present environment and experience.

The common factor in these two otherwise disparate critical incidents is the physical experience of pain. It is beyond reasonable doubt that the body is remembering and in a sense reliving something of that time, but is it actually remembering? Rothschild suggests that we look beyond (or beneath) the narrative memory of that traumatic time; that is to say, we look to implicit memories (Rothschild, 2000). Implicit memories are those that are not rooted in one particular time or situation – most of us know how to hold and use a pen without needing to recall the particular times in childhood when we learned these skills. We remember the physical procedure and we do this remembering without thought. I form a mental picture of Pavlov's dogs, salivating upon the sound of the bell, as Rothschild makes the case that post-traumatic stress symptoms are examples of classic conditioning – the entirely healthy way in which we make associations between particular stimuli and concomitant events/consequences, typically so that we have a preconscious means of detecting and avoiding situations that are dangerous or frightening, or of being drawn to situations that may hold the promise of something good. Implicit elements of traumatic experience may be identified: these would not be unique to that situation but would be elements we will have encountered before and indeed have encountered since. That night, as with any ecstasy trip, concentration drifted. It would not hold in place; I felt groundless, not able to take hold of a situation that seemed to slip through my fingers. I remembered

feeling hollow – almost literally out of not eating, but also of being a little fragile and exposed, the way you might feel if you were coming down with a cold but you were still at work or had business to do in town. The tidal wave of events seemed to sweep me up violently and without my consent leading to the experience of becoming a passenger and to the fact that an ability to surf upon or otherwise navigate these currents of life was found wanting; beyond my capability and level of skill. Continuing the seafaring metaphor, in such situations the vessel may appear steady and under control, but I am merely bailing out the water. Seen through this lens the jaw pain is not so much a symbol pointing back to that particular time and situation, but rather an index to a complicated web of associations – certain physical modes that I shift through in many diverse times and situations. It became what Freud might have called a ‘boundary idea’ (Freud, 1954, p. 154) – a symbol that can enter consciousness and indeed prevail in consciousness; it is associated with the trauma but crucially along a chain of associations is one step removed – its function being to protect us from a conscious reliving of the traumatic experiences. As to the question of why it was that jaw pain became that symbol, Freud would perhaps have regarded it as quite appropriate:

If the traumatic event formed an outlet for itself in a motor manifestation, it will be this that becomes the boundary idea and the first symbol of the repressed material. (Freud, 1954, p. 154)

In the traumatic situation I was powerless, there was very little I could actually do, but channelling all that excess tension to the jaw was something that I was inadvertently doing, and this pattern appears to have become locked in.

Reflection: themes of alienation in the patient experience

Writing about her mother’s experiences living with chronic pain, Wilbers observed that when the physician can discern no tangible ‘cause’ of the pain, and where there is no objective way of quantifying the pain, that sufferers of chronic pain can feel their symptoms are not being taken seriously, they can’t surely be as bad as they are making out (2015). Wilbers reflects that when there is ‘diagnostic uncertainty’ about the cause of the pain, there can be a stigma associated with the person and their complaints that would not be present had they been suffering with a legitimate diagnosis such as cancer. In such circumstances, physicians can become suspicious about a person’s motivations, suspecting secondary gains such as a person’s desire for disability benefit payments or opioid base pain killers (Wilbers, 2015). The danger of this growing suspicion between doctor and patient is this can lead to the relationship becoming strained or even hostile and thus the collapse of any capacity for empathy that may have been possible (Elwood, 2012). When Ann Neville-Jan’s doctor decided that her own pain was ‘psychogenic’ she felt this was tantamount to him washing his

hands of the situation – if the pain was ‘all in the head’ then somehow it wasn’t real (Neville-Jan, 2003). Subsequently, she feared admitting to doctors she was taking antidepressants in case this only validated their dismissal of her physical complaints. However in her autoethnography, Neville-Jan neatly dispatched with the false dichotomy between mental and physical aetiology: ‘Is it psychogenic or real? The answer is it’s pain’ (Neville-Jan, 2003). Neville-Jan reported feeling the pressure to deliberately look unwell for her consultations; she felt as though the doctor would be looking at her and thinking that she looked too good to be suffering as much as she said. The FA’s experience of chronic pain is that although it is never debilitating, it is a permanent fixture of his experience, it always makes its presence known, and yet in the medical consultations he appears to be fit, well and functioning; thriving even. Under the care of a dental surgeon, he was once asked to rate his pain on a scale of 0–10 where 0 was no pain at all and 10 was worst pain ever. He struggled with placing his experience on a one-dimensional scale when it seemed to take on meaning, value and quantity in the context of an ecology of references and associations. He felt the pressure to talk up his pain and so gave it a ‘7’. Months later, following a treatment of botox injections that was intended to paralyse his jaw muscles and thus afford them a rest, he was asked to give his pain another rating. His best answer at that time was a ‘5’ that the surgeon then cited as evidence that the botox injections had made a positive difference although he sat there knowing that the injections had not made any difference and mumbled something to the effect that he must have overstated the pain in the first place. Such is the challenge of communicating an intensely subjective experience in such a fashion such as it can be ascribed an economic value.

Although the various practitioners were courteous, kind even, he has felt like a piece of flesh to be worked on, as a mechanic would work on a broken down machine. The FA has been prescribed a change of diet, jaw exercises, pain killers, antidepressants, a mouth guard to wear in the nighttime and the aforementioned botox injections for the pain. Independently, he has tried osteopathy, has bought magnesium oils to rub into the site of the jaw tension and has had two long term periods of counselling. However, all those diverse treatments were experienced as so many fragments – they threw the kitchen sink at it and nothing helped. This left him feeling frustrated, at a loss of faith that anything now can make any difference with corresponding feelings of self-blame and failure, an experience reported by other sufferers of chronic pain (as in Doran, 2014). The image is of a patient who has no voice, no capacity to articulate his own illness and is only playing a passive role within his own care. Aside from a basic exchange of information between patient and practitioner, the conversation between them can typically be little more than a social convention whilst the

practitioner does their work. This localism is understandable – to treat a cancer we need to kill or otherwise take out the cancerous cells; to fix a hearing impairment a hearing aid is fitted. However, the physical site may be more appropriately considered as the epicentre of the pathology, and from here its effects ripple out through the whole body.

As Kierans observed in the narratives of people with chronic kidney failure: ‘Headaches, nausea, pain, excesses of bodily hair, weight gain, and so on are also markers of manifold bodily sensations and imagery that become subject to constant interpretation and meaning-making’ (2005, p. 348). It may even be that the physical site of the pathology may serve as the material symbol of a more complex pathology. So, in this study, as discussed, the jaw pain is also an index for mental states that include the slipping of attention, the inability to get a foothold or the feeling of being out of one’s depth. To work at the physical site of pain alone would seem a rather primitive attitude – if the smoke alarm is sounding we would not necessarily try to repair the alarm itself but search for the source of the smoke.

We hypothesise that such examples of unacknowledged pain, dismissal of the client’s point of view and therapeutic pressure to conform to the practitioner’s point of view are pervasive in the therapy profession as well as the medical profession. The failure to acknowledge the client’s point of view is well-documented. Fonagy and Bateman (2006), speaking specifically about borderline personality disorder, ascribe the phenomenon to the therapist’s failure to understand mentalisation and see the client’s mind as separate from the therapist’s mind. Driven by clinical theory, relational or otherwise, the therapist fails to appreciate the state of mind of the client. This may result in pseudo mentalising in which the client tries to please the therapist by conforming to his/her point of view as in the above examples or it may lead to anger (Fonagy & Bateman, 2006, p. 2) or just failing to return to sessions. Lees (2016) gives an example of failing to address the physical pain of a client suffering from Parkinson’s disease because of a preoccupation with relationality and how it was necessary for the therapist, once he had realised this, to comment on the distance between the client’s and the therapist’s point of view.

The next critical incident gives a thick description of the FA’s experience of depersonalisation which seems to indicate a dysfunctional relationship between the conscious, decision-making parts and other body parts more typically in the autonomic domain. Subsequent reflection indicates that dissociative symptoms serve as another psychosomatic response to the original traumatic episode.

Critical incident three: depersonalisation attack on the bus whilst reading a newspaper

A bright May afternoon in 2013. I'm standing at a bus stop in the centre of town with one or two others looking down the road waiting for our bus to appear. I've just been to a meeting and am smartly dressed, I had made a lot of notes and have a lot of ideas to digest but rather than digesting them now I am allowing my thoughts just to wander, and this is more out of tiredness than any healthy decision – too much for me to process right now. As the bus arrives I take my usual window seat and retrieve the newspaper from my bag. My physical experience is of being firmly planted in my seat, my body shifting as the bus turns, my arms are raised before me and the texture of the newspaper between my thumb and fingers is rough. My attention tunes in to the content of the newspaper and I read through an article as long as it holds my interest – in the Middle East Israeli jets have entered Syrian airspace to target a weapons facility, and in Germany a 93-year-old former Auschwitz guard has been arrested on charges of murder. I 'forget' that I'm sat on my seat on the bus, or about the pressure the window makes against my arm and shoulder as we go around a corner, and particularly about the feel of the paper in my hands – my awareness is centred around the content of the individual articles and my reactions to them; the judgements I make. There's nothing strange about this – neurobiologist Bernard Baars referred to the spotlight of selective attention (Blackmore, 1996); that in consciousness remain only the necessary elements as illuminated by the spotlight, with other elements falling back into the shadows, and because the physical elements slip out of conscious awareness it becomes a disembodied experience. What is strange is what happens next – suddenly, as though a tipping point has been reached, I have an awareness that I can no longer 'feel' the paper between my fingers. It is as though my holding the paper has become a conscious idea before the sensation of me holding it returns to awareness. My experience of this is described best at first as an 'out of body experience' – are those my arms holding the paper? I become very afraid all of a sudden and shake the paper and slightly jump in my seat so as to remind myself that yes these are my limbs, yes I am embodied. I am relieved to observe that no-one else on the bus seems to have noticed my wobble, and the fear quickly passes.

Reflection: towards explanations of dissociation and depersonalisation

To gain a sense of what it felt like try sitting with your hands still on your lap, but then whilst your arms physically remain where they are imagine that they raise and open up as though to hold a newspaper. There is the impression that the arms are there but there's nothing of substance about them – they appear as phantom limbs. In his own autoethnographic

account, *A Leg to Stand On*, Sacks gives an account of his recovery after a serious climbing accident detached the quadriceps muscle in his left leg. Although the operation to repair the damage was a success, in the days following the operation Sacks experienced a complete disassociation from his leg – it no longer felt like his leg, completely paralysed, a dead weight, and wrote about it seeming to exist in another dimension, with its own kind of reality

The more I gazed at that cylinder of chalk, the more alien and incomprehensible it appeared to me. I could no longer feel it was 'mine', as part of me. (Sacks, 1984, p. 72)

In Sacks' account, it is as though his mind's remembering of what his leg ought to be like, how it ought to feel, did not chime with how the leg presented itself, thus triggering for him terrifying anxieties about the nature of existence itself. Indeed when Sacks did eventually recover sensation and movement, and was able to walk again he had described his experience as a spiritual drama and a journey to the underworld and back (Sacks, 1984). Whilst Sacks' experience was sustained and the more terrifying for that, the momentary experience of physical derealisation had a similar nature. But this begs the question as to why, if the sensation of the paper in between the fingers slipping out of consciousness is an entirely natural event, something that would happen to any of us, how then it became a frightening disassociation event. Returning to the experience of chronic pain in the light of this, we take the view that the experiences display a phobia of numbness and paralysis. It is as though numb limbs, such as you might encounter had you been sleeping in an awkward position in the night, have become a symbol of death. In addition to flight or fight strategies, the human being may alternatively deploy a 'conservation-withdrawal' mechanism, in which parasympathetic nervous system activity predominates over sympathetic activity and one is immobile, passive and unresponsive (Schoenberg, 2007). We may imagine scenarios in which neither flight nor fight is possible – where there is no escape – and so instead one freezes, plays dead, with a potential evolutionary return if the aggressor then loses interest and moves on. However, as Levine (1997) observes, this immobilisation can potentially be traumatic – the impulse towards a surge in sympathetic activity through the fight or flight mechanism is not discharged. When we go into freeze mode, it is as though we apply the brakes whilst we are still accelerating thus creating a 'forceful turbulence in the body resembling a tornado' (Levine, 1997, p. 27). The internal re-cycling of affect can easily be imagined in the case of a person appearing outwardly composed and instead channelling all that excess of affect into jaw tension. Experiences of disassociation seem to appear in times of heightened anxiety and stress. It is like an overflow mechanism, like the overflow in a sink. We can cope with and digest the stresses and anxieties of every day up to a threshold level,

but beyond this point psychosomatic symptoms are activated – it is as though they have become receptacles for excesses of affect.

Having a body vis-à-vis being a body

Where we experience our selves dualistically the body performs physical functions, such as digesting food, circulating blood and oxygen, and providing locomotion when the mind wills it so, but the mind is the source of ideas, of decision-making and memory; the mind is still synonymous with the spirit that depends on the body but is not the same as the body. As such we experience ourselves as having a body. In contrast embodied consciousness notices how the stomach churns in anxiety and fear, how the cheeks flush with blood when we feel embarrassed, how eyes can fill with tears of sadness or joy, and how glaring teeth or tense muscles may indicate a sense that one is under attack. We then experience ourselves as being a body.

It is easier to appreciate the experience of being a body when somatic symptoms quieten. We can then identify with layers of bone and muscle, bile and blood and circulatory organs and tissues, the brain and the central nervous system and the nervous fibres branching out to all extremities, and the bulbs of sensory organs through which we relate with other bodies. However, this is easily overwhelmed by the more common concept that we have a body, and indeed that it has to be disciplined (Frank, 2010). Periods of tiredness, or of being on a low ebb, or of a lot of feelings to digest and work through, are unwelcome distractions when we have much work to do. Rather than heeding these calls for a change in rhythm or position, we opt to push on through; the agenda setting part of the mind overrides these apparently unwanted and unproductive physical aspects. It often tends to be in precisely those moments when we opt to push on through that the pain surges, a pattern observed by other sufferers of chronic pain (see Doran, 2014).

We take the view that the journey that has been described in this article charts a tentative personal migration from a state of having a body – from the mind/body dualism implicit in that idea – towards an internalised sensibility of being a body, that is, that we are our body. Practically this means responding to the ebbs and flows of being a body, resisting the urge to ‘push on through’, and embracing the spectrum of emotions that colour our perceptions rather than attempting to rise above to a more ‘objective’ position. Contemporary literature advocates a more collaborative approach to the treatment of psychosomatic conditions, with a deeper quality of communication between the patient and practitioners, and indeed between the practitioners themselves (as in Burton, 2014; Druss & Walker, 2011; Edwards et

al., 2010). The division of labour in conventional medicine can have the effect of excluding the emotional colouring of experience from the sphere of legitimate medical data, and likewise that psychotherapy, in the pursuit of free association and metaphor, loses its moorings in biology and ecology; from where psyche owes her origins. The FA has found that as he is able to re-embodiment thought and emotion, that depersonalisation attacks are less frightening, and indeed less common. The acceptance and recognition of vulnerabilities – such as, in the case of this investigation, a phobia of numbness and paralysis – also had the effect that in real-time experiences of depersonalisation the symptoms could be ‘turned down’ or would dissipate altogether. In this case, progress with the jaw pain was less tangible and understanding the triggers and patterns of the pain is much clearer. Nevertheless, the symptoms have demanded reflection upon them and this has facilitated a heightened level of self-awareness and an ability to see oneself as a body, rather than as merely having a body. The essential issue here for therapists is whether therapeutic practice supports clients’ experience of being in a body or not. Our hypothesis is that it does not because of excessive psychologising as a result of the emphasis on the relationship and the underlying antagonisms towards medical thinking and by implication somatic phenomena. When therapists do focus on somatic experiences, they tend to do so in a relational and psychologising way. An example of this would be the concept of somatic countertransference which is viewed as informing the therapist of the inner psychological state of the client (Orbach, 2009). In other words the body is psychologised. Only when the body is addressed as body is the reality of being a body fully addressed; otherwise, it remains an appendage of the psyche and therapists are no different from those doctors referred to in the section on alienation. They also fail to recognise the dissociative mechanisms described in this section. Embodied therapy requires an explicit focus on the body.

Implications for practice

Those therapists who have experienced being both patient and practitioner, and have researched into this, find that their practice is influenced and shaped by the research. For instance, as a practicing psychological therapist presently working with people who suffer with MUS, the FA follows his own principle of regarding symptoms as serving as an overflow for excesses of affect and has found it important to treat symptoms as symptoms. Very typically in the therapy literature psychosomatic symptoms are treated as serving a symbolic function, and as such have to be decoded. However, this approach does not tend to be helpful to the sufferer and may reaffirm the idea that the symptoms are ‘all in your head’ even though they know that the symptoms are very real. Furthermore, therapeutic focus on

the symptoms in and of themselves may collude with the person's increasing preoccupation with them – a tendency that is known to lead to less healthy behavioural patterns, which in turn exacerbate the symptoms further (as in Webster, Thompson, & Norman, 2015). Treating symptoms as symptoms communicates to the sufferer that MUS can, and often do, naturally recede as wider quality of life, self-esteem and capacity for emotional experience improves. Recognising the materiality of symptoms, it is for the GP and other health professionals to work on the symptoms, for example, through pain relief or physical therapies. Instead we stress the importance of assisting the person to develop an embodied awareness – becoming more aware of the psychosocial triggers, patterns and contexts that underpin the flare-ups of symptoms. This awareness can be encouraged through the deployment of autoethnographic methods such as diarying where the patient is willing and able to do this. The process of contextualisation of symptoms enables the sufferer to develop their own narrative account of their condition within their life story as retold in the therapeutic situation. As the evidence indicates, people who are able to develop their own narrative explanation for their symptoms have a better prognosis than those who are mystified by them (Deary, Chalder, & Sharpe, 2007). The person may thus be assisted in identifying more helpful health beliefs and patterns of behaviour that enable them to live well despite their condition. Recognising the social dynamics of MUS, and particularly the stigma often associated with these, it is also important for the person to be assisted in managing the impact of the condition on their relationships – for example, with partners, carers, family and work colleagues – and indeed over their own identity: how their own sense of being in the world has been challenged by their condition. Finally, as trauma often serves as a seminal event in the appearance of MUS and especially in functional syndromes such as fibromyalgia, therapists should not only attend to the question of when symptoms first appeared but also the appropriateness of doing trauma work with the person. Here Levine (1997) and Rothschild (2000) provide essential guidance for the practitioner. It is our belief that a person does not need a concrete diagnosis or medical explanation for their physical symptoms in order for them to begin to make substantial progress in sense making and improving their quality of life. Indeed talking therapy with its emphasis on context and meaning is well placed to accommodate the psychosocial dynamics of uncertainty.

Conclusion

We have endeavoured in this article to demonstrate through thick descriptive accounts of somatic symptoms, the wider contexts in which these symptoms are expressed. A GP ascribed the term 'depersonalisation attacks' to the FA's strange out of body experiences

years ago but it was only recently upon reflection in depth that the connection with a phobia of numbness and paralysis and its basis in traumatic experience became apparent. This then provided significant relief from those symptoms.

Thick description accounts demonstrate that if we are to make sense of medical conditions that for whatever reason have become 'stuck', particularly where there are discernible psychosomatic qualities, we may consider a great many layers of personhood, and symptoms and pathologies reverberate throughout these. An ongoing process of recontextualisation may yield tangible insights about the aetiology, management of and recovery from those symptoms. Thus, ethnography, as a result of broadening the scope and viewing old problems through fresh eyes, must be considered a crucial research strand.

In view of these considerations, there is a strong case for further research into the multi-layered contexts of MUS – patient narratives of their experiences may be enlightening, but so may the experiences of counsellors and psychotherapists whom will assist the person in uncovering these contexts. Research that aimed to understand the processes through which recontextualisation was facilitated, what recontextualisation looked like, and the tangible consequences this had for the management, incidence and experiencing of symptoms may lead to important innovations in the care offered by counsellors and psychotherapists and thereby give psychological therapists a greater sense of confidence and direction when encountering these often mysterious physical symptoms.

Disclosure statement

No potential conflict of interest was reported by the authors.

Notes on contributors

John Hills completed his MA in Counselling and Psychotherapy at the University of Leeds in 2014. He is a practicing counsellor, BACP registered, and since submission of his dissertation has been presenting his research in various conference and CPD settings, and has begun his Ph.D. research in October 2016.

John Lees is senior lecturer in Mental Health at the University of Leeds. He is a UKCP-registered psychotherapist and a BACP senior-accredited practitioner, has edited a Routledge journal, a book series and four books and has written numerous book chapters and peer reviewed articles. His research interests include the microphenomena of clinical practice, psychosomatics, the interface between therapy and CAM, creative qualitative research methodologies and anthroposophic psychotherapy.

Dawn Freshwater is Professor of Mental Health at the University of Leeds and Senior Deputy Vice Chancellor at the University of Western Australia. She is a nurse, psychotherapist and a researcher, with interests in psychological therapies research and offender health. Dawn is an experienced author, research supervisor and educator with an international reputation for developing transformational research approaches.

Jane Cahill is a senior research fellow at the School of Healthcare, University of Leeds. She has published widely in the field of psychological therapy effectiveness and continues to work and publish within the field of mental health. Her current programme of research supports the mental health research programme within the School having an especial focus on the therapeutic alliance, practice-based evidence approaches, workforce mental health issues, and complementary and alternative approaches to mental health.

References

- Alliance for Counselling and Psychotherapy. (2009). Quote from Aldridge, S. (2009). Making your mind up. *Therapy Today*, 20(4). Retrieved March 5, 2016, from <http://www.therapytoday.net/article/show/365/making-your-mind-up/>
- Andersen, R. S., & Risør, M. B. (2014, December). The importance of contextualisation: Anthropological reflections on descriptive analysis, its limitations and implications. *Anthropology and Medicine*, 21(3), 345–356.
- Anderson, V. R., Jason, L. A., Hlavaty, L. E., Porter, N., & Cudia, J. (2012). A review and meta-synthesis of qualitative studies on Myalgic Encephalomyelitis/chronic fatigue syndrome. *Patient Education and Counseling*, 86(2), 147–155.
- Barry, C. A. (2006). The role of evidence in alternative medicine: Contrasting biomedical and anthropological approaches. *Social Science & Medicine*, 62(11), 2646–2657.
- Bermingham, S. L., Cohen, A., Hague, J., & Parsonage, M. (2010). The cost of somatisation amongst the working-age population for the year 2008–2009. *Mental Health in Family Medicine*, 7(2), 71–84. Blackmore, S. (1996). *Conversations on consciousness*. New edition. Oxford: OUP.
- Burton, C. (2014). Can we explain medically unexplained symptoms? (Editorial). *Family Practice*, 31(6), 623–624.
- Clifton, S. (2014). Grieving for my broken body: An autoethnographic account of spinal cord injury as an experience of grief. *Disability and Rehabilitation*, 36(21), 1823–1829.
- Deary, V., Chalder, T., & Sharpe, M. (2007). The cognitive behavioural model of medically unexplained symptoms: A theoretical and empirical review. *Clinical Psychology Review*, 27(7), 781–797.
- Doran, N. J. (2014). Experiencing wellness within illness: Exploring a mindfulness-based approach to chronic back pain. *Qualitative Health Research*, 24(6), 749–760.
- Druss, B. G., & Walker, E. R. (2011). *Mental disorders and medical comorbidity*. The Synthesis Project, Report number 21.
- Edwards, T. M., Stern, A., Clarke, D. D., Ivbijaro, G., & Kasney, L. M. (2010). The treatment of patients with medically unexplained symptoms in primary care: A review of the literature. *Mental Health in Family Medicine*, 7, 209–221.
- Elwood, T. W. (2012). Viewing health care through a semiotic veil of signs. *Journal of Allied Health*, 41(1), 3–13.
- Ettorre, E. (2005). Gender, older female bodies and autoethnography: Finding my feminist voice by telling my illness story. *Women's Studies International Forum*, 28, 535–546.
- Fisher, P., & Lees, J. (2015). Narrative approaches in mental health: Preserving the emancipatory tradition. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*. Advance online publication. doi:10.1177/1363459315600774

- Fonagy, P., & Bateman, A. (2006). Progress in the treatment of borderline personality disorder. *The British Journal of Psychiatry*, 188, 1–3.
- Frank, A. W. (2010). *The wounded storyteller: Body, illness and ethics*. Chicago: University of Chicago Press.
- Freud, S. (1954). *The origins of psychoanalysis: Letters to Wilhelm Fliess, drafts and notes 1887–1902*. New York, NY: Basic Books.
- Gask, L., Dowrick, C., Salmon, P., Peters, S., & Morriss, R. (2011). Reattribution reconsidered: Narrative review and reflections on an educational intervention for medically unexplained symptoms in primary care settings. *Journal of Psychosomatic Research*, 71, 325–334.
- Geertz, C. (1973). *The interpretation of cultures: Selection of essays*. New York, NY: Basic Books.
- Gerrish, K., & Lacey, A. (Eds.). (2010). *The research process in nursing* (6th ed.). Oxford: Wiley-Blackwell.
- Hinton, D., & Kirk, S. (2016). Families' and healthcare professionals' perceptions of healthcare services for children and young people with medically unexplained symptoms: A narrative review of the literature. *Health and Social Care in the Community*, 24(1), 12–26.
- Kierans, C. (2005). Narrating Kidney disease: The significance of sensation and time in the emplotment of patient experience. *Culture, Medicine and Psychiatry*, 29, 341–359.
- Lees, J. (2011). Counselling and psychotherapy in dialogue with complementary and alternative medicine. *British Journal of Guidance and Counselling*, 39(2), 117–130.
- Lees, J. (Ed.). (2016). *The future of psychological therapy: From managed care to transformational practice*. London: Routledge. Unpublished manuscript.
- Leone, S. S., Wessely, S., Huibers, M. J. H., Knottnerus, J. A., & Kant, I. (2011). Two sides of the same coin? On the history and phenomenology of chronic fatigue and burnout. *Psychology and Health*, 26(4), 449–464.
- Levine, P. A. (1997). *Waking the tiger: Healing trauma*. Berkeley, CA: North Atlantic Books.
- McEwan, B. (2000). Allostasis and allostatic load: Implications for neuropsychopharmacology. *Neuropsychopharmacology*, 22(2), 108–124.
- Meany, B. (2001). Maternal care, gene expression, and the transmission of individual differences in stress reactivity across generations. *Annual Review of Neuroscience*, 24, 1161–1192.
- Mobini, S. (2015). Psychology of medically unexplained symptoms: A practical review. *Cogent Psychology*, 2, article no. 1033876.
- Neville-Jan, A. (2003). Encounters in a world of pain: An autoethnography. *American Journal of Occupational Therapy*, 57(1), 88–98.
- Orbach, S. (2009). *Bodies*. London: Picador.
- Quillman, T. (2013). Treating trauma through three interconnected lenses: Body, personality, and intersubjective field. *Clinical Social Work Journal*, 41(4), 356–365.
- Ramo-Fernandez, L., Schneider, A., Wilker, S., & Kolassa, I.-T. (2015). Epigenetic alterations associated with war trauma and childhood maltreatment. *Behavioral Sciences & the Law*, 33(5), 701–721.

- Ricciardi, L., & Edwards, M. J. (2014). Treatment of functional (Psychogenic) movement disorders. *Neurotherapeutics*, 11, 201–207.
- Roth, W. M. (2012). *First person methods: Towards an empirical phenomenology of experience*. Rotterdam: Sense.
- Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment*. New York, NY: W.W. Norton & Company.
- Royal College of General Practitioners (RCGP). (2014). Guidance for health professionals on medically unexplained symptoms (MUS) [online]. Retrieved February 16, 2015, from <http://www.rcgp.org.uk/clinical-and-research/clinicalresources/~media/Files/CIRC/Mental%20Health%20-%202014/4%20Medically%20Unexplained%20Symptoms%20%20guidance%202014.ashx>
- Sacks, O. (1984). *A leg to stand on*. New York, NY: Harper & Row.
- Schoenberg, P. (2007). *Psychosomatics: The uses of psychotherapy*. Basingstoke: Palgrave Macmillan.
- Steiner, R. (1920 [1975]). *Spiritual science and medicine*. London: Rudolf Steiner Press.
- Suzuki, L. A., Auhluwalia, M. K., Mattis, J. S., & Quizon, C. A. (2005). Ethnography in counseling psychology research: Possibilities in application. *Journal of Counseling Psychology*, 52(2), 206–214.
- Webster, R., Thompson, A. R., & Norman, P. (2015). 'Everything's fine, so why does it happen?' A qualitative investigation of patients' perceptions of noncardiac chest pain. *Journal of Clinical Nursing*, 24, 1936–1945.
- Wilbers, L. E. (2015). She has a pain problem, not a pill problem: Chronic pain management, stigma and the family – An autoethnography. *Humanity & Society*, 39(1), 86–111.

Appendix 1.2: Indices of Change

Hills, J., Cahill, J., Lees, J. and Freshwater, D. 2018. Indices of change: Analysing the indexical properties of data from psychotherapy case work to discern patterns of therapeutic change over time. In: Costa, A.P., Reis, L.P., Souza, F.N.D., and Moreira, A. eds. 2018. Computer Supported Qualitative Research. Advances in Intelligent Systems and Computing. Berlin: Springer Verlag, pp.418-424

Indices of change: analysing the indexical properties of data from psychotherapy case work to discern patterns of therapeutic change over time

John Hills, Dr Jane Cahill, and Dr John Lees of the University of Leeds
 Prof. Dawn Freshwater of the University of Western Australia
 Correspondence: John Hills, School of Healthcare, Baines Wing, University of Leeds,
 LS2 9TJ. hc11j3wh@leeds.ac.uk

Abstract. With reference to semiotic theory, a form of data analysis is proposed that explicitly unpacks the indexical properties of data from psychotherapy case studies. The approach is observed to happen within the therapeutic hour as a co-production between the client and their therapist. Thus analysing the data in this way seeks to address two common charges against traditional research into psychotherapy processes: that it fails to capture the true value of the therapy and lacks the sensitivity to measure outcomes. Two case vignettes will demonstrate the utility of this approach in lived context, with meaning emerging as therapy continues.

Keywords: Psychotherapy, case study research, practitioner research, change process research, semiotics

Introduction

In recent decades, research into the processes and outcomes of psychotherapy have come under increasing criticism for not capturing the value of therapy as understood by practitioners [1], nor generating appropriately sensitive means of measuring outcomes for therapy clients [2]. Research methodologies that studied psychotherapies on the basis that

a process, e.g. a psychotherapeutic method, could be tested against an outcome, e.g. whether a client scored better on measures of wellbeing, were not able to capture the complexity of the therapeutic exchange [3]. The now established field of *change process research* (CPR) considers not just the existence of causal relationships between process and outcome, but also the nature of those relationships; including the sequential nature of change during and across therapy sessions [4]. The analysis of case studies presents particularly rich opportunities to reveal those processes [5]: in addition to capturing the longitudinal nature of the psychotherapy process, case studies offer a form of ‘narrative knowing’ that is deeply contextualised [6].

Whilst we do not provide a comprehensive review of existing theory in CPR, in this paper we will make reference to several exemplary theoretical approaches. However our purpose is to propose a novel approach to the analysis of case data that we consider to prove complementary to these existing strands. We seek to draw attention to a naturalistic form of data analysis that can be observed to take place within the ordinary therapeutic hour. Emergent ideas may be treated by both the client and their therapist to reveal meanings through association and hidden underlying patterns. Such data include the emergence of symptoms, whether psychological or psychosomatic; trigger events associated with those symptoms; happenings within the therapeutic relationship and extra-therapeutic events that apparently heralded change; and the appearance of signs, both material and experiential, associated with change.

Indicators of change – existing concepts in change process research

Skjerve et al’s *topic change* approach takes the transcript data from therapy sessions and ascribes individual utterances e.g. words, phrases etc. according to their topic – the focus of conversation [7]. These topics are constituted out of a sequence of utterances that is only broken by a shift to another topic. Once a sequence of utterances is identified to form a topic, this can then be analysed for the *perspective* taken on the topic e.g. whether the topic is regarded positively or negatively, the emotional content corresponding to it, the client’s own appraisal of cause and effect etc. Skjerve et al’s method identifies longitudinal recurrences of a topic and seeks to discern shifts in perspective over time.

Significant events studies discern important moments in therapy by reference to multiple sources including client feedback forms on what they considered helpful about therapy and

video-recorded interviews [8]. These significant events are considered sequentially as representing the unfolding process between therapist and client through time. These studies typically seek to tie indicators of change within therapy to indicators of good outcome post session and post therapy. It is the concreteness and explicit nature of the significant events that mean this approach is attractive to practitioner researchers in developing 'micro theories' [9].

Gonçalves et al devised a systematic approach to the coding of case data designed to identify what were discerned to be *innovative moments* in therapy [10]. The concept of an innovative moment emerged from narrative therapy and is defined as the expression of an idea or an action by the client that would not be predicted by the dominant story they tell about themselves. The emergence of an alternative selfnarrative is considered by narrative therapists as a crucial opportunity to facilitate psychotherapeutic change [11].

Whether we seek in individual data an indicator of shift in perspective, a significant event or an innovative moment, a high degree of context sensitivity is necessary on the part of the researcher. Data considered *prima facie*, without a rich appreciation of the client's life history and styles of meaning-making are likely to yield generic inferences. Implicit in the idea of making inferences from explicit and concrete data is the capacity to look beyond the data: to treat them as emergent 'signs' in the therapeutic process and consider what they 'signify' and it is this aspect of the analysis that leads us to consider the indexical properties of case data.

Indexicality

Indexicality is one of three fundamental sign modalities identified in the semiotic theory of Charles Sanders Peirce; the other two being iconicity and symbolism [12]. An index is a sign that 'points to' an object by virtue of having some contiguity with it in its own context. If one were to look out across the horizon and observe a pillar of smoke it could be reasonably deduced that there was fire below. In this example the visible pillar of smoke serves as an index for the presently invisible fire. Indexicality has utility in disciplines such as medicine - a blood test that revealed abnormal levels of glucose may serve as an index for diabetes; and

ecology – the presence of species such as the stonefly or of blood worms in a river serve as indexical of the levels of pollution in the river [13].

The utility of indexicality in psychotherapy research and practice

Psychotherapists similarly observe indices in the stories their clients present to them. When a client reports struggling to get out of bed in the morning, if their attendance at work becomes erratic or they neglect to attend to personal hygiene, these may well be indexical of a state of depression and the therapist will want to explore the greater context in which these signs apparently sit. Likewise if the client reports a new confidence in social situations, that others have noticed them smiling or brighter than before, or that they find they have a ‘spring in their step’; these may be considered to be indices of a recovery from depression, that may have been facilitated by shifting patterns of thought, beliefs, relation to others etc. Certain indices may also represent ideas that the client is presently unconscious of or is too ashamed to discuss directly. For example, a client reacts very negatively to a passing comment the therapist made about their relationship with a family member – the intensity of the reaction betrays some presently hidden significance that is not being made explicit in the consulting room.

Coding and the emergence of a change orientation

In coding case data, and particularly in the induction of analytic themes, individual items are implicitly treated as signposts; pointing beyond themselves to greater phenomena. In the therapeutic situation, individual indices will be landed upon because they are perceived to have an implicit semiotic potential e.g. they appear to signify a departure from the client’s dominant narrative. This is usually ‘felt’ between therapist and client before its meanings are explored together. Alves et al described the coding of client utterances as innovative moments where they appeared as ‘exceptions to the rule, as they introduce novelty into a client’s life’ [14]. These indices can be observed to cluster around what Alves et al identify as ‘pronarratives’ that in successful therapy will evolve into a ‘new self-narrative’ [15]. These stages may be considered as analogous to tiers of analytic induction. The therapist may explicitly ask the client to consider the bigger picture – “what do you think this tells us about what change looks like for you”? Gonçalves et al describe the client as ‘decentering’ in

this exploratory stage, which is being able to stand back and consider the merits of alternative self-narratives – this allows the client to project themselves into the future and sustain the change [16]. Individual indices may be considered as markers representing phases of change e.g. that the client realizes they are going through at the moment; these discernible stages of change have been observed in Styles’ assimilation model [17]. In the medium to longer term these phases might be considered to constitute sequential steps in a consistent pattern of change e.g. the establishment of a new self-narrative, such that the client can look back and realise that they are “in a different place” now.

We will now demonstrate the utility of this approach using two case vignettes. The vignettes are the amalgamations of many actual therapeutic cases, with particular details altered as necessary to protect anonymity.

Case vignettes

Maryam

Maryam was just in her fifties when her husband was diagnosed with a lung cancer – within two months he was dead. She came for therapy one year after her husband’s death – she’d returned to work relatively soon after his death and recognized she hadn’t properly grieved. Now she was beginning to have strange depersonalisation attacks, that felt like ‘out of body experiences’. After several sessions’ the therapist mentioned, almost in passing that “it sounds really lonely”. Although she didn’t say anything at the time the therapist’s comment had stuck with her – “yes, it really is lonely”. When she returned she talked about this with her therapist and they explored further her feelings of alienation. She realized in that session that her strange ‘out of body experience’ would not be surprising given how disconnected she felt from everybody since her husband’s death. Her daughter lived far away, and when friends and colleagues ever asked her how she was she just replied that she was fine – it had become automatic. Maryam understood that she needed to feel reconnected with the world around her and so resolved that if she was asked how she was she wouldn’t just automatically reply that she was fine but would be honest.

Maryam came to a session and talked about a dream that she'd had: She was on the way to the train station, using several different modes of transport, as she was to meet her husband who had been away for a long time. After a long and arduous journey she arrived at the station and as she stepped onto the train platform she saw that the train was already disappearing off into the horizon. The meaning for Maryam was clear – in therapy she said that she knew as though for the first time that she would never see her husband again. This helped her to realise that the house she was living in had become a kind of museum to the life that she had shared with her husband, and that she had remained in it in a state of 'suspended animation'. She made the decision to move closer to her daughter, who was herself about to become a mother. One session towards the end of her therapy upon arrival she noticed that she felt genuinely pleased to see the therapist; feeling the warmth of his greeting in return. This felt important to her and upon exploration she realized that it had made her feel that she was no longer phantom-like, but that she had a future. Previous to this she had felt no desire or inclination to have a social life and to return to activities she had enjoyed before her husband's death, now she felt in a place to reconnect with old friends and took up lessons in flower arrangement and needlework.

Andrew

Andrew came for therapy after several angry outbursts directed towards family members and colleagues at work about which he felt ashamed and afraid. With the therapist's encouragement Andrew began to tell his life story. Andrew's own father had died when he was just a baby and his mother remarried, going on to have more children. Andrew grew up feeling that he was different, and even that the family would be happier without him in it. The therapist suggested to Andrew that he carried a great deal of anger with him from his childhood that could not be directed legitimately – it wouldn't seem 'fair' to direct his anger towards his stepfather, his mother, or even his deceased father, but as a consequence it spilled out over relatively trivial frustrations. Andrew had noticed that his angry outbursts only occurred when he felt under pressure at work; that his results would be scrutinized as being poor quality in comparison with that of colleagues. When asked to consider when else he might have felt this way he was able, for the first time, to associate this with his childhood experience in the family home. As a consequence he was able to stop seeing his outbursts as frightening and random - he began to understand that they followed a pattern.

The following session Andrew reported an experience when he'd been driving and another driver had selfishly pulled out in front of him on a busy road at rush hour. Andrew had flown into a rage disproportionate to the event. However in a moment of clarity had caught himself – why am I getting so angry? – and recalled the discussion of the previous session. After the event Andrew noticed a profound feeling of calm. He coined a phrase that became a guiding rule for him: "I'm in control, not my anger". As he put this rule into practice, other people began to notice that he seemed brighter and more at ease. Andrew confirmed that he felt different: not having to be perfect all the time; he realized that he was well liked, and that his work was of a good quality, saying for the first time, he really felt like "Andrew".

The included figure overleaf illustrates how from the narrative data of the vignettes, individual elements can be selected for their indexical properties. Each of the indicated phases of change is 'discovered' by Maryam and Andrew and their therapist through curiosity about the indices as they emerge in therapy.

Conclusion

As is typical in case study research, originating within unique local contexts, questions of generalization need to be considered carefully. Stake proposed a form of 'naturalistic generalisability' [18] contingent on the practitioner observing points of contact between a study and their own experience e.g. 'that reminds me of my work with X and that insight might be useful'. Elliott advocated a research approach similar to the precedents established by a body of case law to discern patterns of

Indices of Change

| Maryam's story | <i>Analogous phases of change</i> | Andrew's story |
|--|---|---|
| "Yes it really <i>is</i> lonely" | <i>Therapist comment appears to spark a new realisation</i> | "I suppose I always felt like that at home" |
| "And when she asked me how I was I was just honest with her" | <i>Moment of lucidity</i> | "Why am I getting so angry?" |
| Reality sinking in: "I'll never see him again" | <i>Noticing a shift in internal experience</i> | "I felt like this weight had been lifted from my shoulders" |
| "I have to turn the page; I have to write a new chapter" | <i>Client names change orientation</i> | "I'm in control, not my anger" |
| Feeling the warmth of therapist greeting: "it really felt as though you cared" | <i>Client's sense of self has shifted</i> | "For the first time I really feel like Andrew, you know?" |

TIME

psychotherapeutic change and the conditions that facilitate change between cases [19]. In the language of the present study: a unique case study may be considered as indexical of more generalized therapeutic phenomena. Thus, we will now apply this novel analytic approach within a case series of psychotherapeutic work undertaken by the first author. In addition to identifying patterns of change within cases, attention will also be drawn to analogous patterns of change between cases: to what extent are these patterns congruous; to what extent do they diverge?

In this paper we have demonstrated how a naturally-occurring exploration of the indexical properties of case data takes place between the client and their therapist in the ordinary therapeutic hour. Furthermore we have proposed that this same indexical analysis may be utilised in complementary fashion with existing approaches to data analysis within

the Change Process Research tradition. The deliberate and purposeful exploration of the indexical properties of case data may also provide a useful tool for counsellors and psychotherapists in their training, for example in increasing their sensitivity to the signs (indices) that emerge within the therapeutic conversation and may point the way to significant therapeutic change.

References

1. A.C. Bohart, K.L. Tallman, G. Byock, & T. Mackrill. The "Research Jury" Method: The Application of the Jury Trial Model to Evaluating the Validity of Descriptive and Causal Statements about Psychotherapy Process and Outcome. *Pragmatic Case Studies in Psychotherapy*, Volume 7, Module 1, Article 8, pp. 101-144 (2011)
2. Green, D. Making the case for using personalised outcome measures to track progress in psychotherapy, *European Journal of Psychotherapy & Counselling*, 39-57 (2016)
3. Elliott, R. Psychotherapy change process research: Realizing the promise, *Psychotherapy Research*, 20:2, 123-135 (2010)
4. Ibid
5. Skjerve, J., Reichelt, S. & McLeod, J. Topic change processes in psychotherapy: a case study approach, *Qualitative Research in Psychology*, 13:4, 271-288 (2016)
6. McLeod, J. *Case Study Research*. Sage Publications : London (2010)
7. Skjerve, J., Reichelt, S. & McLeod, J. Topic change processes in psychotherapy: a case study approach, *Qualitative Research in Psychology*, 13:4, 271-288 (2016)
8. Elliott, R. Psychotherapy change process research: Realizing the promise, *Psychotherapy Research*, 20:2, 123-135 (2010)
9. Ibid
10. Gonçalves, M.M., Ribeiro, A.P, Mendes, I. Matos, M. & Santos, A. Tracking novelties in psychotherapy process research: The innovative moments coding system, *Psychotherapy Research*, 21:5, 497-509 (2011)
11. Ribeiro A.P. & Gonçalves M.M., *Commentary Innovation and Stability within the Dialogical Self: The Centrality of Ambivalence. Culture and Psychology* (2010)
12. Peirce, C.S.: *A Syllabus of Certain Topics of Logic*. Alfred Mudge & Son, Boston (1903)
13. Nuffield Foundation, <http://www.nuffieldfoundation.org/practicalbiology/monitoring-water-pollution-invertebrate-indicator-species>
14. Alves, D., Fernández-Navarro, P., Ribeiro, A.P., Ribeiro, E. & Gonçalves, M.M. Ambivalence and Innovative Moments in Grief Psychotherapy. *Psychotherapy* 2014, vol.51, number 2, pp308-321 (2014)
15. Ibid
16. Gonçalves, M.M., Ribeiro, A.P, Mendes, I. Matos, M. & Santos, A. Tracking novelties in psychotherapy process research: The innovative moments coding system, *Psychotherapy Research*, 21:5, 497-509 (2011)
17. Styles, W.B. Assimilation and the process of outcome: Introduction to a special section. *Psychotherapy Research*, August 2006; 16(4): 389_392 (2006)

18. Stake, R.E. The Case Study Method in Social Inquiry in Gomm, R., Hammersley, M. & Foster, P.. Case Study Method: Key Issues, Key Texts. Sage Publications, London (2000)
19. Elliott, R. Hermeneutic Single-Case Efficacy Design, *Psychotherapy Research*, 12:1, 1-21 (2002)

Appendix 1.3: The Psychosomatics of Distress

Hills, J. 2018. The psychosomatics of distress: Case study insights into lived experience and therapeutic change. *Self and Society*, 46(2), pp. 58-65

The psychosomatics of distress: case study insights into lived experience and therapeutic change

John Hills

Before beginning psychotherapy, Q went to see his GP complaining about tremors in his upper body that he was feeling increasingly self-conscious about. There was no question of the original cause of the tremors – Q had gone through complications at birth that had left him with permanent nerve damage. However, now in his forties, Q was becoming acutely aware that other people might see these tremors and pass their own judgements on him. In a vicious cycle, he recognised that the more self-conscious he became, the more exaggerated became the tremors. The GP suggested a course of diazepam but Q thought: 'I'm not going down that road' and instead sought out therapy. It was in that context that I began working with Q and during our time together he discovered he was not fated to fall into that vicious cycle, and that he could continue to feel in charge in those situations that had been so uncomfortable for him. Q did not regret his decision to decline diazepam. This article will consider the contentious and often stigmatised position that people find themselves in when physical symptoms appear to be associated with psychosocial distress. Deeply ingrained public misunderstanding about what might be described as the psychosomatic can have powerful influences over a person's relationships and sense of self. I will consider the role that psychotherapy can play in working with clients who present with bodily symptoms, and introduce my own research, presently underway: a multi-case study of 12 months of clinical practice, concerned with two key questions: what does change look like, and how is change facilitated?

History and terminology

The word psychosomatic – literally a union of psyche and soma - originated in the romantic period of the late eighteenth and early nineteenth century when poets and naturalists alike pushed back against a dominant mechanistic worldview that appeared to reduce human beings to mere biological machines (Schoenberg, 2007). First associated with the work of German physician JCA Heinroth, psychosomatic conditions were those which had an emotional as well as a physical aspect. That idea predates the naming of it however. Heaton (2012) observed throughout the entirety of Shakespeare's plays frequent reference to physical malady associated with the distress of the characters, including ten symptoms of grief such as panting, vomiting, toothache, and hair turning white. In 1688 as the last English Catholic King James II saw his support haemorrhaging in favour of the arriving William of Orange, famously his nose began to bleed heavily, in what is understood by contemporary historians to have been a psychosomatic event, and he fled to France (Starkey, 2006). In the 20th century and in popular culture psychosomatics are most typically associated with the work of Freud and those who carried his work forward. Freudian thought typically considers psychosomatic symptoms to perform a symbolic role – the body converting intense emotional distress into a physical form in order to protect oneself from experiencing the distress directly. The legacy of the term, though literally meaning the unity of psyche and soma, is that it is considered to mean that physical symptoms are 'all in the mind', with no organic cause for them (Kornelsen et al., 2015).

Because of the potential stigmatising effect of such an idea, the word is not now normally used by health professionals and psychotherapists to describe physical expressions of distress. The preferred contemporary term is medically unexplained symptoms or MUS – meaning symptoms for which an organic explanation is absent or inadequate. The subtext to the use of the term is typically to indicate the presence of emotional or social factors, however the use of the term is as such controversial, with examples of serious organic illnesses being missed following a MUS diagnosis (Wilshire and Ward, 2016). Common MUS include chronic pain; irritable bowels; dermatological conditions such as eczema or alopecia; cardiac expressions such as ectopic or racing heart beats; or neurological events such as numbness, blackouts, or seizures. In studies conducted across the USA, UK, The Netherlands and Denmark, MUS presentations have been found to feature in between 15-40% of all General Practitioner appointments, with even greater frequencies observed in presentations to secondary care (Konnopka et al., 2012; Zonneveld et al., 2013; JCPMH, 2017).

However increasingly it is being recognised that the boundaries between conditions that can be described as medically unexplained and those with an organic aetiology are becoming blurred. Subjective experience of all physical symptoms may be modulated by psychological factors (e.g. Kirmayer et al., 2004; Wiech et al., 2008; Figueredo & Griffith, 2016). Creed (2016) observes that in cases of common functional syndromes such as irritable bowel and chronic fatigue syndromes that both organic and psychological causal factors can be discerned. Shoenberg (2007) identifies amongst the many physical symptoms of depression: fatigue, constipation, loss of appetite, and loss of libido. Likewise sufferers of chronic anxiety may experience tremors, diarrhoea, nausea and vomiting, and palpitations (ibid). The position taken in this article is that because psyche and soma are inextricably associated, all physical symptoms are real, regardless of uncertainty about their aetiology. The suggestion that some sufferers of bodily distress may be funnelled into a psychological category has had a profound impact on relationships and sense of self as will now be considered.

The lived experience and social consequences of diagnostic uncertainty There can be serious social consequences for those of us whose physical conditions lack a tangible and socially accepted diagnosis. Being diagnosed with conditions such as cancer, heart disease, chronic lung disease, or renal failure provide a tangible and socially acceptable label for one's illness. A medically unexplained diagnosis can leave people anxious that a serious condition may be being missed (Gask et al., 2011), and even that they are to blame for their condition (Anderson et al., 2012). People can strongly resent the implication of stress or emotional factors in their physical conditions, in some cases precipitating an ambivalent relationship with physicians, psychiatrists or psychotherapists (Shoenberg, 2007; IAPT, 2014). Those that seek repeated consultations and investigations may be suspected of seeking secondary gains, for example access to disability payments or opioid prescriptions (Wilbers, 2015). GPs and other health professionals can feel demoralised and deskilled when working with people suffering with these conditions (Burton, 2014), and patients in turn may resort

to tactics such as deliberately looking unwell e.g. arriving for the consultation in their dressing gown in order to be taken seriously (as in NevilleJan, 2003).

Kornelsen et al. (2015) conducted a phenomenological study on the lived experience of 38 Canadians living with MUS. The study found that some of the participants in Kornelsen et al.'s study did believe that a MUS diagnosis was satisfying in comparison to no diagnosis at all, and did at least have some practical functions, for example in being able to fill out disability benefit forms and apply for travel insurance. However almost all of the participants expressed the anxiety that once such a diagnosis had entered their medical records that it would prejudice all future consultations towards psychiatric interpretations and against further medical investigations. The study also found that most participants, despite holding to a belief that their conditions had a biological basis, nonetheless had fleeting moments of self-doubt – when their experience was of being told that their physical problems were all in their head, occasionally they would wonder whether a psychological root cause was possible.

Rossen et al. (2017) performed an ethnographic study accompanying 13 Danish people who had lived with MUS from periods ranging from just a few months to fourteen years. One of the participants had complained of sensory disturbances in a circular region around his leg. His GP had understood that such a presentation did not indicate an organic cause as a circular pattern would not correspond to the nerve pathways, however agreed to refer him to a multiple sclerosis clinic to 'protect the trusting relationship' (ibid, p8). The participant explained that his illness career had affected his marriage – whilst he held to the idea that he had a 'legitimate' disease, his wife had 'lost faith' in his symptoms being caused by a 'real disease'. Another participant, after seeking continual repeat consultations and investigations, was eventually diagnosed with multiple sclerosis (MS). She described this as a turning point: not only was she now 'legitimately ill', but 'she had a right to be ill', which for her meant that health professionals would now take some responsibility for the management of her condition, and she would now be able to cancel engagements citing physical pain, something she'd not felt able to do before (ibid, p12).

Living with a chronic physical condition can challenge and redefine a person's sense of self, as Patel (2016) demonstrated. Describing her own experience of living with chronic pain, Patel's physical condition soon became central: 'my world and self-concept was all about pain'. Patel goes on to describe successful therapeutic work with a client living with chronic pain. Through the therapy the client's relationship to her pain gradually transformed. She discovered that she could feel independent and strong, and eventually negotiated with her GP a withdrawal from pain medication and anti-depressants. We shall now consider the existent contemporary literature on how psychotherapists have helped clients who suffer with physical conditions.

Psychotherapeutic approaches

Typically in the UK people with persistent medically unexplained symptoms will be referred by their GP for psychological therapies whilst continuing to receive support

from other professionals such as physiotherapists, occupational therapists and specialist nurses. Challenging illness beliefs and personal cognitions about symptoms is the aim of cognitive behavioural therapies in this area (Van Dessel et al., 2014). Interventions include targeting vicious cycle effects such as a person responding to a symptom flare-up by excessively reducing their physical activity, thus exacerbating physical problems, or preoccupation with them, further. However people with MUS may also be referred for, and derive benefit from psychodynamic, interpersonal and humanistic therapies. The alleviation of or recovery from medically unexplained symptoms may also involve the production of illness narratives, through which the person is able to make sense of their symptoms (Kirmayer et al., 2004; Deary et al., 2007). People presenting with MUS who are able to narrate

their distress, and appreciate its characteristics and context, feel more confident in terms of self-management of their symptoms than those who continue to be mystified by their condition (Kirmayer et al., 2004). Interestingly the benefits of illness narratives held even where they were incongruent with biomedical explanations (ibid), indicating the importance of clients finding their own subjective truths. There is also in some cases a relational dimension to MUS presentations. In Luyten et al.'s (2012) mentalisation approach to working with MUS, the middle sequence of therapy works explicitly on establishing connections between somatic (physical) and interpersonal experience, thus facilitating the client's increasing capacity to understand their bodily experience in terms of their relationships with others.

The contemporary picture of psychotherapeutic work in this area therefore is that recontextualising physical symptoms can have benefits in terms of clients being less frightened by their symptoms and better able to manage affect in situations associated with symptom flare-ups. Where affect becomes more manageable, subjective perceptions of the intensity of somatic symptoms can diminish (as in Flo and Chalder, 2014; Dura-Ferrandis et al., 2017). However the more effective management of affect can also mean the reduction of objective measures of symptom expression, for example in the frequency of non-epileptic seizures (LaFrance et al., 2014) or of irritable bowel symptoms (Kenwright et al., 2017).

As Johnstone and Watson (2017) observe, there is an alternative to the quest to diagnose and thus medically explain a person's condition. Instead psychological formulation, which they conceptualise as 'a process of ongoing collaborative sense-making', is advocated for mobilising the person's own strengths and resources, and orienting in the direction of recovery and renewal. Luyten et al. (2012) addressed the same issue in designing their mentalisation-based approach to working with somatic disorders. Here the first four therapy sessions involve arriving at a 'common, acceptable illness theory' with the client (ibid).

Case study literature – learning from the last ten years

The previous decade has seen a small but nonetheless insightful number of case studies written by psychotherapists from different modalities, working with clients

presenting with MUS, with potentially transferable accounts of change. In some cases it was clinically significant for the client to experience having the therapist witness the expression of their physical symptoms in session. Atnas (Atnas & Lippold 2013) witnessed her client Rachel, a woman in her twenties, have two non-epileptic seizures during her CBT therapy. Both Atnas and Rachel, who comments on her own case study, reported these as positive experiences. Rachel experienced a feeling of cold immediately before having a non-epileptic seizure. As a result when Rachel felt cold she associated with the danger of having a seizure and associated fears such as having to go into hospital or even dying. Rachel explored those situations in which she became anxious of having a seizure using what she called a 'hot cross bun chart' with the four corners being spaces for thoughts, behaviour, feelings, and body respectively. This helped Rachel to challenge some of the thoughts and beliefs she'd built up around her body signals, and feel less afraid of having a seizure in certain identified situations.

Likewise Bronstein (2014) witnessed her client Annie, whom she saw between the ages of 8 and 11, have an asthma attack in session. Bronstein was able to provide a psychological context to the symptomatic expression. It had been Annie's birthday and she was showing Bronstein her cards. Despite an apparent show of pleasure in receiving these cards, Bronstein observed that she did not look happy and felt sadness for her. Annie covered her face and Bronstein wondered out loud whether Annie was trying not to cry. Annie replied: 'I am not crying, I am rubbing my eyes'. She began to breathe with difficulty and gasp for air. Bronstein felt 'concerned, impotent, hopeless and very sad'. Bronstein told Annie she understood that she could not feel sad and cry; that instead she felt suffocated by her asthma. This was not taken up directly

by Annie but evidently facilitated a subsequent wondering about whether or not her (biological) mummy had remembered her birthday.

Other case studies demonstrated the importance of historical and traumatic origins of physical symptoms – that in response to a present-day trigger the body was recreating the physical experience of an original trauma. Angelo was living with urinary and faecal incontinence (Dimaggio et al., 2014). During his therapy Angelo recalled childhood humiliation and physical abuse at the hands of his father: the encounters were so frightening that as a boy Angelo felt a pressing need to urinate and anxiety about not getting to the toilet in time. Angelo's present day needs to dash to the toilet were evidently triggered in situations where he experienced being under the scrutiny of others.

Minna – a woman in her thirties who presented with tremors and a history of seizures – began to express symptoms in session, including a tick in the eye, back pain, and numbness or spasms in the arm (Vorne, 2011). Her therapist pointed out that when these symptoms appeared in session Minna had just been speaking about her mother or her father, her deceased sister, men or motherhood; Minna herself had not noticed these associations. At seven years old Minna woke one night and saw her five year old sister Hanna 'convulsing in agony' – Hanna died that night from a cerebral haemorrhage. Through her therapy Minna eventually accepted the possibility that her

cramps and convulsions were psychic in nature, recognising the similarity between her own twitches and arching of her back, to those of her sister's as she was dying.

The case study literature also reflects instances where the expressions of physical symptoms appear to be associated with certain relationships and the dynamics of those that the client participates within. In Taylor (2008) Anne complained that after the previous therapy session, she woke to find her pelvic pain much worse and extended throughout her body. Anne recognised a feeling of guilt that from the previous session she had disclosed to her therapist how her mother behaved when she was under the influence of alcohol when Anne was a girl. Reflecting on one instance of when Anne discovered her mother in an inebriated state, Anne recalled how this had triggered a clamping down of her pelvic floor muscles, such that it was understood that Anne would tense these muscles in times of anxiety as a way of 'holding' herself. As the therapy progressed it became clearer that Anne was locked in a 'traumatic' relationship with her mother.

Sara used the first sessions of her psychotherapy to explore her relationships with three physicians (Liotti, 2017). She was particularly angry with one physician who had 'promised' to provide a diagnosis of Chronic Fatigue Syndrome to support her request for sick leave. In the resultant report, instead Sara discovered the diagnosis had been substituted for anxiety and depression, which left her feeling he had betrayed her. Her therapist enquired as to whether she could think of other situations where she felt a significant person went on to betray her trust in them. Sara recalled a significant memory from childhood. She had woken in the night with intense abdominal pain. Her father had entered her room and believing the pain to be psychological 'ordered' her to stop crying as it would only make the situation worse. When Sara did not stop crying he was verbally abusive to her and returned to his room. Later it was discovered that Sara's symptoms were not psychological in nature but instead were caused by a bladder infection.

What is interesting about the existent case study literature is that even given richly contextualised accounts of a client's unique circumstances and experience, nonetheless patterns identified appear to be transferable across cases. It is also notable that those patterns appear to transfer between cases of different modalities e.g. between cognitive behavioural and psychoanalytic therapies. As a practitioner at the beginning of my PhD study I was motivated to understand better what change looks like and how change is facilitated when working with clients who bring physical symptoms. As I became more familiar with the existent case study literature I was inspired by the idea that patterns of change may be observed across cases, and thus the design of my own research project began to take form.

Introducing my own research

My research project is a multi-case study of my own therapeutic work with people who present with somatic symptoms. My supervisors and I settled on the term 'somatic symptoms' because it recognises physical symptoms as real, and also allows

for the possibility of an association with psychosocial distress. I consider my project to belong within the Change Process Research tradition (Elliott, 2010), and in particular research seeking out patterns of change across cases. Because the context of physical symptoms is crucial to understanding their parallels in psychosocial experience, it was apparent early on in the designing of my study that a case study design was most appropriate for the aims of the project. A case study design enables a longitudinal analysis of the therapeutic work e.g. the trajectories of the therapeutic experience over time, and of any changes the client experiences in their lives. Furthermore in attempting to go beyond linear theories of cause and effect in psychotherapy – think billiard balls colliding on the table – and capturing that sense of psychotherapy as a complex intervention, the case study enables us to better represent that complexity and provide more realistic accounts of ‘soft’ or ‘enabling’ causality (Elliott, 2002; Bohart et al., 2011).

However there is also an unmissable autoethnographic strand to my research. I participate in the research project not simply as a researcher and a practitioner, but also as a sufferer of chronic pain. During my training in counselling and psychotherapy, I had a vague understanding that my pain was associated with certain social situations and decided to explore this possibility in my MA dissertation research project (Hills et al., 2016). In conducting that project I learned that my present day pain flare-ups were associated more particularly with situations in which I feel out of my depth or that otherwise push at the edge of my window of tolerance. Furthermore I developed tangible associations between my pain and a traumatic double bereavement I experienced when I was 18. As well as noticing flare-ups of pain associated with particular client work, I have noticed the experience of other physical symptoms as I work with different clients – for example muscle contractions in my throat and my chest – and these I’m documenting in my project alongside other subjective events as I work with my clients. My research project is then ultimately an analysis of 12 months of counselling practice in which I, as well as the clients I’m working with, develop, reformulate meanings, experience life events and personal change. The clients who participate in my study are able to comment directly on their experiences of the therapy, and to provide their own accounts of whether they experienced change and what they believed helped change to come about. This culminates in the production of a case report, in which I aim to preserve the client’s own language as faithfully as possible, that the client themselves then sees and is invited to comment on, and in this way meanings continue to emerge collaboratively.

What I hope to achieve

In my reviewing of the existent case study literature in this area I have found the client’s own voice and appraisals of their therapy to be almost universally unrepresented. Furthermore, whilst therapists have provided theories on what they think has been going on in the therapy work, very few case studies explore the therapists’ subjective experiences and transferences. In my own research I intend to address these gaps. In my project’s emphasis on change and the conditions that

promote change there is a pragmatic contribution I intend to make. As the existent case study literature demonstrates, the patterns of change we observe appear not to be determined by the modality of the therapist. As such I hope to provide practical insights that may be beneficial to fellow practitioners, who may be under-confident in what to do when their clients bring physical symptoms. The promise of this project is in demonstrating that psychotherapeutic work with clients who bring physical symptoms can make progress without having to sign up to any idea about the symptoms having a psychological aspect. Rather, whatever the aetiology of a person's symptoms, we start on the basis of their reality and can do good therapeutic work in addressing the impact of physical conditions on a person's sense of self and quality of life. From chronic physical discomfort and social alienation, clients can and do make the journey back into life. As a psychotherapist my privilege is to champion the client as they chart the way, and as a researcher to document the steps.

John Hills is in his second year of PhD study at the University of Leeds, whilst continuing clinical practice in the third sector. John holds an MA in Counselling and Psychotherapy from the University of Leeds and has been in practice since 2011. John is particularly interested in dialogical approaches to therapeutic change, and also the 'common factors' that appear to facilitate change, beneath the particular modality of therapy being practiced. John has previously published an autoethnographic study of the psychosocial aspects of his own chronic pain in the *British Journal of Guidance and Counselling*, as well as a recent chapter on identifying 'indices of change' in psychotherapeutic case work, as published in *Computer Assisted Qualitative Research*. Email: hc11j3wh@leeds.ac.uk

References

- Anderson, V.R.; Jason, L.A.; Hlavaty, L.E.; Porter, N. & Cudia, J. (2012). A review and meta-synthesis of qualitative studies on Myalgic Encephalomyelitis/ chronic fatigue syndrome. *Patient Education and Counseling*, 86 (2), pp.147–155.
- Atnas, C.I. & Lippold, T. (2013). Cognitive behaviour therapy with a woman in her twenties with a mild intellectual disability presenting with psychogenic non-epileptic seizures. *Advances in Mental Health and Intellectual Disabilities*, 7(4), pp. 245 - 250.
- Bohart, A.C., Tallman, K.L, Byock, G. & Mackrill, T. (2011). The "Research Jury" Method: The Application of the Jury Trial Model to Evaluating the Validity of Descriptive and Causal Statements about Psychotherapy Process and Outcome. *Pragmatic Case Studies in Psychotherapy*, 7 (Module 1, Article 8), pp. 101-144.
- Bronstein, C. (2014). 'I am not crying. I am rubbing my eyes': Annie and the hollow object. *Journal of Child Psychotherapy*. *Journal of Child Psychotherapy*, 40 (2), pp. 135-149.
- Burton, C. (2014). Can we explain medically unexplained symptoms? (editorial) *Family Practice*, 31(6), pp. 623–624.
- Creed, F. (2016). Exploding myths about medically unexplained symptoms. *Journal of Psychosomatic Research*, 85, pp.91-93.
- Deary, V., Chalder, T. & Sharp, M. (2007). The Cognitive Behavioural Model of Medically Unexplained Symptoms: a theoretical and empirical review. *Clinical Psychology Review*, 27(7), pp. 781-797.

- Dimaggio, G., Valeri, S., Salvatore, G., Popolo, R., Montano, A. & Ottavi, P. (2014). Adopting metacognitive interpersonal therapy to treat narcissistic personality disorder with somatization. *Journal of Contemporary Psychotherapy*, 44(2), pp. 85-95.
- Dura-Ferrandis, E., Ferrando-Garcia, M., GaldonGarrido, M.J. & Andreu-Vaillo, Y. (2017). Confirming the mechanisms behind cognitive-behavioural therapy effectiveness in chronic pain using structural equation modeling in a sample of patients with temporomandibular disorders. *Clinical Psychology & Psychotherapy*, 2017(24), pp.1377–1383.
- Elliott, R. (2002). Hermeneutic Single-Case Efficacy Design, *Psychotherapy Research*, 12(1), 1-21.
- Elliott, R. (2010). Psychotherapy change process research: Realizing the promise, *Psychotherapy Research*, 20(2), pp.123-135.
- Figuieredo, J.M & Griffith, J.L. (2016). Chronic Pain, Chronic Demoralization and the Role of Psychotherapy. *Journal of Contemporary Psychotherapy*, 46(3), pp. 167–177.
- Flo, E. & Chalder, T. (2014). Prevalence and predictors of recovery from chronic fatigue syndrome in a routine clinical practice. *Behaviour Research and Therapy*, 63(2014), pp. 1-8.
- Gask, L., Dowrick, C., Salmon, P., Peters, S., & Morriss, R. (2011). Reattribution reconsidered: Narrative review and reflections on an educational intervention for medically unexplained symptoms in primary care settings. *Journal of Psychosomatic Research*, 71(2011), pp.325–334.
- Heaton, K.W. (2012). Somatic expressions of grief and psychosomatic illness in the works of William Shakespeare and his coevals. *Journal of Psychosomatic Research*, 73(4), pp. 301-306.
- Hills, J., Lees, J., Freshwater, D. & Cahill, J. (2016). Psychosoma in crisis: an autoethnographic study of medically unexplained symptoms and their diverse contexts. *British Journal of Guidance & Counselling*, DOI: 10.1080/03069885.2016.1172201.
- IAPT. (2014). *Medically Unexplained Symptoms / Functional Symptoms: Positive Practice Guide*. IAPT Medically Unexplained Symptoms Evaluation Task and Finish Group (2012-13)
- JCPFMH. (2017). *Guidance for Commissioners of Services for People with Medically Unexplained Symptoms*. [Online]. Joint Commissioning Panel for Mental Health. Royal College of General Practitioners and the Royal College of Psychiatrists. Available at: www.jcpmh.info/resource/guidance-commissionersservices-people-medically-unexplained-symptoms/ [Date Accessed: 5TH July 2018].
- Johnstone, L. & Watson, J. (2017). Just Listen to their Stories. *Therapy Today*, 28(3), pp.30-33.
- Kenwright, M., McDonald, J., Talbot, J. & Janjua, K. (2017). Do symptoms of irritable bowel syndrome improve when patients receive cognitive behavioural therapy for co-morbid anxiety disorders in a primary care psychological therapy (IAPT) service? *Behavioural and Cognitive Psychotherapy*, 45(5), pp. 433-447.
- Kirmayer, L.J., Groleau, D., Looper, K.J., & Dao, M.D. (2004). Explaining medically unexplained symptoms. *Canadian Journal of Psychiatry*, 49(10), pp. 663-72.
- Konnopka A, Schaefer R, Heinrich S, Kaufmann, C., Lupp, M., Herzog, W. & König, H.H. (2012). Economics of medically unexplained symptoms: a systematic review of the literature. *Psychotherapy and Psychosomatics*, 81(5), pp. 265-275.
- Kornelsen, J., Atkins, C., Brownell, K. & Woollard, R. (2015). The Meaning of Patient Experiences of Medically Unexplained Physical Symptoms. *Qualitative Health Research*, 26(3), pp. 367-376.
- LaFrance, C.W., Baird, G.L., Barry, J.J., Blum, A.S., Webb, A.F., Keitner, G.I., Machan, J.T., Miller, I. & Szafarski, J.P. (2014). Multicenter Pilot Treatment Trial for Psychogenic
- Nonepileptic Seizures: A Randomized Clinical Trial. *JAMA Psychiatry Issue*, 71(9), pp. 997–1005.
- Liotti, G. (2017). The Multimotivational Approach to Attachment-Informed Psychotherapy: A Clinical Illustration. *Psychoanalytic Inquiry*, 37(5), pp. 319-331.
- Luyten, P., Van Houdenhove, B., Lemmac, A., Target, M. & Fonagy, P. (2012). A mentalization-based approach to the understanding and treatment of functional somatic disorders. *Psychoanalytic Psychotherapy*, 26(2), pp. 121–140.
- Neville-Jan, A. (2003). Encounters in a world of pain: An autoethnography. *American Journal of Occupational Therapy*, 57(1), pp. 88–98.
- Patel, K. (2016). Chronic Pain and the Self. *Therapy Today*, 27(5), pp.10-15.
- Rossen, C.B., Buus, N., Stenager E. & Stenager, E. (2017). Identity work and illness careers of patients with medically unexplained symptoms. *Health*, DOI: 10.1177/1363459317739440.

- Shoenberg, P. (2007). *Psychosomatics: The uses of psychotherapy*. Basingstoke: Palgrave Macmillan.
- Starkey, D. (2006). Monarchy, Season 3, Episode 2, *The Glorious Revolution*. Channel 4. 20th November.
- Taylor, G.J. (2008). The challenge of chronic pain: a psychoanalytic approach. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, 36(1), pp. 49-68.
- Van Dessel, N., Den Boeft, M., Van Der Wouden, J. C., Kleinstauber, M., Leone, S. S., Terluin, B., Numans, M. E., Van Der Horst, H. E. & Van Marwijk, H. (2014). Non-pharmacological interventions for somatoform disorders and medically unexplained physical symptoms (MUPS) in adults. *Cochrane Database of Systematic Reviews 2014, Issue 11*. Art. No.: CD011142. DOI: 10.1002/14651858.CD011142.pub2.
- Vorne, A. (2011). Conversion symptom as condensation of childhood traumata. *The Scandinavian Psychoanalytic Review*, 34(1), pp. 13-22.
- Wiech K., Ploner, M. & Tracey, I. (2008). Neurocognitive aspects of pain perception. *Trends in Cognitive Sciences*, 12(8), pp. 306-313.
- Wilbers, L. E. (2015). She has a pain problem, not a pill problem: Chronic pain management, stigma and the family – An autoethnography. *Humanity & Society*, 39(1), pp. 86–111.
- Wilshire, C. & Ward, T. (2016). Psychogenic Explanations of Physical Illness: Time to examine the evidence. *Perspectives on Psychological Science*, 11(5), pp. 606 – 631.
- Zonneveld LN, Sprangers MA, Kooiman CG, Spijker, A. & Buschbach, J.J.B. (2013). Patients with unexplained physical symptoms have poorer quality of life and higher costs than other patient groups: a crosssectional study on burden. *BMC Health Services Research*, 13(1), pp. 520.

Appendix 1.4: Mechanisms of change in psychotherapy with physical symptom presentations

Hills, J., Cahill, J., Lees, J., Freshwater, D. and Krivzov, J. 2020. [currently under peer review]. Mechanisms of change in psychotherapy with physical symptom presentations: a qualitative synthesis of case study evidence

Mechanisms of change in psychotherapy with physical symptom presentations: a qualitative synthesis of case study evidence

John Hills, University of Leeds¹¹ (orcid.org/0000-0002-6852-8261)

Twitter: @johnhillsmusic; LinkedIn: <https://www.linkedin.com/in/johnhills81/>

Dr Jane Cahill, University of Leeds (orcid.org/0000-0003-3409-5864)

Dr John Lees, University of Leeds

Professor Dawn Freshwater, University of Western Australia (orcid.org/0000-0002-1225-9007)

Juri Krivzov, Ghent University

www.researchgate.net/profile/Juri_Krivzov; www.singlecasearchive.com

Corresponding author: Mr John Hills, The School of Health and Community Studies, Leeds Beckett University, City Campus, Leeds, LS1 3HE United Kingdom; j.hills@leedsbeckett.ac.uk

¹¹ Since the production of this research John Hills' new affiliation is to Leeds Beckett University

Abstract

The purpose of this research study is to synthesise evidence from published case studies on psychotherapies for people presenting with physical symptoms, to discern which mechanisms are associated with therapeutic change.

Ten cases, from eight selected studies published between 2012 and 2018, were retained for the synthesis. Nine general mechanisms of change were identified.

In the production of the synthesis, two pathways for therapeutic change emerged, corresponding to short and long term therapy. Change is observed to centre upon clients' discoveries of interpersonal and psychosocial contexts to their symptoms and thus the reframing of their physical experience, with corresponding behavioural changes and actual relief from symptoms.

Key words: mechanisms of change; psychotherapy; medically unexplained symptoms; persistent physical symptoms; meta-synthesis

Introduction

Medically Unexplained Symptoms (MUS) are symptoms presented by a person that cannot be adequately explained by organic processes. Common MUS include chronic pain or fatigue; digestive difficulties such as nausea, vomiting or irritable bowels; dermatological conditions such as eczema or alopecia; cardiac expressions such as ectopic or racing heart beats; or neurological events such as numbness, blackouts, or seizures. In studies conducted across the USA, UK, The Netherlands and Denmark, MUS presentations featured in between 15-40% of all primary care physician appointments, with even greater frequencies observed in presentations to secondary care (Konnopka et al., 2012; Zonneveld et al., 2013; JCPMH, 2017). Though plentiful evidence exists associating MUS with factors such as childhood neglect and abuse, stressful life events, and anxiety (ibid), psychological treatments are still in their infancy (Mobini, 2015).

There is much overlap between the different terms used to describe symptom presentations commonly referred to as medically unexplained; including psychosomatic symptoms, conversion disorders, functional syndromes, and bodily distress. Furthermore, the boundaries between conditions considered medically unexplained and those with an organic explanation are increasingly becoming blurred (Creed, 2016). In the present study we will simply refer to physical symptoms – taking our lead from the recent emergence of the less problematic term of persistent physical symptoms (PPS) (den Boeft et al., 2017).

Psychotherapy Practice

When clients commencing psychotherapy present with physical symptoms, symptom incidence and intensity may also be influenced by relational contexts and psychosocial factors (Hatcher & House, 2003; Landa et al. 2012). Contemporary psychotherapeutic approaches to working with medically unexplained or somatoform physical symptom presentations may be placed into two dominant strands of practice. Cognitive behavioural schools typically conceive of these symptoms as the product of cognitive mis-attribution e.g. a person with health anxiety catastrophizing about physical sensations (Allen and Woolfolk, 2006; Brown, 2004). Psychoanalytic schools typically conceive of symptoms as originating in states of repression, such that the symptoms indicate a failure to bind physical sensations to psychic content and/or dissociation from rejected or disowned parts of self (McDougall, 1989; Gubb, 2013).

Challenging illness beliefs and personal cognitions about symptoms are core aims of cognitive behavioural therapies in this area (Van Dessel et al., 2014). Allen and Woolfolk's (2006) Affective Cognitive Behavioural Therapy for Somatization Disorder protocol ordinarily spans ten sessions and is based upon a conception of addressing inadequate processing of affect, which is associated with somatic symptoms. Thus, their protocol includes emotion identification and interpersonal skills. The final phase includes a renegotiation of the client's 'sick role' in the context of improved interpersonal functioning.

Whereas earlier psychoanalytic approaches focused predominantly on uncovering of "repressed" conflicts (Bronstein, 2011), current psychoanalytic approaches place central importance on the client learning to mentalize – that is

to recognise and understand themselves and others as having mental states - as the core mechanism of change (Gubb, 2013) for example in those situations in which physical symptoms are activated. This development is realised through an attuned relationship between client and their therapist, and conscious utilisation of transferences, the implicit relational dynamics that emerge between therapist and client (ibid). Luyten et al.'s (2012) Mentalization-Based Approach to the Treatment of Functional Somatic Disorders ordinarily spans sixteen sessions and the therapeutic work focuses on the client's interpersonal problems and associating interpersonal experience with bodily experience and vice-versa.

Rationale

The evidence from systematic reviews of clinical trials of psychological therapies in the treatment of medically unexplained physical symptoms consistently demonstrates moderate improvements in primary outcomes compared with treatment as usual (e.g. Van Dessel et al., 2014; Menon et al., 2017). However, studies that seek to account for the mechanisms of change underpinning psychotherapy for physical symptom presentations are absent and needed (Koelen et al. 2014). A mechanism describes the 'basis for the effect i.e. the processes or events that are responsible for the change; the reasons why change occurred or how change came about' (Kazdin, 2009). Case studies are gaining more attention as a unit of analysis, as it is argued that the case study is well placed to provide the 'sufficiently rich' (Bohart et al., 2011) and therapeutically contextualised data necessary to uncover complex causal mechanisms; a more realistic 'soft' account of causality in effective therapy

(Elliott, 2002). While a single case study can provide insights into the mechanism in a particular case, meta-syntheses of case study evidence have the potential to generate insights that ‘go beyond’ (Iwakabe & Gazzola, 2009; Tong et al., 2012) those of individual case studies and thus elucidate principles identified in existing theoretical literature with more descriptive depth.

No existing meta-syntheses of mechanisms of change in the facilitation of successful therapy with this client group have been identified, thus constituting a gap in the evidence base. A recent meta-synthesis analysed a broad range of literature sources including empirical studies, conceptual articles and treatment manuals to discern eight common therapeutic strategies in psychotherapeutic working with medically unexplained symptom presentations (Řiháček & Čevelíček, 2019). The research presented here then may be considered complementary to the findings of Řiháček and Čevelíček, in that focusing on case studies we sought finer-grained, descriptive and longitudinal accounts of change in order to discern the underlying mechanisms through which therapeutic strategies were successful.

The interest of the present synthesis is in the population of psychotherapy clients who present with physical symptoms associated with psychosocial distress. The intervention includes a broad range of individual talking therapies, falling into four general categories: psychoanalytic/psychodynamic; cognitive and behavioural; humanistic and existential; and systematic (a taxonomy described by McCormack and Chalder, 2018). Studies were sought that reported within their outcomes change in a client’s physical experience i.e. how they experience their bodies, including quantitative changes in symptom

frequency or intensity. We identified mechanisms that were associated with therapeutic outcomes and which were well-evidenced within the studies.

The synthesis is reported in two stages:

- 1) A results section on the emergent mechanisms of change
- 2) A synthesis section that consolidates the emergent mechanisms of action into two alternative pathways which may be observed in psychotherapies for clients presenting with physical symptoms.

In response to the growing number of published syntheses of qualitative research in health care, Tong et al. (2012) developed the 'Enhancing transparency in reporting the synthesis of qualitative research': ENTREQ statement. The ENTREQ statement consists of 21 guidelines in the reporting of qualitative syntheses to clarify the process and conceptual basis under which the synthesis is carried out. In the reporting of the present study we have sought to address each of the ENTREQ guidelines.

Aims of the Synthesis

The present study aimed to answer the following questions:

What patterns of therapeutic change were described in the cases?

What mechanisms were identified as being responsible for the observed changes?

Methods

Identification of studies

On the 14th July 2018, a search was performed using the following electronic databases: PsycInfo, Embase, and Medline; selected for their focus on research in psychological, health care and biomedical fields.

Within the three databases, the search combined physical symptoms terms in title OR abstract:

psychosoma* OR medically unexplained OR functional syndrome* OR functional symptom* OR functional disorder* OR somatisation OR somatization OR somatic symptom* OR somatoform OR conversion disorder OR psychogenic OR persistent physical symptom* OR bodily distress OR somatic anxiety OR somatic depression

AND

Therapy terms in title OR abstract OR journal name:

psychotherap* OR psychoanaly* OR counsel* OR behavioural therapy OR behavioral therapy OR cognitive therapy OR analytic therapy OR jungian OR analytic psychology OR commitment therapy OR schema therapy OR systemic therapy OR brief therapy OR gestalt OR object relations therapy OR psychosynthesis OR transactional analysis

AND the term 'case' in title OR abstract OR journal name.

Study Selection

Studies were included according to a two-tiered process in which they were appraised for 1) relevance and 2) utility, a form of purposive sampling (Noyes et al., 2008; Booth, 2019). Initial criteria for inclusion were developed through an iterative ideographic approach (Weed, 2005) – each title and abstract was interrogated according to its apparent relevance – thus yielding the inclusion and exclusion criteria detailed in Table 1.

Insert Table 1

On completion of this stage 345 records were screened, and 33 articles were selected (see Figure 1 below). It was decided to appraise studies selected for reading for their utility rather than on methodological quality per se (Dixon Woods et al., 2006; Thomas and Harden, 2008) and this appraisal was used as a basis for final inclusion. An inflexible approach to quality appraisal may otherwise have meant studies with clinical utility were excluded on the basis of non-critical methodological flaws (Sandelowski et al., 1997; Dixon-Woods et al., 2006). The reviewers generated explicit criteria for utility through the critical appraisal of the studies selected for reading. In the present investigation the criteria centred upon the question of whether a study provided sufficient descriptions of the mechanisms of change that were purported to be at work in the case, and evidence to support these claims.

The search strategy prioritised studies based on recentness of publication, and no further studies were selected for inclusion once the same codes were observed to repeat and no new codes were necessary to label apparent mechanisms of change – an indicator of theoretical saturation (Benoot et al., 2016). The final selection therefore includes studies from 2012 to 2018. At the completion of this stage eight articles documenting ten cases studies were retained. The following PRISMA diagram (Moher et al., 2009), adapted for relevance to the present synthesis, charts this study identification and selection process.

Insert Figure 1

Analysis

Analysis was performed primarily by the first author ** and fifth author ##, both postgraduate research students specialising in case study methodologies and cross-case analysis. ** is presently in clinical practice working within a narrative/dialogical framework and ##'s clinical experience is in a secondary care setting providing psychodynamic psychotherapy. Both authors had worked therapeutically with clients presenting with physical symptoms prior to the production of this research. ## was not involved in the project at its inception and was invited to join in the coding and analysis stages as an external auditor to increase the transparency of coding and to bring an 'outsider' perspective onto the project (Benoot et al., 2016). The remaining co-authors are each in senior academic positions and contributed to critical reappraisal of the synthesis at the interpretive stages of the analysis.

Using NVivo 11 software, data from the studies were extracted from the whole text of the published case studies where they appeared to evidence or explain mechanisms of change considered to have been active in the case. In an inductive process data extractions were coded using the principles of thematic analysis (Thomas and Harden, 2008) in which descriptive themes were developed into analytic themes based on ** and ##'s clinical understandings of mechanisms of change. Given the heterogeneous modalities and styles of reporting, the second stage of analysis was guided by the principles of meta-ethnography (Noblit & Hare, 1988; Toyne et al., 2014) and meta-synthesis (Walsh and Downe 2005; Edwards & Kaimal, 2016) with their emphases on translation of concepts between different interpretive frameworks. Data from

the codes were retrieved and verbatim extracts from the cases were arranged according to their similarities and differences along a continuum i.e. at any point along the continuum two neighbouring extracts were those considered to share the most common features (Walsh and Downe, 2005; Iwakabe and Gazzola, 2009). In the following visual illustration of this process, qualities of similarity and difference emerge from the comparison of three cases – Sara (Colognori et al., 2014), Peter (Quinn et al., 2012), and Sarah (Liotti, 2017) – relating to the mechanism of interpersonal repositioning:

Insert figure 2

The objective of the final stage of analysis was to ‘go beyond’ a mere summary of the primary studies (Iwakabe & Gazzola, 2009; Tong et al., 2012); so in the synthesis two pathways emerge, combining observed mechanisms of change in short-term and long-term therapies.

Appraising the reliability of accounts of change

As a consequence of searching for studies that reported outcomes relating to change in the clients’ physical or embodied experience, each of the ten selected cases claims to be a successful treatment. However, there was significant diversity in how case studies were reported and thus in how accounts of change and successful outcomes were evidenced. Five studies were appraised as belonging to the systematic case study genre – i.e. case studies based on data from multiple sources, including quantitative measures applied before, during and after therapy, and analysed within a research team. The remaining five were

classified as clinical case studies – i.e. narrative accounts of therapy provided by the therapists themselves based on their own understandings of the case (Iwakabe & Gazzola, 2009). Where claims are made in case studies about causality and effectiveness of the intervention, two protocols for qualitatively appraising these are Elliott's (2002) Hermeneutic single Case Efficacy Design, and Bohart et al.'s (2011) Research Jury Method, both of which set out a series of guidelines for testing the plausibility of causality claims. Examples of guidelines set out in these protocols include: changes corresponding to specific events or processes in therapy (Elliott, 2002), or, on the other hand, changes constituting scripted/clichéd descriptions of what might be expected to happen in psychotherapy (ibid), clients themselves observing that therapy had helped (Bohart et al., 2011), or reported changes being plausible given extent of problem (ibid). These guidelines were applied formally in scrutinising the claims made in the cases by **, with a sample of cases appraised independently by \$\$ with disagreements resolved through group discussion. In this process, passages were excluded that did not appear to have sufficient evidence to support them but no further cases were excluded at this stage.

Insert Table 2

Results

The descriptions of change in the resultant selection centre upon clients' discovery of interpersonal and psychosocial contexts to their symptoms' origins. Aside from actual relief from physical symptoms, change manifested behaviourally for all clients. Physical symptom presentations were idiosyncratic

to each of the ten cases, reflecting the diversity of presentations identified as somatoform or otherwise medically unexplained.

Five cases reported therapeutic working within a cognitive behavioural therapeutic modality, including two cases identifying Acceptance and Commitment Therapy. A further three cases identified with psychodynamic approaches, including two psychoanalytic cases. The remaining two did not identify modality, but descriptions indicate a pluralistic approach. Four cases were authored or co-authored by the therapist in the case; in two cases the therapist was not an author of the study, however in the four remaining cases it is not clear whether the therapists had also authored or co-authored the study.

From the qualitative analysis of the cases, nine general mechanisms of change (MOC) were identified:

- 1) Consensual Formulation
- 2) Responsiveness to client's motivational state
- 3) Contextualisation of symptoms
- 4) Repositioning within interpersonal dynamics
- 5) Exposures
- 6) Acceptance
- 7) Commitment to values
- 8) Identification of historic/traumatic origins of present pathology
- 9) Use of the therapeutic relationship

The coverage of each of the identified mechanisms across the ten cases is represented in table 3.

Insert Table 3

Descriptions of each of these mechanisms are detailed below, with examples drawn from the case studies in order to demonstrate the identified mechanism:

Mechanisms of change

1) Consensual formulation

Three cases described a formulation of the client's problems, including their physical symptoms presentation, and an agreed focus for the therapy, which was collaborative and based on consensus between the client and the therapist as creating the conditions for therapeutic change. In Okita et al. (2013), fourteen year old **Yu** had received cognitive behavioural therapy (CBT) after ten months with chest pain that limited his activities and meant he had stopped attending school. In the early stages Yu's therapist, mindful that clients are often resistant to psychosocial explanations for their own symptoms, engaged with Yu's own opinions on his chest pain and did not 'force' a psychosocial model on him. Through experiential learning, Yu and his therapist developed a CBT model based on a vicious cycle of selective attention and reduced activity, which Yu adopted in the course of his therapy.

Similarly, when 35 year old **Sara** began therapy, her therapist made it very clear he would not be challenging her own view that her physical symptoms – including fatigue, painful menstruations and blurred vision - were neurological in nature and instead that therapy could focus on the relational impact of her

conditions, e.g. in personal relationships, in how she related to doctors etc.

When Sara asked Liotti if he believed her symptoms were imaginary, he affirmed that he believed her suffering was real.

2) Responsiveness to the client's motivational state

In four cases there is evidence of how the structure of the therapy was determined by the client's present motivational state – as the content of their own beliefs about their conditions changed, the pace or the focus of the therapy shifted accordingly, typically resulting in the therapy passing through distinct phases.

For example, in the case of **Yu** (Okita et al., 2013), a virtuous cycle effect is observed whereby his initial symptom monitoring in his diary recording a reduction in pain-related episodes motivated him to increase his performance of behavioural tasks. Yu's therapist only introduced the distraction techniques once Yu himself began to express an interest in the relationship between cognition and pain. With the success of these techniques, Yu came to accept the psychosocial model of his pain experience, which further consolidated his engagement in therapy.

In the case of **Sara**, Liotti (2017) describes a therapeutic work in three phases in which Sara became more open-minded about the relational contexts of her physical symptoms. The therapeutic emphasis shifted away from symptoms and towards exploration of her childhood relationships, and finally to the revision of her care-seeking behavioural strategies in the present day.

3) Contextualisation of symptoms

With coverage in seven out of the ten cases, contextualisation of symptoms was observed to be the most universal of mechanisms of change in psychosomatic experience. Clients were observed to place their original symptom experience – which typically seemed random and disconnected with anything else in their life – within a wider context; e.g. noticing situational patterns underpinning symptom flare-ups. Contextualising symptoms in this way enabled clients to shift their focus from the symptoms per se to underlying sources of affect. Sixteen year old **Andrew** began CBT after suffering with headaches and anxiety for approximately two years (Cognori et al., 2014). After he kept a symptom diary for two weeks, it became evident that the two were closely associated with ‘anticipatory anxiety’ at the beginning of the school week and before tests and class presentations. Thus a context emerged: Andrew was putting exceptional pressure on himself to get the grades necessary to go to an Ivy League college. Cognori et al. (2014) also report the case of 11-year-old **Sarah**, who was suffering with nausea, gas and abdominal pain that was disrupting her school attendance. Here too, a two-week symptom diary revealed flare-ups associated with being travelling, being away from home, and proximity to a bathroom.

4) Repositioning within interpersonal dynamics

In three cases, identification of an interpersonal dynamic and the client’s repositioning within that dynamic promoted change in their physical experience. In this mechanism, the symptoms’ origins or patterns underpinning flare-ups are associated with roles the client plays in relation to certain significant others. By

identifying these and the underlying affect, clients can take active steps to redefine how they relate to their significant others.

Whilst **Sarah**'s successful exposure helped to build her confidence in going to school even with gastrointestinal symptoms, her paediatrician observed that Sarah's mother would often be the one to suggest that Sarah stayed home on a day that she had symptoms (Colognori et al., 2014). Sarah's mother sought reassurance from the paediatrician about her parenting skills and there appeared to be a separation anxiety between mother and daughter. The paediatrician suggested that Sarah's mother take a different position, praising her for her bravery and capacity to manage her discomfort independently.

Peter recognised in therapy that he had taken up a career in the banking industry because of his family's values which were centred upon power, and incongruent with his own (Quinn et al., 2012). When Peter was first hospitalised with Psychogenic Non-Epileptic Seizures (PNES), he explained that he knew 'deep down' there was nothing physiologically wrong with him but it was a relief to be in hospital. Before hospitalisation, Peter had not been able to discuss his needs with his mother who responded with self-pity, calling herself a 'terrible mother'. However, according to Peter, his PNES had forced change in the family dynamic, and had thus achieved what he had not been able to do previously.

5) Exposures

Five cases describe processes in which a client is exposed to a situation associated with distress and anxiety. Typically, the clients in agreeing to

participate in the exposure experience a shift from feeling passive in situations that they were afraid of (and therefore seeking to avoid) to an active orientation in which they gain a sense of control. **Sarah**, whose school attendance had begun to deteriorate due to daily nausea, gas and abdominal pain, was encouraged, as an ‘experiment’, to go into school on a morning when she nonetheless was experiencing gastrointestinal symptoms (Colognori et al., 2014). Sarah reported feeling nauseous for the first thirty minutes of the school day before the symptom passed. Similarly, **Andrew**, whose headaches had been found to be associated with pressure he placed on himself around his grade performance, created and enacted a ‘hierarchy of exposure’, including deliberate acts such as making a mistake on his homework, or arriving for class five minutes late (ibid).

6) Acceptance

In three cases, clients can be observed to take on a degree of acceptance about their physical symptoms and related distress. Acceptance may be considered as a form of exposure, but here acts as a mechanism of change observed to create a degree of distance from a problem, e.g. by personification of it, and thus clients realise that they are not consumed by it, but instead are able to discover new, previously un-perceived ways of improving their quality of life.

For example, **John** began a course of Acceptance and Commitment Therapy (ACT) after suffering with anxiety associated with chest pain and dizziness following a stroke in his early forties (Graham et al., 2015). He was encouraged to become mindful of his own thoughts and thus to foster a sense of distance from them, e.g. by framing his observations as ‘There goes that old story X

again'. Furthermore, John was encouraged to personify his chest pain and settled on it being an annoying television character. In so doing, John learned to accommodate his anxiety without experiencing being merged or inseparable from it. **Claire** also began ACT in her early twenties, presenting with pelvic spasms and muscle weakness (Graham et al., 2017). She was encouraged to develop a metaphor within her therapy that her unwanted thoughts and feelings were like passengers on a bus that she was trying to drive in the direction of her values. Through extended use of the metaphor, Claire came to recognise that she could continue to travel in a personally meaningful direction, even with those unwanted passengers as part of her experience.

7) Commitment to values

Commitment to values was identified in two cases. When clients identify their personal values - what is important to them in life - commitment to these can yield a sense of purpose and direction that enables them to transcend present problems in pursuit of a bigger picture.

John came to understand how avoidance behaviours associated with his anxiety around chest pain and dizziness were in direct contradiction to his values – he being otherwise a 'sociable, sporting, caring and ambitious' person (Graham et al., 2015). **Claire** realised in her therapy that she was not clear on what her values were, and so had made important life decisions without reference to them. Framing questions, such as 'when you feel most alive what are you doing?', enabled Claire to become clearer about what her values were and the behaviours that would help her to realise them.

8) Identification of historic/traumatic origins of present pathology

Three cases identified breakthroughs in the therapy where clients discovered in their own life history a traumatic situation that had in some ways been re-enacted in present difficulties. Discovery of this historical context enabled clients to move beyond that history and find new ways of relating.

Peter came to understand during his therapy that the physical experience of his PNES in adulthood could be mapped onto this childhood behaviour during his parents' explosive rows, which was to curl up in the foetal position, shaking (Quinn et al., 2012). Peter further observed that his PNES:

“...started at work when we got this new boss, who was well known throughout the organization as just an absolute and utter bully.” He explained, “I suppose the parallels with home life were with a ... very domineering mother and a sister who was doing medicine and was the apple of mum’s eye and all that sort of stuff.”

(Quinn et al. 2012, p 691)

As **Sara** began to explore more deeply the relational context of her physical condition, she began to uncover significant moments from her own childhood that had defined her attitudes towards illness and care-seeking (Liotti, 2017). In one instance when she was about seven years old, she had awoken in the night to severe abdominal pain. Her father came and concluded that her symptoms were psychological. He ordered her to stop crying and take deep breaths. Only when

Sara's urine was tinged with blood and she saw her family doctor was it determined that she actually had a bladder infection.

9) Use of the therapeutic relationship

In five cases, the therapeutic relationship is observed to promote therapeutic change and as a consequence change in somatic experience. These cases described ways in which the client's relationship with the therapist provided a model for how it might be possible to relate differently to others, or indeed come to terms with historical painful experiences within relationships. **Peter's** therapist reflected on his experience of their relationship from the beginning of their work: 'he knew I liked him [...] and it was a mutual thing' (Quinn et al., 2012). Peter's therapist is described as a 'gentle and intelligent' man, who thus modelled for Peter a different kind of masculinity. **John's** relationship with his therapist modelled a different way of containing conflict (ibid). In being able to work with and contain anger in the relationship, John learned skills that enabled him to assert himself in the workplace. And because of the strength of the relationship, John was able to share with his therapist 'graphic and disgusting' fantasies and 'rampage and escape'. Both Peter and John's total recovery from PNES, conceptualised as a behavioural means of escape from situations of intense distress, are attributed in part to the relational modelling and skills they acquired in their therapy.

Synthesis

Through comparison of the cases, it was observed that the first four mechanisms were present in therapies across the selection, i.e. there appeared to be no contextual factors determining their appearance. However, the selection of cases did appear to fall into two groups depending on whether the other five mechanisms were observable. Exposures, acceptance and commitment to values were only observed in relatively short-term therapies of 5- 24 sessions, which were also each cognitive behavioural therapies (n=5). Conversely, discovery of historic or traumatic origins to present pathology, and the use of the therapeutic relationship, were only observed as mechanisms in the relatively long-term therapies: those cases spanning two to six years of therapy (n=5). In this second group therapeutic modalities are more diverse or not as clearly defined. We therefore derive the following synthesis, in which two general pathways emerge for the psychotherapeutic treatment of physical symptom presentations, based on the mechanisms of change that may be observed in successful therapy:

Insert figure 3 here

Discussion

Of the nine mechanisms of change identified from the analysis of the ten cases, four of these appear to be present across the selection, for example they do not appear to depend on modality. It is logical to propose that consensual formulation and responsiveness to motivational state are foundational mechanisms underpinning psychotherapeutic work with this client group (Luyten et al., 2012). If there is a fundamental disagreement between client and

therapist about the premise and purpose of their work together, or if the therapist attempts to enforce his or her aetiological model of the somatic condition, it is difficult to imagine meaningful therapeutic progress. However, the client's recontextualisation of their symptoms and discovery of relational dynamics within their symptom experience may feedback into a consensual formulation of the therapy and indeed permit the client to move through different states of motivation. These observations reflect some of the difficulties identified in existing literature in establishing a therapeutic alliance with this client group (Shoenberg, 2007; IAPT, 2014).

While within the ten studies there was not an example of a disconfirmatory case (Benoot et al., 2016), the cases did fall into two groups. From the basis of the current selection it is not clear whether the mechanisms associated with the short term therapies may be correctly described as cognitive behavioural, and those with the longer-term therapies described as psychodynamic. Indeed, concepts such as acceptance may be recognisable to psychodynamic therapists (Stewart, 2014), and likewise cognitive behavioural therapists may consider that they too utilise the therapeutic relationship (Villatte, 2016). Therefore, the most discernible contextual factor determining which of the two pathways of change is taken appears to be the length of time of the therapy. A question emerges as to how a practitioner beginning work with a client knows whether the work they are to undertake will be relatively short or long term. While the present selection of 10 studies does not provide justifications for the length of the therapies, some insights from theory may be informative. Both Karasu (1979) and Sifneos (1983) argued that some clients with somatic presentations would be unsuitable for longer-term analytic work, or may have to be readied for it.

Karasu envisaged an initial phase to psychotherapeutic work based on concepts relating to re-attribution, interpersonal experience and behavioural exposures, lasting about a year, before the client was able to progress to ‘true’ analysis. In the terms of the present synthesis it may be that some clients who have realised a degree of mastery in their psychosomatic experience through the short-term mechanisms of change, are then in a position to progress to longer-term therapeutic work.

Situating the observed Mechanisms of Change within the dominant theoretical approaches

The general mechanism of cognitive re-attribution identified in the introductory section appears to be facilitated by the contextualisation of symptoms, and the identification of historic or traumatic origins of present pathology. Where the present study observes repositioning within interpersonal dynamics, this echoes theoretical principles in cognitive behavioural approaches in working with this client group, e.g. renegotiating the client’s sick role. This mechanism, and the use of the therapeutic relationship, may offer tentative evidence for the role of mentalization in successful psychotherapy with this client group; however, the term was not used explicitly in any of the ten selected cases. Conversely, the mechanism of exposure which appears to have been influential in five of the ten cases is not identified as a core factor in the leading theories of psychotherapy when working with physical symptom presentations. This is despite a strand of thought within general psychotherapy theory that exposure may be a primary and unifying mechanism across modalities (Carey, 2011). A recommendation

for further research is for further primary studies on the role of exposure as a psychotherapeutic mechanism for working with physical symptom presentations, across different modalities.

Implications for psychotherapy case study reporting

With reference to the Elliott (2002) and Bohart et al. (2011) protocols, we found that the general quality of case study reporting in this area impacted upon the credibility of causality claims made. With the exception of the cases of John and Peter (in Quinn et al., 2012), where the clients themselves were interviewed to seek their own views on their therapy, and recognising the difficulties in collecting and reporting on such data in case work involving children, we believe that each of the selected studies could have done more to represent the client's appraisals of their therapy –whether they believed changes were substantial, whether they agreed with the therapist's interpretations or had alternative views etc. We regard this as a significant shortcoming in quality to be rectified by future case study reporting. Additionally, whilst the psychoanalytic/psychodynamic studies relayed some data about therapists' subjective experiences of the therapeutic relationship, these disclosures were entirely absent in several of the studies included in this synthesis and under-represented across the selection. Meganck et al. (2017) in their survey of psychoanalytic case studies published between 1955 and 2011 found almost a complete absence of information about the therapist themselves in most of the studies reviewed. Likewise in four of the ten studies selected here, the therapist(s) who delivered the interventions are unidentified. Therefore, a

further recommendation would be for therapists to disclose more information pertaining to their own role in the therapeutic interaction – these implicit contextual data could provide compelling insights into reported therapeutic events and processes.

Limitations

The present synthesis includes only contemporary cases published since 2012, and we used a narrow range of databases in order to identify eligible cases. Although the research team believes a degree of theoretical saturation was achieved with the present selection, nonetheless the content of more and older case studies may have served to further elucidate the findings and potentially to reframe the mechanisms identified. Neither did the selection include non-English language cases. Language can be very influential in determining how the content of psychotherapy cases is interpreted and how mechanisms of change are framed, and it is possible that the admission of cases in other languages may have modulated our results. There was no explicit representation of humanistic, existential or systemic therapies in the selection of cases. An alternative approach would have seen a purposive sampling of case studies in these modalities in order that they were represented in the present synthesis.

The inclusion within the present synthesis of all clinical presentations identified with the psychosomatic or medically unexplained search terms utilised in our strategy, produced a very broad range of somatic presentations. Further meta-syntheses that took a finer grained view of presentations, e.g. as dysfunctions in

specific body systems, may have more direct utility for clinicians encountering these presentations in their own work.

The present methodological approach also has its limitations. The research team observed that the analytic focus on mechanisms of change could be considered to have a reductionist and de-contextualising effect over the treatment of qualitative data. An alternative approach that presented an overarching analysis of the comparison between cases, instead of coding individual passages in a thematic analysis, may have been more faithful to the original contexts of the individual cases. This is reflected in the format of the present article, in which the methods and results are presented as discrete sections.

Conclusion

Successful working with clients in this area is typically founded upon validation of the client's distress as real and as taking seriously the client's own theories about what is going on for them. Contracting that focuses explicitly on living well and meaningfully with existing physical conditions and/or working on the relational impacts of a client's physical condition has better prospects than an agenda focused on correct diagnosis or cure. Change centres upon clients' discoveries of interpersonal and psychosocial contexts to their symptoms. Subsequent reframing of physical experience corresponded with behavioural changes and actual relief from symptoms. Successful working in the short term involves context-sensitive exposures and repositioning with relational dynamics, and in the long term, discovery of historical contexts and the purposeful use of the therapeutic relationship.

Disclosure of interest

The authors report no conflict of interest.

References

- Allen, L.A. & Woolfolk, R. (2006). Affective Cognitive Behavioural Therapy: A new treatment for somatization. *Behavioural Psychology* vol. 14 (3)
<https://doi.org/10.1891/0889-8391.24.2.116>
- Barnett-Page, E. & Thomas, J. (2009). Methods for the synthesis of qualitative research: A critical review. *BMC Medical Research Methodology*.
<https://doi.org/10.1186/1471-2288-9-59>
- Benoot, C., Hannes, K. & Bilsen, J. (2016). The use of purposive sampling in a qualitative evidence synthesis: A worked example on sexual adjustment to cancer trajectory. *BMC Medical Research Methodology* (2016) 16:21.
<https://doi.org/10.1186/s12874-016-0114-6>
- Bohart, A.C., Tallman, K.L., Byock, G. & Mackrill, T. (2011). The “Research Jury” Method: The Application of the Jury Trial Model to Evaluating the Validity of Descriptive and Causal Statements about Psychotherapy Process and Outcome. *Pragmatic Case Studies in Psychotherapy*, Volume 7, Module 1, Article 8, 101-144 <http://dx.doi.org/10.14713/pcsp.v7i1.1075>
- Booth, A. (2019). Harnessing Energies, Resolving Tensions: Acknowledging a Dual Heritage for Qualitative Evidence Synthesis. *Qualitative Health Research*, Vol. 29 (1) 18-31 <https://doi.org/10.1177/1049732318808247>
- Bronstein, C. (2011). On psychosomatics: The search for meaning. *The International Journal of Psychoanalysis*, 92(1), 173-195
- Bronstein, C. (2014). 'I am not crying. I am rubbing my eyes': Annie and the hollow object. *Journal of Child Psychotherapy*
<https://doi.org/10.1080/0075417X.2014.922752>
- Brown, R.J. (2004). Psychological Mechanisms of Medically Unexplained Symptoms: An Integrative Conceptual Model. *Psychological Bulletin*
<https://doi.org/10.1037/0033-2909.130.5.793>
- Carey, T.A. (2011). Exposure and reorganization: The what and how of effective psychotherapy. *Clinical Psychology Review* 2011 Mar; 31(2): 236-48
<https://doi.org/10.1016/j.cpr.2010.04.004>
- Colognori, D. B., Herzig, K., Reigada, L. C., Leiby, A. & Warner, C. M. (2014). Chapter: Cognitive-behavioral therapy for youth with functional somatic and internalizing symptoms. *Functional symptoms in pediatric disease: A clinical guide*. New York, NY: Springer Science + Business Media; US
<https://doi.org/10.1007/978-1-4899-8074-8>

- Creed, F. (2016). Exploding myths about medically unexplained symptoms. *Journal of Psychosomatic Research*, June 2016, volume 85 91-93
<https://doi.org/10.1016/j.jpsychores.2016.02.007>
- Crombez, G., Eccleston, C., Van Damme, S., Vlaeyen, J.W. & Karoly, P. (2012). Fear-Avoidance Model of Chronic Pain: The Next Generation. *Clinical Journal of Pain* vol. 28 (6) <https://doi.org/10.1097/AJP.0b013e3182385392>
- Deary, V., Chalder, T. & Sharp, M. (2007). The Cognitive Behavioural Model of Medically Unexplained Symptoms: a theoretical and empirical review. *Clinical Psychology Review*. Vol.27(7), 2007, 781-797
<https://doi.org/10.1016/j.cpr.2007.07.002>
- Den Boeft, M., Van Dessel, M.C., Van der Wouden, J.C. (2017). How should we manage adults with persistent unexplained physical symptoms? *BMJ* 2017; 356: j268 <https://doi.org/10.1136/bmj.j268>
- Dixon-Woods M, Cavers D, Agarwal S, Annandale E, Arthur A, Harvey J, Hsu, R., Katbamna, S., Olsen, R., Smith, L., Riley, R. & Sutton, A.J. (2006). Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups. *BMC Medical Research Methodology* 2006;6:35 DOI: [10.1186/1471-2288-6-35](https://doi.org/10.1186/1471-2288-6-35)
- Dura-Ferrandis, E., Ferrando-Garcia, M., Galdon-Garrido, M.J. & Andreu-Vaillo, Y. (2017). Confirming the mechanisms behind cognitive-behavioural therapy effectiveness in chronic pain using structural equation modeling in a sample of patients with temporomandibular disorders. *Clinical Psychology & Psychotherapy*. 2017 <https://doi.org/10.1002/cpp.2114>
- Elliott, R. (2002). Hermeneutic Single-Case Efficacy Design. *Psychotherapy Research*, 12:1, 1-21 <https://doi.org/10.1080/713869614>
- Flo, E. & Chalder, T. (2014). Prevalence and predictors of recovery from chronic fatigue syndrome in a routine clinical practice. *Behaviour Research and Therapy*. Vol.63 2014,1-8. <https://doi.org/10.1016/j.brat.2014.08.013>
- Frank, A. (1995). *The Wounded Storyteller: Bodies, Illness and Ethics*. Chicago: The University of Chicago Press
- Graham, C.D., Gillanders, D., Stuart, S. & Gouick, J. (2015). An Acceptance and Commitment Therapy (ACT)–Based Intervention for an Adult Experiencing Post Stroke Anxiety and Medically Unexplained Symptoms. *Clinical Case Studies* vol. 14 (2) <https://doi.org/10.1177/1534650114539386>
- Graham, C.D., Stuart, S.R., O’Hara, D.J. & Kemp, S. (2017). Using Acceptance and Commitment Therapy to Improve Outcomes in Functional Movement Disorders: A Case Study. *Clinical Case Studies* 2017, Vol. 16(5) 401–416
<https://doi.org/10.1177/1534650117706544>
- Gubb, K. (2013). Psychosomatics Today: A Review of Contemporary Theory and Practice. *Psychoanalytic Review* 2013 Feb;100 (1):103-42
<https://doi.org/10.1521/prev.2013.100.1.103>
- Hatcher, S., & House, A. (2003). Life events, difficulties and dilemmas in the onset of chronic fatigue syndrome: a case–control study. *Psychological Medicine*, 33, 1185–1192 <https://doi.org/10.1017/S0033291703008274>

- Hill, C.E. (ed). (2012). *Consensual Qualitative Research: A practical resource for investigating social science phenomena*. Washington DC: American Psychological Association <https://www.apa.org/pubs/books/4313031>
- IAPT. (2014). Medically Unexplained Symptoms / Functional Symptoms: Positive Practice Guide. IAPT Medically Unexplained Symptoms Evaluation Task and Finish Group (2012-13) <https://www.uea.ac.uk/documents/246046/11919343/medically-unexplained-symptoms-positive-practice-guide-.pdf/55aea215-100e-4925-a968-65d6e89ad9b3>
- Iwakabe, S. & Gazzola, N. (2009). From single-case studies to practice-based knowledge: Aggregating and synthesizing case studies. *Psychotherapy Research*, 19:4-5, 601-611 <https://doi.org/10.1080/10503300802688494>
- JCPFMH. (2017). *Guidance for Commissioners of Services for People with Medically Unexplained Symptoms*. Joint Commissioning Panel for Mental Health. Royal College of General Practitioners and the Royal College of Psychiatrists <https://www.jcpmh.info/resource/guidance-commissioners-services-people-medically-unexplained-symptoms/>
- Johnstone, L. & Watson, J. (2017). Just Listen to their Stories. In April 2017 *Therapy Today* 30-33 <https://www.bacp.co.uk/bacp-journals/therapy-today/2017/april-2017/just-listen-to-their-stories/>
- Kazdin, A.E. (2007). Mediators and Mechanisms of Change in Psychotherapy Research. *Annual Review of Clinical Psychology* <https://doi.org/10.1146/annurev.clinpsy.3.022806.091432>
- Kazdin, A.E. (2009). Understanding how and why psychotherapy leads to change. *Psychotherapy Research*, 19:4-5, 418-428 <https://doi.org/10.1080/10503300802448899>
- Kenwright, M., McDonald, J., Talbot, J. & Janjua, K. (2017). Do symptoms of irritable bowel syndrome improve when patients receive cognitive behavioural psychological therapy (IAPT) service? *Behavioural and Cognitive Psychotherapy*. Vol.45 (5), 2017, 433-447 <https://www.bacp.co.uk/bacp-journals/therapy-today/2017/april-2017/just-listen-to-their-stories/>
- Kirmayer, L.J., Groleau, D., Looper, K.J., & Dao, M.D. (2004). Explaining medically unexplained symptoms. *Canadian Journal of Psychiatry*. 2004 Oct;49 (10):663-72 <https://doi.org/10.1177/070674370404901003>
- Koelen JA, Houtveen JH, Abbass A, Luyten P, Eurelings-Bontekoe EH, Van Broeckhuysen-Kloth SA, Buhring ME, Geenen R. (2014). Effectiveness of psychotherapy for severe somatoform disorder: meta-analysis. *British Journal of Psychiatry* 2014; 204: 12-19 <https://doi.org/10.1192/bjp.bp.112.121830>
- Konnopka A, Schaefert R, Heinrich S, Kaufmann, C., Lupp, M., Herzog, W. & König, H.H. (2012). Economics of medically unexplained symptoms: a systematic review of the literature. *Psychotherapy and Psychosomatics* 2012, 81(5):265-275 <https://doi.org/10.1159/000337349>

- Lachal, J., Revah-Levy, A., Orri, M. & Moro, M.R. (2017) Metasynthesis: An original method to synthesize qualitative literature in psychiatry. *Frontiers in Psychology*, December 2017 <https://doi.org/10.3389/fpsyg.2017.00269>
- LaFrance, C.W., Baird, G.L., Barry, J.J., Blum, A.S., Webb, A.F., Keitner, G.I., Machan, J.T., Miller, I. & Szaflarski, J.P. (2014). Multicenter Pilot Treatment Trial for Psychogenic Nonepileptic Seizures: A Randomized Clinical Trial. *JAMA Psychiatry Issue: Volume 71(9)*, September 2014, p 997–1005 <https://doi.org/10.1001/jamapsychiatry.2014.817>
- Landa, A., Bossis, A. P., Boylan, L. S., & Wong, P. S. (2012). Beyond the unexplainable pain: Relational world of patients with somatization syndromes. *Journal of Nervous and Mental Disease*, 200(5), 413-422 <https://doi.org/10.1097/NMD.0b013e3182532326>
- Lemma, A. (2014) The body of the analyst and the analytic setting: Reflections on the embodied setting and the symbiotic transference. *The International Journal of Psychoanalysis*, 95:2, 225-244 <https://doi.org/10.1111/1745-8315.12147>
- Leuzinger-Bohleber, M. (2012) The ‘Medea fantasy’: An unconscious determinant of psychogenic sterility, in Mariotti, Paola [Ed]. (2012). *The maternal lineage: Identification, desire and transgenerational issues*. (pp. 169-204). xviii, 417 pp. New York, NY, US: Routledge/Taylor & Francis Group; US <https://doi.org/10.1080/02668734.2013.852405>
- Liotti, G. (2017). The Multimotivational Approach to Attachment-Informed Psychotherapy: A Clinical Illustration. *Psychoanalytic Inquiry*, 37:5, 319-331 <https://doi.org/10.1080/07351690.2017.1322426>
- Luyten, P., Van Houdenhove, B., Lemmac, A., Target, M. & Fonagy, P. (2012). A mentalization-based approach to the understanding and treatment of functional somatic disorders. *Psychoanalytic Psychotherapy*, Vol. 26, No. 2, June 2012, 121–140 <https://doi.org/10.1080/02668734.2012.678061>
- McCormack, D. & Chalder, T. (2018). Horses for courses: choosing an evidence-based psychological therapy for your patient. *BJPsysc Advances* (2018) <https://doi.org/10.1192/bja.2018.30>
- McDougall, J. (1989). *Theatres of the Body: A Psychoanalytic Approach to Psychosomatic Illness*. United States of America: W.W. Norton & Company
- McLeod, J. 2010. *Case Study Research in Counselling and Psychotherapy*. London : Sage Publications. <https://uk.sagepub.com/en-gb/eur/case-study-research-in-counselling-and-psychotherapy/book234950>
- McWilliams, L.A. (2017). Adult attachment insecurity is positively associated with medically unexplained chronic pain. *European Journal of Pain* <https://doi.org/10.1002/ejp.1036>
- Meganck, R., Inslegers, R., Krivzov, J. & Notaerts, L. (2017). Beyond Clinical Case Studies in Psychoanalysis: A review of psychoanalytic empirical single-case studies published in ISI-ranked journals. *Frontiers in Psychology* October 2017 | Volume 8 | Article 1749 <https://doi.org/10.3389/fpsyg.2017.01749>
- Menon, V., Rajan, T.M., Kuppili, P.P., & Sarkar, S. (2017). Cognitive Behavior Therapy for Medically Unexplained Symptoms: A systematic review and meta-

- analysis of published controlled trials. *Indian Journal of Psychological Medicine* 2017, 39 (4): 399-406
https://doi.org/10.4103/IJPSYM.IJPSYM_17_17
- Mobini, S. (2015). Psychology of medically unexplained symptoms: A practical review. *Cogent Psychology*, .2, ArtID 1033876
<https://doi.org/10.1080/23311908.2015.1033876>
- Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *PLoS Med* 6(7): e1000097.
<https://doi.org/10.1371/journal.pmed.1000097>
- Noblit, G.W. & Hare, R.D. (1988). *Meta-ethnography: Synthesizing qualitative studies*. Newbury Park, CA : Sage <http://dx.doi.org/10.4135/9781412985000>
- Noyes, J., Popay, J., Pearson, A., Hannes, K. & Booth, A. (2008). Chapter 20: Qualitative research and Cochrane Reviews in Higgins JPT, Green S (editors), *Cochrane Handbook for Systematic Reviews of Interventions*. Chichester : John Wiley & Sons Ltd <https://doi.org/10.1002/9780470712184>
- Okita, K., Kobori, O., Sasaki, T., Nakazato, M., Shimizu, E. & Iyo, M. (2013). Cognitive behavioural therapy for somatoform pain disorder in adolescents: A case study. *Asia Pacific Journal of Counselling and Psychotherapy*
<https://doi.org/10.1080/21507686.2013.779929>
- Quinn, M. C., Schofield, M. J., & Middleton, W. (2012). Successful psychotherapy for psychogenic seizures in men. *Psychotherapy Research*
<https://doi.org/10.1080/10503307.2012.704085>
- Řiháček, T. & Čevelíček, M. (2019). Common therapeutic strategies in psychological treatments for medically unexplained somatic symptoms. *Psychotherapy Research*, DOI: [10.1080/10503307.2019.1645370](https://doi.org/10.1080/10503307.2019.1645370)
- Rosenzweig, S. (1936). Some Implicit Common Factors in Diverse Methods of Psychotherapy. *American Journal of Orthopsychiatry*
<https://doi.org/10.1111/j.1939-0025.1936.tb05248.x>
- Sandelowski M., Docherty S., & Emden C. (1997). Qualitative metasynthesis: issues and techniques. *Research in Nursing and Health* 1997;20:365–71
[https://doi.org/10.1002/\(SICI\)1098-240X\(199708\)20:4<365::AID-NUR9>3.0.CO;2-E](https://doi.org/10.1002/(SICI)1098-240X(199708)20:4<365::AID-NUR9>3.0.CO;2-E)
- Shoenberg, P. (2007). *Psychosomatics: The uses of psychotherapy*. Palgrave
- Stewart, J.M. ed. (2014). *Mindfulness, acceptance, and the psychodynamic evolution: Bringing values into treatment planning and enhancing psychodynamic work with Buddhist psychology*. Oakland, CA, US: Context Press/New Harbinger Publications <https://psycnet.apa.org/record/2014-35000-000>
- Thomas, J. (2017). *Qualitative Synthesis and Systematic Reviews*.
<https://www.youtube.com/watch?v=FXMM8ufcOos#action=share> accessed 27th August 2017

- Thomas, J. & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology* 20088:45 <https://doi.org/10.1186/1471-2288-8-45>
- Tong, A., Flemming, K., McInnes, E., Oliver, S., & Craig, J. (2012). Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. *BMC Medical Research Methodology* 201212:181 <https://doi.org/10.1186/1471-2288-12-181>
- Town, J.M., Lomax, V., Abbass, A.A. & Hardy, G. (2017). The role of emotion in psychotherapeutic change for medically unexplained symptoms. *Psychotherapy Research* <https://doi.org/10.1080/10503307.2017.1300353>
- Toye, F., Seers, K., Allcock, N., Briggs, M., Carr, E. & Barker, K. (2014). Meta-ethnography 25 years on: challenges and insights for synthesising a large number of qualitative studies. *BMJ Medical Research Methodology* 201414:80 <https://doi.org/10.1186/1471-2288-14-80>
- Van Dessel, N., Den Boeft, M., Van Der Wouden, J. C., Kleinstauber, M., Leone, S. S., Terluin, B., Numans, M. E., Van Der Horst, H. E. & Van Marwijk, H. (2014). Non-pharmacological interventions for somatoform disorders and medically unexplained physical symptoms (MUPS) in adults. *Cochrane Database of Systematic Reviews* <https://doi.org/10.1002/14651858.CD011142.pub2>
- Villatte, M. (2016). Evaluating in-session therapist and client behaviours from a contextual behavioural science perspective. In Zettle, R.D., Hayes, S.C., Barnes-Holmes, D. & Biglan, A. eds. (2016). *The Wiley Handbook of Contextual Behavioral Science*. Chichester : Wiley Blackwell. <https://doi.org/10.1002/9781118489857>
- Walsh, D. & Downe, S. (2005). Meta-synthesis method for qualitative research: a literature review. *Journal of Advanced Nursing* 50(2), 204–211 <https://doi.org/10.1111/j.1365-2648.2005.03380.x>
- Weed, M. (2005). “Meta-Interpretation”: A method for the interpretive synthesis of qualitative research. *Forum: Qualitative Social Research* Volume 6, No. 1, Art. 37 – Jan 2005 <http://dx.doi.org/10.17169/fqs-6.1.508>
- Zonneveld LN, Sprangers MA, Kooiman CG, Spijker, A. & Buschbach, J.J.B. (2013). Patients with unexplained physical symptoms have poorer quality of life and higher costs than other patient groups: a cross-sectional study on burden. *BMC Health Services Research* 2013, 13(1):520 <https://doi.org/10.1186/1472-6963-13-520>

Table 1: Inclusion and exclusion criteria for relevance of studies

| Inclusion | Exclusion | Rationale |
|--|--|---|
| English language | Non-English language | We did not have means of translation. |
| Individual psychotherapy | Group therapy | The dynamics of group therapy are different from those of individual therapy; beyond the scope of present investigation. |
| Full case study | Case vignettes intended for illustrative purposes; Secondary commentary from others who have read a case report; Conference abstract | We needed studies with sufficient contextual information as well as detail on mechanisms and their relationship to outcomes |
| Physical symptoms in presentation | No physical symptoms in presentation (e.g. generic use of the psychosomatic term) | Relevance to investigation |
| Counselling/psychotherapy intervention focus of case study | Counselling/psychotherapy referred to only as an intervention within larger | We needed studies with sufficient descriptive |

| | | |
|--|---|---|
| Primary intervention was either psychoanalytic/psychodynamic, cognitive behavioural, humanistic/existential, or systematic therapy | program of treatment Primary intervention was hypnosis | information on mechanisms of change Hypnosis beyond the scope of present investigation |
|--|---|---|

Table 2: General information about the selected case studies

| Reference | Country | Name of client (pseudonym) | Age | Sex | Primary somatic presentation | Length of time of symptoms before beginning therapy | Modality | Who delivered therapy? | No. sessions | Frequency of sessions | Outcomes; (follow up) | Genre of case study |
|---------------------------|-----------|----------------------------|------------------------|---------------|--|---|-----------------------------------|--|------------------------------------|-----------------------|---|---------------------|
| Bronstein (2014) | UK | Annie | 8 to 11 | f | Asthma and eczema | Whole life | Psychoanalytic | Author (Psychoanalyst) | (3 years) | Weekly | Improvements sustained over duration of therapy; (no follow up reported) | Clinical |
| Cognigni et al. (2014) | USA | i) Sarah ii) Andrew | i) 11 ii) 16 | i) f ii) m | i) Daily nausea, gas and abdominal pain ii) Headaches | i) 3 months ii) 2 years | Cognitive Behavioural Therapy | i) Unidentified paediatrician ii) Unidentified paediatric social worker | i) 5 ii) 14 | Weekly | i) Resumed school activities and 'minimal' gastrointestinal symptoms' (one month) ii) improvements in pain, mood and stress levels (no follow up reported) | Clinical |
| Graham et al. (2015) | UK | John | Early 40s | m | Chest pain and dizziness associated with post-stroke anxiety | Several months | Acceptance and Commitment Therapy | First author (Clinical Psychologist) | 9 | Not stated | Free of chest pain, dizziness continued; considerable reductions in anxiety & improvements across several psychometrics; (outcomes held at 2 month follow up) | Systematic |
| Graham et al. (2017) | UK | Claire | Early 20s | f | Functional propriospinal myoclonus – recurrent pelvic spasms/jerking; limb weakness | More than one year | Acceptance and Commitment Therapy | Not stated | 6 | Not stated | Reliable change on FMD symptom interference scores & other measures; (client report of almost complete recovery c5 weeks from end of treatment) | Systematic |
| Liotti (2017) | Italy | Sara | 35 | f | Fatigue, painful menstruations accompanied by vomiting, blurred vision | Five years | Attachment informed psychotherapy | Author (Psychiatrist) | (4 years) | Weekly | 'Clinically significant amelioration' of symptoms; (no follow-up reported) | Clinical |
| Leuzinger-Bohleber (2013) | Germany | Mrs B | 30 | f | 'Psychogenic sterility', migraines, stomach problems, sleep disturbances and eating problems | Not stated | Psychoanalytic | Author (Psychoanalyst) | (6 years) | 4x weekly | Birth of healthy son (three and a half years) | Clinical |
| Okita et al. (2013) | Japan | Yu | 14 | m | Pain in chest | Ten months | Cognitive behavioural therapy | Not stated | 24 | 2x weekly | Return to school, reduction in pain incident frequency (no follow-up reported) | Systematic |
| Quinn et al. (2012) | Australia | i) John ii) Peter | i) 34 ii) early 40s | m | Psychogenic non-epileptic seizures | i) Three years ii) over five years | Not identified | Non-author psychiatrists recruited to study | i) (two years) ii) (four years) | Weekly | i) Seizure free for minimum of two years ii) (minimum of twelve months) | Systematic |

Table 3: Coverage of the mechanisms of change across the ten cases

| Mechanism of change ID of case | Consensual formulation | Responsiveness | Contextualisation of symptoms | Interpersonal repositioning | Exposures | Acceptance | Commitment to values | Discovery of historic origins | Use of therapeutic relationship | |
|---|------------------------|----------------|-------------------------------|-----------------------------|-----------|------------|----------------------|-------------------------------|---------------------------------|---|
| Bronstein (2014) 'Annie' | | | ✓ | | | | | | ✓ | 2 |
| Colognori et al. (2014) 'Sarah' | | | ✓ | ✓ | ✓ | | | | | 3 |
| Colognori et al. (2014) 'Andrew' | | | ✓ | | ✓ | ✓ | | | | 3 |
| Graham et al. (2015) 'John' | | ✓ | | | ✓ | ✓ | ✓ | | | 4 |
| Graham et al. (2017) 'Claire' | ✓ | | ✓ | | ✓ | ✓ | ✓ | | | 5 |
| Liotti (2017) 'Sara' | ✓ | ✓ | ✓ | ✓ | | | | ✓ | ✓ | 6 |
| Leuzinger-Bohleber (2012) 'Mrs B' | | | | | | | | ✓ | ✓ | 2 |
| Okita et al. (2013) 'Yu' | ✓ | ✓ | ✓ | | ✓ | | | | | 4 |
| Quinn et al. (2012) 'John' | | ✓ | | | | | | | ✓ | 2 |
| Quinn et al. (2012) 'Peter' | | | ✓ | ✓ | | | | ✓ | ✓ | 4 |
| TOTAL COVERAGE (N/10) | 3 | 4 | 7 | 3 | 5 | 3 | 2 | 3 | 5 | |

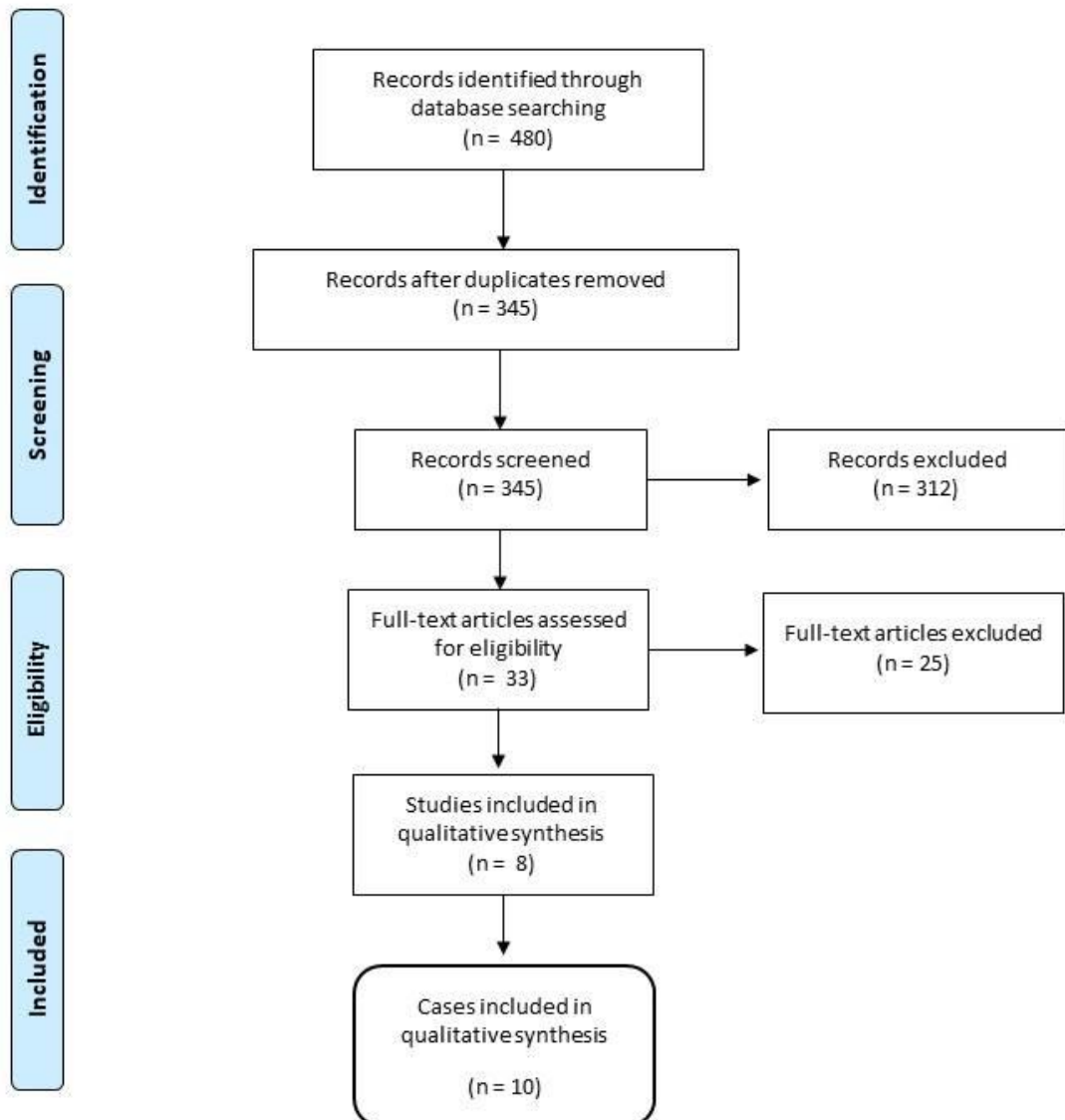
Figure 1: PRISMA diagram of study identification and selection

Figure 2: Visualising the derivation of mechanisms of change through cross-case analysis

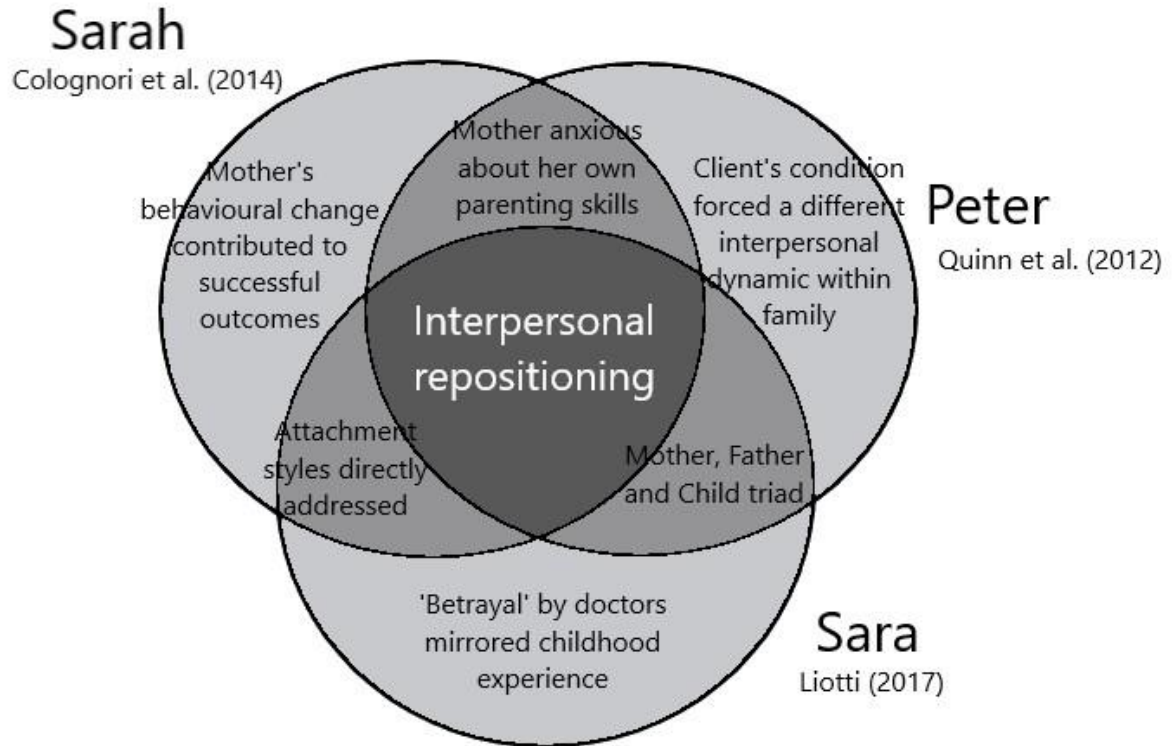
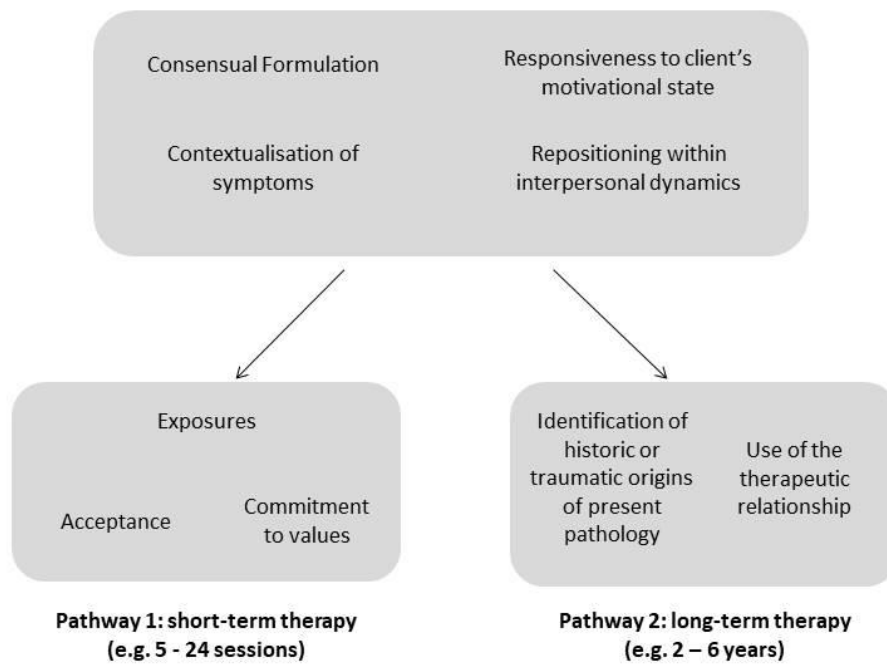


Figure 3: Two pathways along which the mechanisms of change were observed



Appendix 2: Ethical review

Please note that the following ethical review was originally approved on 3rd October 2017, however the red text represents further amendments added to the review and approved by the School of Healthcare Research Ethics Committee on the 11th December 2018.

**UNIVERSITY OF LEEDS RESEARCH ETHICS
COMMITTEE APPLICATION FORM ¹**



UNIVERSITY OF LEEDS

Please read each question carefully, taking note of instructions and completing all parts. If a question is not applicable please indicate so. The superscripted numbers (eg⁸) refer to sections of the guidance notes, available at <http://ris.leeds.ac.uk/uolethicsapplication>. Where a question asks for information which you have previously provided in answer to another question, please just refer to your earlier answer rather than repeating information. Research ethics training courses: <http://www.sddu.leeds.ac.uk/research-innovation/research-ethics-training-and-guidance>

To help us process your application enter the following reference numbers, if known and if applicable:

| | |
|---|------------------|
| Ethics reference number: | |
| Student number and/ or grant reference: | 200676231 |

PART A: Summary

A.1 Which [Faculty Research Ethics Committee](#) would you like to consider this application?²

- Arts, Humanities and Cultures (PVAR)
- Biological Sciences (BIOSCI)
- ESSL/ Environment/ LUBS (AREA)
- MaPS and Engineering (MEEC)
- Medicine and Health (Please specify a subcommittee):
- School of Dentistry (DREC)
 - School of Healthcare (SHREC)
 - School of Medicine (SoMREC)
 - School of Psychology (SoPREC)

A.2 Title of the research³

A multi-case study of psychotherapy for people who present with somatic symptoms: tracking change processes and facilitative elements in collaborative work with the client

A.3 Principal investigator's contact details⁴

| | |
|--|---|
| Name (<i>Title, first name, surname</i>) | Mr John Hills |
| Position | Postgraduate Research Student |
| Department/ School/ Institute | School of Healthcare |
| Faculty | Faculty of Medicine and Health |
| Work address (<i>including postcode</i>) | Baines Wing, University of Leeds, LS2 9TJ |

| | |
|--|--|
| Telephone number | (text redacted) |
| University of Leeds email address | hc11j3wh@leeds.ac.uk |

A.4 Purpose of the research:⁵ (Tick as appropriate)

- Research
- Educational qualification: *Please specify:* PhD
- Educational Research & Evaluation⁶
- Medical Audit or Health Service Evaluation⁷
- Other

A.5 Select from the list below to describe your research: (You may select more than one)

- Research on or with human participants
- Research which has potential adverse [environmental impact](#).⁸ *If yes, please give details:*

- Research working with data of human participants
 - New data collected by qualitative methods
 - New data collected by quantitative methods
 - New data collected from observing individuals or populations
 - Routinely collected data or secondary data
 - Research working with aggregated or population data

- Research using already published data or data in the public domain
- Research working with human tissue samples (*Please inform the relevant [Persons Designate](#) if the research will involve human tissue*)⁹

A.6 Will the research involve NHS staff recruited as potential research participants (by virtue of their professional role) or NHS premises/ facilities?

- Yes No

If yes, ethical approval must be sought from the University of Leeds. Note that [approval](#) from the NHS Health Research Authority may also be needed, please contact FMHUniEthics@leeds.ac.uk for advice.

A.7 Will the research involve any of the following:¹⁰ (You may select more than one)

*If your project is classified as [research](#) rather than service evaluation or audit and involves any of the following an application must be made to the [NHS Health Research Authority](#) via IRAS www.myresearchproject.org.uk as NHS ethics approval will be required. **There is no need to complete any more of this form.** Further information is available at <http://ris.leeds.ac.uk/NHSethicalreview> and at <http://ris.leeds.ac.uk/HRAapproval>. You may also contact governance-ethics@leeds.ac.uk for advice.*

- Patients and users of the NHS (including NHS patients treated in the private sector)¹¹
- Individuals identified as potential participants because of their status as relatives or carers of patients and users of the NHS
- Research involving adults in Scotland, Wales or England who lack the

capacity to consent for themselves¹²

- A prison or a young offender institution in England and Wales (and is health related)¹⁴
- Clinical trial of a medicinal product or medical device¹⁵
- Access to data, organs or other bodily material of past and present NHS patients⁹
- Use of human tissue (including non-NHS sources) where the collection is not covered by a Human Tissue Authority licence⁹
- Foetal material and IVF involving NHS patients
- The recently deceased under NHS care
- None of the above

You must inform the Research Ethics Administrator of your NHS REC reference and approval date once approval has been obtained.

The HRA decision tool to help determine the type of approval required is available at <http://www.hra-decisiontools.org.uk/ethics>. If the University of Leeds is not the Lead Institution, or approval has been granted elsewhere (e.g. NHS) then you should contact the local Research Ethics Committee for guidance. The UoL Ethics Committee needs to be assured that any relevant local ethical issues have been addressed.

A.8 Will the participants be from any of the following groups? (Tick as appropriate)

- Children under 16¹⁶ *Specify age group:*

- Adults with learning disabilities¹²
- Adults with other forms of mental incapacity or mental illness
- Adults in emergency situations
- Prisoners or young offenders¹⁴
- Those who could be considered to have a particularly dependent relationship with the investigator, eg members of staff, students¹⁷
- Other vulnerable groups
- No participants from any of the above groups

Please justify the inclusion of the above groups, explaining why the research cannot be conducted on non-vulnerable groups.

In psychotherapy case research, participant clients usually fall into at least one of the three selected categories. In most counselling work a degree of dependence on the counsellor forms for the client. That dependence is temporary and management of the withdrawal from the counselling relationship (i.e. the ending) is part of the therapeutic process. In counselling case work it is usually the case that the client will be presenting with mild to more severe forms of mental distress or illness – anxiety and depression are very typical presentations - and this is intrinsic to the work. Finally whilst a client will not begin therapy in an emergency situation, nonetheless emergency situations do sometimes arise during the course of therapy – typically the client is in crisis and is having suicidal thoughts. Whilst some clients are at greater risk than others, it is not possible to anticipate whether a person will fall into crisis during therapy and the risks would be the same whether or not the client participated in the research. I as the counsellor and the service I operate from have robust pathways of action for managing emergency situations when they occur which I will elaborate on in forthcoming sections of this review.

It is the researcher's responsibility to check whether a DBS check (or equivalent) is required and to obtain one if it is needed. See also <http://www.homeoffice.gov.uk/agencies-public-bodies/dbs> and http://store.leeds.ac.uk/browse/extra_info.asp?modid=1&prodid=2162&deptid=34&ompid=1&prodvarid=0&catid=243.

A.9 Give a short summary of the research¹⁸

*This section must be completed in **language comprehensible to the lay person**. Do not simply reproduce or refer to the protocol, although the protocol can also be submitted to provide any technical information that you think the ethics committee may require. This section should cover the main parts of the proposal.*

This research is a multi-case study of my work providing psychotherapy for people who suffer from somatic (physical) symptoms. These somatic symptoms might include chronic pain, fatigue, digestive difficulties, nausea, dizziness, or seizures for example. Sometimes somatic symptoms are found to be associated with states of mental, emotional or social distress; and often the medical explanation is unclear. I seek to provide answers to the following questions:

- What patterns did the flare-ups of symptoms follow? How (if at all) were they connected with mental, emotional, and social distress?
- If changes occurred for the client – changes to their symptoms or in their wider life – what were these, and how did they come about?
- What aspects of the therapy and/or the client's wider life appear to be associated with/have supported these changes?

In addition to analysis of recordings of the sessions, clients will be asked to comment both during and at the end of the therapy on how they thought the therapy was going/had gone, whether they experienced change etc. and these views will strongly inform my findings.

People with somatic symptoms have been found to account for up to 10% of all NHS spending. These people typically see their GP frequently, often being referred for further investigations and unsuccessful medical treatments. When working with clients who suffer with somatic symptoms, psychological treatments are under-developed and therapists are under-confident. As such this study is as much about my professional development and my personal experience of working in this area as it is about the clients I treat. I expect in this study to generate insights that will be relatable and useful to psychotherapists who encounter clients with these symptoms in their own practice, feeding into the bigger picture of research in this area aiming to improve therapy and alleviate suffering.

The research project will also involve a supplementary analysis drawing from autoethnographic methods. The therapist's use of reflective diarying, their use of clinical supervision, their use of personal therapy in the context of significant life events have all yielded important data in supporting the sense-making of the entire project. A psychotherapist draws on their own subjective experiencing to enhance the quality of the therapy offered, in accounting for why particular interventions were deployed, and to make sense of the complex 'counter-transferences' that occur in the counsellor-client relationship in ordinary practice. Therefore the autoethnographic analysis of data pertaining to the therapist's experience will enrich the emergent theory from this project as well as yielding research products that are more accessible and relatable to other practitioners in real-world contexts.

A.10 What are the main ethical issues with the research and how will these be addressed?¹⁹

Indicate any issues on which you would welcome advice from the ethics committee.

Confidentiality and anonymity It will be explained to all clients – whether or not they participate in the research – that anonymised notes will be kept about them in the administrative office of (text redacted) in a locked filing cabinet. Notes are usually anonymised by representing names using only the first two letters, and by keeping identification details such as date of birth or address separate from session notes. The only people that have access to those notes are myself as the therapist and the clinical manager of the service. It is explained to all clients that once a month I discuss their therapy with my own clinical supervisor, however in those supervision meetings I do not reveal information that could give away the client's identity to my supervisor. All clients understand that what they tell me in sessions is confidential with the exceptions to confidentiality being in disclosures of terrorism, if requested by law enforcement or following a court subpoena. It's explained to clients that if I suspect that there is a risk of harm to them or to anybody else that we must then have a conversation about how we can make a situation safe and only if I cannot be confident that the situation is safe will I need to take steps to involve other people, constituting a breach of confidentiality.

For clients who participate in the research, special consideration has been made as to disclosures made about criminal activity and these have been explained below.

Data collected for the purposes of research will be anonymised using the following principles: replacing names with numbers or letters, substituting specific ages for age categories (e.g. client in their twenties), substituting specific locations for demographic types (e.g. post-industrial town in Northern England), and altering or omitting of any turns of phrase that may be idiosyncratic to the person or revelatory about their background. If a specific detail in a client's case is essential to appreciating the essence of the data e.g. the client is a nurse and is particularly distressed by an experience on his shift, other details will be altered to conceal identity, for example changing sex or age bracket or another factor that is not essential for appreciating the essence of the data.

Criminal disclosures I have received advice from Dr Janet Holt and Dr Kuldip Bharj on the question of how to handle disclosures from participant clients of their responsibility for criminal acts. The ordinary professional position amongst counsellors and psychotherapists is that confidentiality will not be breached in situations of criminal disclosure unless it was believed that the client themselves or somebody else may be at risk of harm. If a client disclosed that they were smoking cannabis or were shoplifting for example, we would encourage them to desist from these activities – stopping cannabis has health benefits – but the risk of harm to self or others would ordinarily not be considered serious enough to breach confidentiality. Drs Holt and Bharj confirmed that my policy on criminal disclosure would have to be different for research participants, with a broader consideration of disclosures that could potentially bring the university into disrepute. For example current fraudulent activity might be considered to be a serious criminal disclosure justifying breaching confidentiality, whereas other disclosures, such as of a client watching a TV without a license might not justify such a breach. This policy is explained within the Participant Information Sheet so that the participant client understands that the additional conditions of their confidentiality. Where disclosures are made that may fall into the category of a criminal disclosure these will be discussed within the research team e.g. myself and my three supervisors, to decide whether maintenance of confidentiality in this instance might have the potential to bring the university into disrepute and if we could not be satisfied about the appropriate way forward we would seek advice from the University Legal Advisor, without revealing information that may compromise the client's anonymity.

Data storage and handling The participant clients' signed consent forms will be stored in their files at the administrative office of (text redacted) in a locked filing cabinet. All other data pertaining to the research project will be stored in the university hard drive, behind password protection for access to my files, and a second layer of password protection for the individual data files. I will be the only person with access to these files. However in the data analysis process selected files will be shared with members of my supervision team. These files will be sent from my University of Leeds email

account to their University of Leeds email accounts, encrypted with the same double-password protection and will be destroyed as soon as the analytic work has been completed. We do not anticipate needing to print out transcriptions, case notes, or other unpublished client data but if ever we do need to do this we will discuss this as a team in advance of a print-out with a plan to destroy the documents (e.g. with use of a shredder) as soon as the task has been completed. Printed case reports will be sent to clients using a secure courier service such as Royal Mail Special Delivery Guarantee service or equivalent. Clients will be informed that certain pieces of evidence can be destroyed at any time – for example any sound recordings or other materials that may be collected as identified earlier. If a client withdraws from the research, data collected for the research on their case will be destroyed in its entirety. I have decided that the client's opportunity to withdraw from the research will expire upon the deadline Friday, 30th November 2018 so that the thesis can be produced. * Please see justification for this revision of the date in section C12.

The primary research data will be audio recordings of the sessions with participant clients. The client will be informed that they can ask for the recorder to be stopped and/or for recordings to be deleted at any time. It is possible that in any one audio recording there is information that could reveal a client's identity. The digital sound recorder will be in my possession as I leave the therapy situation and the sound file will be transferred to my university hard drive at the earliest opportunity either at the PhD suite in the School of Healthcare or using the remote Citrix software which is approved by the University. That file will then be encrypted using a password especially for the research project and the sound file on the recorder will be deleted. During the period of data collection I will make notes alongside the audio recordings using the NVIVO software. These notes will be anonymised under the principles already set out. Later, selected sound recordings will be fully transcribed and these transcriptions will be similarly anonymised. Sometimes clients also bring clinically relevant materials such as letters or drawings to their sessions. If the client consents to having these included as research data, my procedure will be to take a digital photograph of the item, and then store the actual copy in the client's file at the administrative office of (text redacted), stored in a locked filing cabinet. The digital photograph will be transferred to my university hard drive at the earliest opportunity and the original photograph file will be destroyed.

A further source of data will be the audio recording of my clinical supervision sessions. My supervisor and I have already reached agreement on how these data will be used, stored, reported on and disposed of. The recordings will be made on a digital voice recorder. At the earliest opportunity, recorded files will be transferred onto a password protected server at the University of Leeds and individual audio files will be encrypted separately. The files on the voice recorder will then be deleted and the data will be stored in no other place. Only I will have access to these data. Upon completion of the present research project the audio files will be destroyed. If passages from the recordings are particularly pertinent or representative, I will transcribe these with any client or third party identifying data redacted. As is the

general policy for my study, the client's anonymity will be protected at all times. And if the client has withdrawn from the study through protocols established during their consent process, transcripts from supervision relating to their case work will be destroyed, as will segments of the original audio recordings in which their cases are being discussed.

The scientific purpose of recording the supervision sessions is to capture more of the depth and subtlety of processes involved when I as a practitioner use clinical supervision to facilitate my own practice. Audio recordings are preferable to note taking for the level of detail that can be captured, listened back to and transcribed. As a matter of course I protect my clients' anonymity in discussions with my supervisor, and the nature of the data generated will be around providing insights into my clinical understanding and decision making when working with the clients who are participating in the study, as well as more general insights into my professional development as a counsellor, personal contexts etc. In this respect the audio recordings will serve as an enhancement to ordinary reflective notes made in the process of analysing individual cases and writing my own reflective diary.

Retention of data beyond present research period After the deadline for withdrawal has passed, data will be retained for future publications and prospective further analyses with the express aims as set out in Version 2 of the Participant Information Sheet. Any further analysis will seek to examine whether the data include evidence of change, whether change followed discernible patterns, and how therapy might have facilitated any observed change. Beyond completion of my PhD in 2019, I have been advised by Rachel Proudfoot at the University Research Support that I will be able to transfer my data into dark archival storage on the Faculty of Medicine and Health S Drive, for a period of ten years. Because of the highly sensitive nature of the data, participants will be reassured that I would continue to manage these data and they would not be passed to third-parties. This issue is in my awareness as I recognise an increasing trend towards archiving of data and secondary analyses of data and the knowledge value of these. I expect to have a particularly rich collection of data by the end of this project that may hold significant value beyond the analysis that I propose. Whilst it may be easier just to promise destruction of data upon completion/publication of thesis, I believe that giving clients the option to consent to data being retained allows for the possibility of deriving further value; clients understanding that they can request destruction at any time ongoing.

Informed consent The Participant Information Sheet is written in plain English, tested using a reading age analysis tool at www.thewriter.com it is found to have a reading age of 13-14 years old. This will be provided to the client in the first session to read through over the week and then to return to the second session with any queries they

have before opting to grant consent or not. Where English is not a first language, following the client's assessment information sheets will be translated into the client's preferred language. Human translated versions of documents can be ordered online with costs expected to be approximately £100 for the two-page participant information sheet, and I have received confirmation from my Postgraduate Research Tutor Dr Paul Marshall that should this need arise I would be able to draw from funds in my training budget. Likewise, upon advice from the Royal National Institute of Blind People (RNIB), if a client is blind or partially sighted, they will be given the option of what format they would prefer to receive the Participant Information – with large print, braille (online facilities allow braille documents to be ordered for costs that can be as low as £5 for a two-page document), or audio versions possible to produce, following the general principle of reasonable adjustments. All participants will be prompted to ask any questions they have about the research at any point, and will be reminded that they can withdraw from the study at any time either by telling me or by informing the clinical manager of the charity, without having to provide a reason. In addition clients will be informed that certain pieces of evidence can be destroyed at any time – for example any sound recordings or other materials that may be collected as identified earlier. If a client withdrew from the research, data collected for the research on their case would be destroyed in its entirety.

Exclusion of potential participants Under the recruitment process outlined in the forthcoming section C7, I do not envisage any clients being excluded once they have had assessment and been referred for therapy and have identified as having somatic (physical) symptoms. In the first version of this form I made some statements about informed consent that I have since revised. In section C11 I have set out the special considerations and safeguards that need to be in place to ensure that the client is able to give their informed consent to participate in the research specifically. Given these considerations, I do not believe any client capable of giving their informed consent to participate in an ordinary psychotherapeutic relationship, would be excluded on the basis of the extra considerations of their informed consent to participate in the research. In other words I don't believe the client would need an extra degree of capacity to give their informed consent, rather that the researcher must understand and communicate very clearly the information the client needs to have before they can provide their informed consent.

There are naturally-occurring exclusions based upon those clients who are able to access services at the therapy centre. We do not take clients under the age of eighteen. Whilst all clients are usually expected to make a monetary contribution to their therapy, this is means tested and can be as little as £5 a week, meaning that most people are not priced out of receiving therapy. Some potential clients may not be able to access the service because of mobility issues but these too are natural rather than purposeful exclusions. Additionally it is recognised that psychotherapies are under-

accessed by certain minority populations, for example the substantial demographic of people with Indian sub-continental heritage who live in (text redacted). These exclusions too reflect cultural challenges for the psychotherapy profession as a whole.

Pressure to participate in the research One concern that is often made about psychotherapy research is that a client may feel pressured to participate in order to protect their fledgling relationship with their new therapist for example, or otherwise not to be seen in a negative light. Likewise a client may feel that if they do not participate in the research then they may receive less support than someone who did. Certain principles help to mitigate against these concerns. I have decided that I will only recruit new clients rather than also seeking to recruit existing clients into the study. If I were to ask an existing client to participate in the study they may well feel that they'll lose the relationship they have built up if they do not say yes. Along similar lines initial consent has to be established at the earliest opportunity, and so in my research I will give the client the participant information sheet in our first meeting. They will then have a week to read the documentation and to clarify any queries with me during the second session before opting to give their consent or not. In explaining the research I will stress that the therapy they receive is exactly the same format whether or not they participate, with the only specified differences being: that the confidentiality arrangement is different, that a sound recorder will be present in the sessions, that the client will receive a case report one month after the end of therapy and a 'follow up' phone call three months after the end of therapy. Because it may feel awkward for clients to question whether they wish to remain in the study following an initial granting of consent and the development of a therapy relationship, I will check with the client at frequent intervals (for example at the six week reviews) whether they are happy to continue to participate in the study. Bringing this possibility regularly back into explicit consideration will allow the client 'permission' to talk about any feelings or doubts they have about their continued participation, and mitigate against the fear that their withdrawal may cause a rupture in our relationship.

A system of obtaining continued consent also ensures that the client has every opportunity to withdraw from the study if they wish. However we propose a a patient-centered design – that the power is in the clients hands to determine the frequency (a minimum of once every six weeks), and the mode (e.g. verbal, written, email etc.) through which continued consent is obtained from the client. These options are set out in the Participant Consent Form and are thus agreed upon at the beginning of their participation in the research.

Safeguarding with respect to vulnerable participants As is required in my practice I am fully DBS checked and this is updated every 12 months as it will be throughout the research period. As a practicing psychotherapist I have a duty of care to all my clients

with respect to their safeguarding. This includes looking out for any signs of abuse or neglect, taking seriously any implicit or explicit suggestion that the client or somebody else may be at risk of harm and taking actions in this instance that may result in confidentiality being breached if I cannot be confident that a situation has been made safe. My clinical manager and my clinical supervisor will be aware of which of my clients are participating in the research and it is understood that they will be frank with me if they believe that a client's participation in the research is interfering with the quality of the therapy received or is having any other detrimental impact on the client. In these instances we will then discuss how the situation can be resolved in the best interests of the client. As the therapy provided to participant clients will be the same format as that provided to non-participants, I do not believe participation in the research will increase risk to the client. The most substantial difference that participant clients will experience is at the end of the process when they will be sent a case report of their own therapy, and invited to write a response letter or record an audio response.

Impact of receiving the case report My own literature review of published case studies from the five-year period 2012-2016 found that the client's own voice was conspicuous in its absence and this reduced the scientific value of the papers and the plausibility of the claims made. In addition case study research has been historically accused of being vulnerable to the subjective biases of the researcher/author – presenting data selectively to make their hypotheses stand up. Providing direct responses from the client is one of the primary means of mitigating against these biases and so I regard it as an essential feature of my own design. However receiving case reports can sometimes be distressing for participant clients as previous research has found – the client may feel they have been presented in an unfair and negative way, they may feel distressed that the relationship they thought they had with their therapist was experienced completely differently by the therapist, or they may even be disappointed that the therapist overlooked something that they believed to have been important. I've taken steps to mitigate against these. The most important of these is that approximately every six weeks, the client will have a review session and this is the case whether or not they participate in the research. In a review session, the client will be invited to take a step back and comment on how they think the therapy is going, whether they believe there are any changes in their symptoms or wider experience, and what they believe might have caused the change. Giving the client this opportunity not only helps them to flag up which aspects of the therapy they believe are helpful and which are not – improving therapy going forward – but also to emphasise aspects most important to them, and any new areas they want to 'work on'. I will treat any appraisals by the client of the therapy or their own change process as primary data and as such when they receive the case report the ideas contained within it should not be experienced as coming 'out of the blue' but in fact should be experienced as ideas co-produced by the therapist and themselves. Furthermore participant clients will have the option of requesting the audio recorder to be stopped

in session and of having any particular audio passages deleted even whilst they continue to participate. (This sentence has been re-worded to recognise the Reviewer's Guidance that there should be no rolling opportunity for withdrawal – however the opportunity for the client to request the stopping of the recorder and/or the deletion of certain passages remains a part of the research design for purposes of maintaining confidence and trust. Having this option up to the withdrawal date may also mean clients feel more confident about remaining in the study). Thus I regard the probability of a case report causing significant distress as low. Nonetheless at the point of receiving the case report, participant clients will be provided the opportunity of a free therapeutic session to clarify anything about the case report, and if any issues have been stirred up at that point that require further attention/care then the client can be referred for counselling with a different therapist and/or any other services that may be required.

If a participant client's therapy goes on beyond the closure of the data collection window, my considered decision is that their case will be included in the research report, with the same rights to withdraw as other clients. This needed to be considered carefully as the client might find it harder to raise their doubts at the member checking stage, e.g. responding to the case report, whilst they are still in the middle of their therapy, and if their therapy continues long enough their case may be included in publications whilst they are still having therapy. My reasoning for this policy was that the impact of receiving and responding to the case report can be managed with existing clients given that their therapy continues and they have time to 'work through' any feelings provoked by the case report and of course to come to a decision to withdraw if it feels right for them. Such a client will have already consented to participate in the research at the beginning of their therapy, and had this consent checked in on frequently, making this situation qualitatively different from a scenario in which I would invite clients already having therapy to participate – something I've decided against. Another strong practical argument in favour of this policy is that I might otherwise be faced with a situation in which I lose a huge amount of data overnight for no other reason than that it makes clinical sense for a client's therapy to continue beyond the closure of the data collection window.

Impact of publication of thesis and subsequent research products It will be explained to the participant client that how they are represented in the case reports will be how they are represented in the thesis and publications relating to the same research project; that is the case reports include everything that could possibly be said about them in these publications. At the point of receiving the case report clients will be invited to provide a written or audio recorded response to the report, and their views on the report will also constitute primary data, shaping the hypotheses that will eventually emerge from this multi-case study. At each stage of the research design are built-in aspects to ensure that the hypotheses are collaborative in nature and not analyses 'done on' the client. It is reasonable to expect that if the client is happy with how they are represented in the case report that they will be happy with how they are

represented in the subsequent publication. Indeed previous research has found that in some cases clients have reported therapeutic benefits to having their cases published, for example in 'crystallising' the work done together and of publication being a milestone event in their own life story.

Observer effects Another concern that is sometimes raised about psychotherapy case studies is that the client will a) want to present a picture of progress and recovery in order to please their therapist, or b) believe that they must be getting a good therapy by taking part in the research and thus believe they must surely be getting better – a placebo effect. In our literature review into 2012-2016 case studies, we used criteria set out by Arthur Bohart and colleagues to tackle these scientific concerns. These include looking out for clients being able to be specific about change processes, being able to say which aspects of therapy helped and which did not, recognising that some things haven't changed, and any evidence of clients' 'wishful thinking' or a desire to please their therapist. This again highlights the importance of the six week reviews, not just in being able to discern what evidences of change are trustworthy but moreover to explore with the client how substantial or sustained these changes are. Here too my monthly sessions with my clinical supervisor will be an important resource in identifying any potential biases or blind spots in my work with clients. Also in my research design is a standard three-month follow up with the clients following the end of their therapy to learn whether changes they identified to their symptoms and wider life have been sustained to that point.

Researcher status as a chronic pain sufferer It is important to disclose that in addition to my status as researcher and therapist, I am also a sufferer of chronic pain. Even if I were not, it is crucial for a practitioner-researcher to keep in mind and to be very honest about any personal biases or blind spots that may be interfering with their empirical attitude towards the research or more important still, the subtle non-verbal communications with the client. In psychotherapy we call these subtle non-verbal communications *transference* and it is essential for all therapists to be conscious and reflective about their own transferences. I keep a regular reflective diary in which I analyse my own personal biases, blind spots etc. as I will throughout the research period. Furthermore I share these feelings with my clinical supervisor where they are relevant and we consider together their impact on case work. I also seek out personal therapy for myself as and when feels appropriate, and have allotted private funds to be able to take this up as required. It is understood amongst psychotherapists that whilst transference is unavoidable, what we must be, crucially, is conscious and mindful of our transferences. In addition to researcher reflectivity throughout the research process, I will report on the most significant of these intersections with my personal experience in the thesis and subsequent research products. It is increasingly understood in qualitative research that there is no such thing as a truly objective position, but that all researchers must fully own their subjective situation within the

research and this is what I will do.

Management of risks as identified in Risk Assessment Form The nature of the fieldwork for this research project is that I will be collecting data in the same setting as I would normally be offering therapy – that being the case there are no greater risks associated with fieldwork during the data collection period than in ordinary therapy practice. I have identified on the form several potential risks. Threatening, abusive or violent behaviour is managed by including in each therapy room a panic alarm. Whilst I have never experienced physical violence in my practice I have been given self-defence training in my capacity as a counsellor working in a prison setting. My practice does include an element of lone working for the later sessions. This will be managed through an arrangement with my clinical manager whereby I will send her a text message at the end of each evening's sessions. If she does not receive a text message then she will take actions to ensure my wellbeing, beginning with a call to my mobile and culminating in a request for the police to attend to the charity building if she has not received assurances about my wellbeing. I also know how to evacuate the building in the case of a fire, including multiple exit routes for myself and my clients. Potential emotional and psychological effects are managed primarily through my sessional work with my clinical supervisor but I also benefit from having a supportive relationship with each of the three members of my supervision team, including two highly experienced counsellors and psychotherapists. However at times where I do feel I could benefit from further support I have reserved private funds to take up personal therapy as required.

Self-care In addition to the management of risks to myself as the researcher identified above, as a psychotherapist it is particularly important for me to pay attention to my own wellbeing and stress-levels week by week. Each therapist cares for self in ways unique to them, and for me self-care means spending time with my family, making music, going for walks in nature, meditation, and writing. Activities like these permit me to put the stresses and strains of my roles as therapist and researcher into context, and provide me with some breathing space to process sometimes challenging work.

Use of autoethnographic data and analysis in supplementing the emergent theory from this project

The significant ethical challenges posed here are around a) the impact upon participating clients of reading research reports that disclose personal material i.e. material from the therapist's personal experience, and b) Protecting the interests of loved ones and family members who are also implicated in some of the relevant experiences documented in the autoethnographic strand. In addressing the first of these ethical challenges I will work on the principle that the relevance of

autoethnographic data is not in how it is mapped on to the client's experience, but rather my development and 'performance' as a therapist. So for example if my work with my client involved their difficult relationship with a family member, I would not be seeking to either map directly on to that work either that I was experiencing something equivalent or that my own experience had been different. The reasoning here is that it is important that the client feels that their experience and their story is appreciated as being intrinsically valuable, in and of itself, rather than that I was in some way projecting my own experience onto theirs or not actually 'with them' during the experience, which might be experienced as underhanded, insincere or otherwise invalidating our relationship as the client experienced it. Instead I will make a parallel account of my personal experience and development as therapist and researcher *at the level of the cross-case analysis*. Where personal material is directly relevant to particular client work e.g. personal feelings of anxiety, these will be owned in the case reports received by the clients at the member checking stage but made sense of in the context of the process between us, as is the case in normal therapy, rather than in reference to any autobiographical events. As discussed in section C.17 the case reports provide an important opportunity for the participant client to express any feelings of disappointment that their therapy had not been represented in the way that they had experienced it, or that important details had been missed. As well as providing a passive opportunity for the clients to respond to the material in the case reports I will also anticipate particular concerns or issues that the client may have experienced and ask them directly about these, stressing the principle of developing and improving practice through research.

As to the second challenge around the interests of my loved ones and family members who may be implicated in certain autobiographical events, I will work on the basis of the SHREC's own guidance on autoethnographic methods which is to write about and account for my own personal experience – which is always subjective – as directly relevant to my development and performance as a therapist and therefore as directly relevant to the research, rather than in any way writing about my loved ones or family members including any judgements about their own actions or experiences. To use a generic example: if an autoethnographer felt she was neglected by her father in childhood, rather than say 'my father was neglectful' she would write about her experience of feeling neglected and the implications of that for her.

In all qualitative research the importance of the researcher(s) owning and accounting for their subjectivity in a transparent and reflexive way is an important benchmark of quality and trustworthiness of the analysis. In using autoethnographic methods to account for my own subjective experience and its impact upon both my performance as a therapist and my capacity to make sense of the data as a researcher, I believe I am formalising and enhancing this ordinary reflexivity, and this will ultimately be in the service of better quality research with more relevant and applicable theoretical outputs.

| |
|--|
| |
|--|

PART B: About the research team

| B.1 To be completed by students only²⁰ | |
|--|--|
| Qualification working towards (eg Masters, PhD) | PhD |
| Supervisor's name (Title, first name, surname) | Dr Jane Cahill |
| Department/ School/ Institute | School of Healthcare |
| Faculty | Faculty of Medicine and Health |
| Work address (including postcode) | Baines Wing, University of Leeds, LS2 9TJ |
| Supervisor's telephone number | 0113 343 1468 |
| Supervisor's email address | j.l.cahill@leeds.ac.uk |
| Module name and number (if applicable) | N/A |

| B.2 Other members of the research team (eg co-investigators, co-supervisors) ²¹ | |
|---|--|
| Name (<i>Title, first name, surname</i>) | Dr John Lees |
| Position | Senior Lecturer |
| Department/ School/ Institute | School of Healthcare |
| Faculty | Faculty of Medicine and Health |
| Work address (<i>including postcode</i>) | Baines Wing, University of Leeds, LS2 9TJ |
| Telephone number | 0113 343 3911 |
| Email address | j.lees@leeds.ac.uk |

| | |
|-----------------------------------|--|
| Name (Title, first name, surname) | Prof Dawn Freshwater |
| Position | Vice-Chancellor |
| Department/ School/ Institute | The University of Western Australia |
| Faculty | (former Head of School of Healthcare, University of Leeds) |
| Work address (including postcode) | Vice-Chancellery, The University of Western Australia (M464), 35 Stirling Highway, PERTH WA 6009, Australia |
| Telephone number | 0061 8 6488 2801 |
| Email address | dawn.freshwater@uwa.edu.au ; d.freshwater@leeds.ac.uk |

Part C: The research

C.1 What are the aims of the study?²² (Must be in language comprehensible to a lay person.)

Through data collected from my psychotherapeutic work with clients that present with somatic (physical) symptoms, I seek to provide answers to the following questions:

- What patterns did the flare-ups of symptoms follow? How (if at all) were they connected with mental, emotional, and social distress?
- If changes occurred for the client – changes to their symptoms or in their wider life – what were these, and how did they come about?
- What aspects of the therapy and/or the client's wider life appear to be associated with/have supported these changes?

The study will culminate in a thesis in which emergent hypotheses – particularly based upon patterns identified within and between cases – will be reported on to provide answers to the research questions. The study will also analyse my professional experience as a practitioner working with clients that present with these symptoms, e.g. exploring ideas about decision making and professional development. Also analysed will be any relevant personal material identified, for example my experience as a sufferer of chronic pain, or my discoveries of any biases or blind-spots.

Direct outputs from the study will also include articles for journal publication that will focus on particular hypotheses formulated in the thesis.

C.2 Describe the design of the research. Qualitative methods as well as quantitative methods should be included. (Must be in language comprehensible to a lay person.)

It is important that the study can provide information about the aims that it intends to address. If a study cannot answer the questions/ add to the knowledge base that it intends to, due to the way that it is designed, then wasting participants' time could be an ethical issue.

The design of this research project situates it within the Change Process Research tradition. Change Process Research (CPR) methods began to emerge about thirty years ago in response to criticisms that psychotherapy research was not capturing the value of the therapy as appreciated by practitioners, nor being sensitive enough to measure different outcomes for clients. CPR goes beyond ideas about cause and effect in therapy e.g. hypotheses about what the therapist did that led certain changes as experienced by the client. Rather CPR considers what might be called 'soft causality' or 'enabling causality' e.g. what aspects of the therapy enabled change to take place?

In the twelve-month period November 2017 to November 2018 when people begin a course of psychotherapy with me and make any reference either in their initial assessment or the first therapy session to having somatic (physical) symptoms, they

will be invited to participate in the research study: the participant information sheet will be provided in the first session, and if they do wish to participate, the consent form will be completed in the second. There is a large variety in the number of sessions a client will have to complete therapy – some therapies last just 6 sessions, others may be in therapy for years and every person's needs are unique.

Participant clients' sessions will be audio recorded, and these recordings will be the primary source of data for the study. As previously observed, the structure and methods used in their therapy are the same as if they were not participating. Other sources of data will include: any other materials such as drawings or letters that the client produces, my case notes, my reflective diaries, the client's written or recorded response to the case reports, and notes from the three-month 'follow up' phone call.

I will organise and store all of these data using the NVIVO software. NVIVO will enable me to generate 'descriptive codes' and 'analytic themes' to associate with the data as I input them. A descriptive code allows me to label a piece of evidence e.g. a passage from a recording as belonging to a certain category. For example if a client is anxious about attending a work social, I may categorise that as 'anticipatory anxiety'. An analytic theme is when pieces of evidence are labelled according to hypotheses that are emerging about what the data might be telling us. For example that same passage might provide evidence for a theory about symptoms of anxiety being related to pressure on the person to perform a certain role in their work life.

When data collection has finished for a certain client, I will then revisit the whole data collected on their case and use analytic methods to be applied to the different pieces of evidence and produce transcripts of selected audio recordings to generate and make the case for certain hypotheses. It is important to remember that the client will have their own hypotheses about their therapy and these will be influential as I work with the data as well as those views being included in the data.

I envisage using two general methods to analyse the data: the first is called 'innovative moments coding' and was developed by Miguel M. Gonçalves at the University of Minho in Portugal, and colleagues. In this approach individual pieces of data are highlighted if they seem to mark a departure from the client's ordinary narrative i.e. the story they usually tell about themselves. So in the work social example, the client may say something like: "but it will good to see Peter, we always have a good time" i.e. the prospect of the work social is not 100% dread-ful. Gonçalves and colleagues then have a system to categorise these pieces of data according to what function these expressions serve for the client. Using ideas from 'semiotic' theory it may be possible to treat these pieces of data as signposts e.g. what alternative narrative do they seem to be pointing to?

The second method of analysis I presently envisage is called Qualitative Comparative Analysis (QCA). In QCA the data is analysed to discern whether certain qualities are present or absent. So for example, I could look for evidence within the client's retelling of the events of their week to discover whether they had brought into mind any of the things we'd discussed in the previous session. So if the evidence is there, the quality is present, if not the quality is absent, and these are scored 1 or 0

respectively. A QCA is then done using a piece of computer software that generates models of cause and effect. E.g. in order for the client to have a good time at the work social it was necessary for her to put into practice the method we'd worked on in the session for dealing with her anxiety. Both these approaches to analysis will generate hypothesis that will allow me to return to the 'rich' case data for the client as a whole and consider: does the hypothesis fit – how would this proposal play out in their unique life experience?

Out of the analysis will emerge a series of hypotheses about a client's case and these will form the structure of the case reports. The hypotheses will then be written about in a narrative form and backed up with evidence e.g. quotes from audio recordings. The reports will then be sent to the client for their written or audio recorded response. Data from these responses, and the subsequent three-month 'follow-up' phone calls, will also inform the analyses as set out in the thesis.

As well as seeking to identify and evidence patterns emerging from individual cases, I will also highlight analogous patterns between cases, as well as demonstrating points of contact with my own professional and personal experience. All resultant hypotheses will aim to provide answers to the three general questions I have previously identified.

Ideally I would like to recruit up to twelve participants to the study to maximise opportunities for cross-case analyses. I have set out elsewhere my policy towards withdrawal that allows participants to withdraw from the study at any point up to Friday, 30th November 2018 (Change of date is justified in section C12). It is important to keep in mind the question of how I might handle a large amount of withdrawals. I see within my research design the capacity to balance relatively small vs relatively large numbers of participants along two sliding scales. The first is the question of how much this case study is 'about' my clients and how much is it 'about' me as the therapist – this question is one highlighted in literature about psychotherapy case study research. In the event of a large loss of participants I would seek to draw greater focus on my work and professional development as a therapist working with clients who present with somatic symptoms. I would still be able to chart chronological developments in my theoretical platform and practice, intersections with my personal experience as a chronic pain sufferer and as a researcher, and development of theoretical models and the evolution of these over time, with data the derived from my reflective diaring and clinical supervision. In other words the research questions can be addressed indirectly through reference to my experience as the therapist, as well as directly through client case data. The other sliding scale is one typical in qualitative research about the play-off between breadth and depth. In a scenario in which I am left with just one or two clients, analytic methods such as QCA may no longer be useful, but other analytic methods for working at depth with Change Process Research may prove more complementary to the innovative moments coding and semiotic approach. For example, Styles' Assimilation Model with its Assimilation of Problematic Experiences scale is a leading analytic approach for working on single cases at depth.

The research project will also involve a supplementary analysis drawing from autoethnographic methods. The therapist's use of reflective diarying, their use of clinical supervision, their use of personal therapy in the context of significant life events have all yielded important data in supporting the sense-making of the entire project. A psychotherapist draws on their own subjective experiencing to enhance the quality of the therapy offered, in accounting for why particular interventions were deployed, and to make sense of the complex 'counter-transferences' that occur in the counsellor-client relationship in ordinary practice. Therefore the autoethnographic analysis of data pertaining to the therapist's experience will enrich the emergent theory from this project as well as yielding research products that are more accessible and relatable to other practitioners in real-world contexts.

C.3 What will participants be asked to do in the study?²³ (e.g. number of visits, time, travel required, interviews)

Whether or not a client decides to participate in the study, their therapy will be just the same week by week – meaning meeting weekly for fifty minute sessions, and then approximately every six weeks having a review session. Usually in the review sessions we decide together whether it will be helpful to book more therapy sessions and what would be helpful to work on together in those sessions.

If a client decides to take part in the study approximately one month after the end of their therapy they will be sent a report about their therapy and will be invited to write a response letter or record a spoken response. They'll also have the opportunity of a free therapy session to come back to the therapy service building and explore their thoughts and feelings about the report and have any questions answered. However they won't have to do anything if they do not want to. I would expect writing the response letter or recording the spoken response to take up to an hour. The spoken response could be recorded on the same day as the free therapy session so as not to duplicate travel times.

Three months after the end of a client's therapy I will make contact to ask how things are for them at that point, about their symptoms and whether any changes we did identify in our work together have held. However they won't have to provide any information if they do not want to. This phone call I would expect to take a maximum

of twenty minutes.

C.4 Does the research involve an international collaborator or research conducted overseas:²⁴

(Tick as appropriate)

Yes No

If yes, describe any ethical review procedures that you will need to comply with in that country:

N/A

Describe the measures you have taken to comply with these:

** Please note that Prof Freshwater's contribution to the data analysis will be conducted in the UK with any documents needing to be shared using her University of Leeds email address **

Include copies of any ethical approval letters/ certificates with your application.

C.5 Proposed study dates and duration

Research start date (DD/MM/YY): __02/10/17__ Research end date (DD/MM/YY):
____30/09/19__

Fieldwork start date (DD/MM/YY): __01/11/17__ Fieldwork end date
(DD/MM/YY): ____30/11/18__

C.6. Where will the research be undertaken? (i.e. in the street, on UoL premises, in schools)²⁵

(text redacted) The charity that I provide psychotherapy through.

RECRUITMENT & CONSENT PROCESSES

How participants are recruited is important to ensure that they are not induced or coerced into participation. The way participants are identified may have a bearing on whether the results can be generalised. Explain each point and give details for subgroups separately if appropriate.

C.7 How will potential participants in the study be:

(i) identified?

Clients are provided with an initial assessment at the charity in which they meet with a different psychotherapist who asks them a series of questions to determine their needs. At present, because of my long-standing interest in the area, clients who talk about having somatic (physical) symptoms in their assessment are ordinarily referred to me. If a client is referred to me and has identified somatic symptoms in their assessment then I would consider them a potential participant. However even if a client had not identified somatic symptoms in their assessment but had done so in the first therapy session I would still identify them as a potential participant.

(ii) approached?

In the first therapy session there is paperwork relating to the service to be gone through together with the client, and once the client has had all their questions about this normal paperwork clarified we sign the documents together. I will introduce the idea of the research project during that first session once the normal paperwork has been signed off. I'll say a couple of sentences about it, and then give the client the participant information sheet which they will then take away with them to read over the coming week. My contact details are provided on the information sheet and they can contact me during the ensuing week with any questions, or ask me these questions

in the next therapy session (the second session).

(iii) recruited?²⁶

At the beginning of the second session the client will be reminded about the research study, and prompted to raise any questions they have. Once the client and I are satisfied that the questions have been answered, I will ask the client whether they wish to participate. If they do we will run through the individual items on the consent form and sign that form together.

C.8 Will you be excluding any groups of people, and if so what is the rationale for that?²⁷

Excluding certain groups of people, intentionally or unintentionally may be unethical in some circumstances. It may be wholly appropriate to exclude groups of people in other cases

Under the recruitment process outlined in the previous section (C7) I do not envisage any clients being excluded once they have had assessment and been referred for therapy and have identified as having somatic (physical) symptoms. In the first version of this form I made some statements about informed consent that I have since revised. In section C11 I have set out the special considerations and safeguards that need to be in place to ensure that the client is able to give their informed consent to participate in the research specifically. Given these considerations, I do not believe any client capable of giving their informed consent to participate in an ordinary psychotherapeutic relationship, would be excluded on the basis of the extra considerations of their informed consent to participate in the research. In other words I don't believe the client would need an extra degree of capacity to give their informed consent, rather that the researcher must understand and communicate very clearly the information the client needs to have before they can provide their informed consent.

There are naturally-occurring exclusions based upon those clients who are able to access services at the therapy centre. We do not take clients under the age of eighteen. Whilst all clients are usually expected to make a monetary contribution to

their therapy, this is means tested and can be as little as £5 a week, meaning that most people are not priced out of receiving therapy. Some potential clients may not be able to access the service because of mobility issues but these too are natural rather than purposeful exclusions. Additionally it is recognised that psychotherapies are under-accessed by certain minority populations, for example the substantial demographic of people with Indian sub-continental heritage who live in (text redacted). These exclusions too reflect cultural challenges for the psychotherapy profession as a whole.

C.9 How many participants will be recruited and how was the number decided upon?²⁸

It is important to ensure that enough participants are recruited to be able to answer the aims of the research.

1 to 12.

Because of the qualitative nature of the research, in which I am particularly interested in the depth rather than the breadth of data, and because the research is also concerned with my personal and professional experience of providing psychotherapy in this area, I can envisage a viable research project being based upon the case data of just one or two clients. It may prove very difficult to recruit clients and/or I may find that clients wish to withdraw from the study, for example if they do not desire the further feelings of 'exposure' that having their stories published in research might invoke.

However I would like to recruit 8-12 participants. This is the number of individual cases that will allow me to perform a Qualitative Comparative Analysis (described in section C2) on the whole data and generate hypotheses of cause and effect. Case study research does not aim to produce 'representative' samples of populations, but rather case studies may reveal in unique cases recognisable points of contact for other practitioners in their own work with clients e.g. 'that reminds me of my work with X and that insight/approach might be useful'.

Remember to include all advertising material (posters, emails etc) as part of your

application

C10 Will the research involve any element of deception?²⁹

If yes, please describe why this is necessary and whether participants will be informed at the end of the study.

The issue of what to call the symptoms that are the focus of this study has been a source of contention for many decades. Traditionally physical symptoms associated with mental, emotional, or relational distress would be labelled 'psychosomatic' although it is widely recognised that sufferers resent this description. The term is interpreted as meaning that the symptoms are 'all in the mind', 'not real', and that they may even be the person's fault. The more contemporary term of Medically Unexplained Symptoms is rejected by NHS Improved Access to Psychological Therapies because it implies that no treatment options exist and leaves the sufferer in a kind of limbo. As a research team we decided that 'somatic symptoms' is the best term to use as it is treated as equivalent to 'physical symptoms' in psychotherapeutic literature but recognises the *possibility* of association with mental, emotional, or social factors. Furthermore the semantic use of the term somatic symptoms recognises that the symptoms are real and not products of the mind or imagination.

As a team we were concerned that uses of different terms to describe the research project might provoke a negative reaction for the client e.g. to stigmatise what they have told me and so the use of this term we regard to be the one that would be least likely to provoke a negative reaction on the part of the client.

C.11 Will [informed consent](#) be obtained from the research participants?³⁰

Yes No

If yes, give details of how it will be done. Give details of any particular steps to provide information (in addition to a written information sheet) e.g. videos, interactive material. If you are not going to be obtaining informed consent you will

need to justify this.

As previously described, potential participants will be provided with Participant Information Sheets in their first therapy session and if they wish to participate in the study, the consent form will be completed during their second therapy session. The Participant Information Sheet is written in plain English, tested using a reading age analysis tool at www.thewriter.com it is found to have a reading age of 13-14 years old. This will be provided to the client in the first session to read through over the week and then to return to the second session with any queries they have before opting to grant consent or not. Where English is not a first language, following the client's assessment information sheets will be translated into the client's preferred language. Human translated versions of documents can be ordered online with costs expected to be approximately £100 for the two-page participant information sheet, and I have received confirmation from my Postgraduate Research Tutor Dr Paul Marshall that should this need arise I would be able to draw from funds in my training budget. Likewise, upon advice from the Royal National Institute of Blind People (RNIB), if a client is blind or partially sighted, they will be given the option of what format they would prefer to receive the Participant Information – with large print, braille (online facilities allow braille documents to be ordered for costs that can be as low as £5 for a two-page document), or audio versions possible to produce, following the general principle of reasonable adjustments.

In the second session, all potential participants will be prompted to ask any questions they have about the research at any point, and will be reminded that they can withdraw from the study at any time either by telling me or by informing the clinical manager of the charity, without having to provide a reason. In addition clients will be informed that certain pieces of evidence can be destroyed at any time – for example any sound recordings or other materials that may be collected as identified earlier. If a client withdrew from the research, data collected for the research on their case would be destroyed in its entirety.

Whilst a client may be determined to be capable of giving their informed consent to participate in the therapeutic relationship – for example in considerations of confidentiality and data storage – the principles that underpin their capacity to consent to participate in research require further considerations. Primarily consent to participate in research hinges upon the client understanding why they were invited to participate in the study, the possible benefits and drawbacks of being a participant, any extra commitments on their time, what their opportunities for withdrawal from the study are, and how research findings will be disseminated. These extra considerations are set out in the Participant Information Sheet which the potential participant is urged to read and consider carefully. Then in the second session, at which point the client completes their decision as to whether to participate, they are

first invited to ask any questions they have in relation to the research and there is a special line on the consent form where the client explicitly recognises that they have received satisfactory answers to all their questions. These built in safeguards and explicit considerations of research participation all serve to ensure that the participant has been able to provide their informed consent.

Continued consent will be sought from participant clients under a patient-centered principle – that the power is in their hands to determine the frequency (a minimum of once every six weeks), and the mode (e.g. verbal, written, email etc.) through which continued consent is obtained from the client. These options are set out in the Participant Consent Form and are thus agreed upon at the beginning of their participation in the Research.

Because it may feel awkward for clients to question whether they wish to remain in the study following an initial granting of consent and the development of a therapy relationship, I will check with the client at frequent intervals (for example at the six week reviews) whether they are happy to continue to participate in the study. Bringing this possibility regularly back into explicit consideration will allow the client ‘permission’ to talk about any feelings or doubts they have about their continued participation, and mitigate against the fear that their withdrawal may cause a rupture in our relationship.

If participants are to be recruited from any of potentially vulnerable groups, give details of extra steps taken to assure their protection. Describe any arrangements to be made for obtaining consent from a legal representative.

Copies of any written consent form, written information and all other explanatory material should accompany this application. The information sheet should make explicit that participants can withdraw from the research at any time, if the research design permits. Remember to use meaningful file names and version control to make it easier to [keep track of your documents](#).

Sample information sheets and consent forms are available from the University ethical

review webpage at <http://ris.leeds.ac.uk/InvolvingResearchParticipants>.

C.12 Describe whether participants will be able to withdraw from the study, and up to what point (eg if data is to be anonymised). If withdrawal is not possible, explain why not.

Any limits to withdrawal, eg once the results have been written up or published, should be made clear to participants in advance, preferably by specifying a date after which withdrawal would not be possible. Make sure that the information provided to participants (eg information sheets, consent forms) is consistent with the answer to C12.

As previously explained, following the initial granting of consent by the client to participate in the relationship in their second therapy session, it is explained to them that they are able to withdraw from the study at any point up to deadline of Friday, 30th November 2018 – this deadline exists to allow the production of the thesis. The client is able to withdraw either by telling me or by informing the clinical manager of the charity, without having to provide a reason.

In the first version of this form, as reviewed by the SHREC in May, I had suggested two options for a withdrawal deadline – one at the closure of the data collection window and one at the end of the analytic period – I had expressed a preference for the later deadline but requested further guidance on this from the Reviewers. In the Reviewer's Comments I have been advised that above and beyond the practical arguments for and against either date, the ethical principle was that the participant had a clear withdrawal date, and that this date allowed for a viable data set so that participants' time was not wasted. Following this advice I consulted again with my supervisors again on this matter and we settled on this date.

The client will be asked regularly whether they wish to continue their participation to ensure that they do not feel obliged to continue, and me bringing it back into explicit consideration may mean they have the 'permission' to raise doubts and concerns. It will be explained to the client that if they withdraw from the study any data collected about them for the purposes of the study will be destroyed. It will also be explained to the client that they can request to have destroyed certain pieces of data whilst they remain participants in the study. These principles are all explained in the Participant Information Sheet.

In keeping with the agreement established by my clinical supervisor Steve Page and I, we have agreed that the same deadline will apply for Steve's opportunity to withdraw consent for use of audio recordings of our sessions as data in this research project. Steve understands that he will be able to withdraw his consent at any point up to the deadline of Friday, 30th November 2018.

C.13 How long will the participant have to decide whether to take part in the research?³¹

It may be appropriate to recruit participants on the spot for low risk research; however consideration is usually necessary for riskier projects.

The client will have a minimum of one week to consider all the details of the research as set out in the Participant Information Sheet between their first and second therapy sessions. In the second session the client will be prompted to ask any questions they have about the research process and the consent form will be filled out together once both I as the therapist and they as the client are satisfied that all questions have been answered.

C.14 What arrangements have been made for participants who might have difficulties understanding verbal explanations or written information, or who have particular communication needs that should be taken into account to facilitate their involvement in the research?³² *Different populations will have different information needs, different communication abilities and different levels of understanding of the research topic. Reasonable efforts should be made to include potential participants who could otherwise be prevented from participating due to disabilities or language barriers.*

The Participant Information Sheet is written in plain English, tested using a reading age analysis tool at www.thewriter.com it is found to have a reading age of 13-14 years old. This will be provided to the client in the first session to read through over the week and then to return to the second session with any queries they have before opting to grant consent or not. Where English is not a first language, following the client's assessment information sheets will be translated into the client's preferred language. Human translated versions of documents can be ordered online with costs expected to be approximately £100 for the two-page participant information sheet, and I have received confirmation from my Postgraduate Research Tutor Dr Paul Marshall that should this need arise I would be able to draw from funds in my training budget. Likewise, upon advice from the Royal National Institute of Blind People (RNIB), if a client is blind or partially sighted, they will be given the option of what format they would prefer to receive the Participant Information – with large print, braille (online facilities allow braille documents to be ordered for costs that can be as low as £5 for a two-page document), or audio versions possible to produce, following the general principle of reasonable adjustments.

It is occasionally necessary to find a therapy room on the ground floor of our building for clients who are not able to climb the stairs. Likewise blind or partially sighted clients may be guided to their room and seat.

It is not financially feasible to provide ongoing translation services during psychotherapy for clients for whom English is not a first language at the charity I operate from. However as a general principle if following assessment a client is deemed capable of entering into an ordinary psychotherapy relationship – a private conversation in the English language between two people facing one another – then they are also capable of participating in the research receiving therapy in the same way without any special adjustments made to the weekly sessions. Such a client would retain the translated Participant Information Sheet to consult throughout the period of their participation.

C.15 Will individual or group interviews/ questionnaires discuss any topics or issues that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could take place during the study (e.g. during interviews or group discussions)?³³ The [information sheet](#) should explain under what circumstances action may be taken.

Yes No *If yes, give details of procedures in place to deal with these issues.*

It is intrinsic to psychotherapeutic work that topics discussed in the recorded sessions will include sensitive, embarrassing or upsetting themes. This will have been explained to the client at the point at which they grant consent to participate in the research but my responsibility as their therapist is to ensure their continued confidence in the principles by which I maintain their anonymity in any written reports. Being a qualified psychotherapist with six years' practice experience, and having the support of my clinical supervisor and the clinical manager behind me, I am able to manage safely situations in which the client becomes distressed or embarrassed.

Likewise, as previously observed, if and when emergency situations arise for example a fear that the client or somebody else may be at risk of harm, I and the charity I work for have robust pathways of action in place to manage these crises. These include as a

first step having a conversation with the client about making a situation safe – this usually involves their agreement to involve significant others in their care and to identify other protective factors for example placing themselves in situations where they feel comfortable. If I can be confident that a client is not at immediate risk but has nonetheless expressed significant distress, I will normally follow up with a phone call in the next day or two to check how they are doing. If following the therapeutic conversation I cannot be confident that a client or another person of concern will be safe I explain to the client that it is necessary for me to break confidentiality. The usual steps are to inform my clinical manager, the client's GP, my own clinical supervisor and the client's significant others if appropriate so that all take responsibility and appropriate actions for keeping the client or another person of concern safe. If the assessment of risk is particularly acute I may have to make a call to emergency services and/or the local first response team to request actions such as assuming immediate care for the client.

I have received advice from Dr Janet Holt and Dr Kuldeep Bharj on the question of how to handle disclosures from participant clients of their responsibility for criminal acts. The ordinary professional position amongst counsellors and psychotherapists is that confidentiality will not be breached in situations of criminal disclosure unless it was believed that the client themselves or somebody else may be at risk of harm. If a client disclosed that they were smoking cannabis or were shoplifting for example, we would encourage them to desist from these activities – stopping cannabis has health benefits – but the risk of harm to self or others would ordinarily not be considered serious enough to breach confidentiality. Drs Holt and Bharj confirmed that my policy on criminal disclosure would have to be different for research participants, with a broader consideration of disclosures that could potentially bring the university into disrepute. For example current fraudulent activity might be considered to be a serious criminal disclosure justifying breaching confidentiality, whereas other disclosures, such as of a client watching a TV without a license might not justify such a breach. This policy is explained within the Participant Information Sheet so that the participant client understands the additional conditions of their confidentiality. Where disclosures are made that may fall into the category of a criminal disclosure these will be discussed within the research team e.g. myself and my three supervisors, to decide whether maintenance of confidentiality in this instance might have the potential to bring the university into disrepute and if we could not be satisfied about the appropriate way forward we would seek advice from the University Legal Advisor, without revealing information that may compromise the client's anonymity.

C.16 Will individual research participants receive any payments, fees, reimbursement of expenses or any other incentives or benefits for taking part in this research?³⁴

Yes No

If Yes, please describe the amount, number and size of incentives and on what basis this was decided.

RISKS OF THE STUDY

C.17 What are the potential benefits and/ or risks for research participants in both the short and medium-term?³⁵

It will be explained to clients that by taking part in this study they will help us to develop new theories on how we can better help people who come for psychotherapies suffering with somatic (physical) symptoms. It is recognised that one of the primary motivating factors for people in their decision to participate in healthcare research is an altruistic desire to help others and the satisfaction they can derive from that.

As the therapy provided to participant clients will be the same format as that provided to non-participants, I do not believe participation in the research will increase risk to the client. The most substantial difference that participant clients will experience is at the end of the process when they will be sent a case report of their own therapy, and invited to write a response letter or record an audio response.

As previously observed, some clients may find that the final report and publications help them to see their therapy as an important milestone in their life, thus 'crystallising' the work done together. However some clients may be disappointed to receive the final report as they believe they have been misunderstood or that important things have been missed. In the six week reviews the client will be invited to take a step back and comment on how they think the therapy is going, whether they believe there are any changes in their symptoms or wider experience, and what they believe might have caused the change. Giving the client this opportunity not only helps them to flag up which aspects of the therapy they believe are helpful and which

are not – improving therapy going forward – but also to emphasise aspects most important to them, and any new areas they want to ‘work on’. I will treat any appraisals by the client of the therapy or their own change process as primary data and as such when they receive the case report the ideas contained within it should not be experienced as coming ‘out of the blue’ but in fact should be experienced as ideas co-produced by the therapist and themselves. Thus I regard the probability of a case report causing significant distress as low. Likewise the provision of the free therapeutic session and opportunity at that point to signpost the client to further counselling or other services are built in to the research design to protect the client in the unlikely event that the case report causes significant distress.

Because the therapy is no different week by week whether or not a client chooses to take part, there’s no additional time commitment. However clients writing or recording their responses at the end of therapy, coming in for the free therapy session, and providing feedback over the phone three months after their therapy ends will take up some of their time if they decide to take these opportunities. As previously identified, I would expect the written/recorded response to take up to an hour and the follow-up phone call to take up to twenty minutes.

C.18 Does the research involve any risks to the researchers themselves, or people not directly involved in the research? *Eg lone working*³⁶

Yes No

If yes, please describe: ____ The normal risks inherent to practicing psychotherapy. For example of the client becoming physically aggressive in the therapy session. My work does also include an element of lone-working as sometimes I am the only member of the charity present in the building when I’m providing therapies. _____

Is a **risk assessment** necessary for this research?

Yes No If yes, please include a copy of your risk assessment form with your application.

NB: Risk assessments are a University requirement for all fieldwork taking place off campus. For guidance contact your Faculty Health and Safety Manager or visit <http://ris.leeds.ac.uk/HealthAndSafetyAdvice>.

RESEARCH DATA

C.19 Explain what measures will be put in place to protect personal data. E.g. anonymisation procedures, secure storage and coding of data. Any potential for re-identification should be made clear to participants in advance.³⁷ Refer to <http://ris.leeds.ac.uk/ConfidentialityAnonymisation> and <http://ris.leeds.ac.uk/ResearchDataManagement> for guidance.

Data storage and handling It will be explained to all clients – whether or not they participate in the research – that anonymised notes will be kept about them in the administrative office of (text redacted) in a locked filing cabinet. Notes are usually anonymised by representing names using only the first two letters, and by keeping identification details such as date of birth or address separate from session notes. The only people that have access to those notes are myself as the therapist and the clinical manager of the service. It is explained to all clients that once a month I discuss their therapy with my own clinical supervisor, however in those supervision meetings I do not reveal information that could give away the client’s identity to my supervisor.

The participant clients’ signed consent forms will be stored in their files at the administrative office of (text redacted) in a locked filing cabinet. All other data pertaining to the research project will be stored in the university hard drive, behind password protection for access to my files, and a second layer of password protection for the individual data files in accordance with the Data Protection Act 1998. I will be the only person with access to these files however in the data analysis process selected files will be shared with members of my supervision team. These files will be sent from my University of Leeds email account to their University of Leeds email accounts, encrypted with the same double-password protection and will be destroyed as soon as the analytic work has been completed. We do not anticipate needing to print out transcriptions, case notes, or other unpublished client data but if ever we do need to do this we will discuss this as a team in advance of a print-out with a plan to destroy the documents (e.g. with use of a shredder) as soon as the task has been completed. Printed case reports will be sent to clients using a secure courier service such as Royal Mail Special Delivery Guarantee service or equivalent.

The primary research data will be audio recordings of the sessions with participant clients. The client will be informed that they can ask for the recorder to be stopped and/or for recordings to be deleted at any time. It is possible that in any one audio recording there is information that could reveal a client’s identity. The digital sound recorder will be in my possession as I leave the therapy situation and the sound file will be transferred to my university hard drive at the earliest opportunity either at the PhD suite in the School of Healthcare or using the remote Citrix software which is approved

by the University. That file will then be encrypted using a password especially for the research project and the sound file on the recorder will be deleted. During the period of data collection I will make notes alongside the audio recordings using the NVIVO software. These notes will be anonymised under the principles already set out. Later, selected sound recordings will be fully transcribed and these transcriptions will be similarly anonymised. Sometimes clients also bring clinically relevant materials such as letters or drawings to their sessions. If the client consents to having these included as research data, my procedure will be to take a digital photograph of the item, and then store the actual copy in the client's file at the administrative office of (text redacted), stored in a locked filing cabinet. The digital photograph will be transferred to my university hard drive at the earliest opportunity and the original photograph file will be destroyed.

Where participants remain in the study beyond the final deadline, their data collected for the purposes of the study will be retained for the prospect of further analysis/research with the express aims as set out in Version 2 of the Participant Information Sheet. Any further analysis will seek to examine whether the data include evidence of change, whether change followed discernible patterns, and how therapy might have facilitated any observed change. Beyond completion of my PhD in 2019, Beyond completion of my PhD in 2019, I have been advised by Rachel Proudfoot at the University Research Support that I will be able to transfer my data into dark archival storage on the Faculty of Medicine and Health S Drive, for a period of ten years. Because of the highly sensitive nature of the data, participants will be reassured that I would continue to manage these data and they would not be passed to third-parties.

Confidentiality All clients understand that what they tell me in sessions is confidential with the exceptions to confidentiality being in disclosures of terrorism, if requested by law enforcement or following a court subpoena. It's explained to clients that if I suspect that there is a risk of harm to them or to anybody else that we must then have a conversation about how we can make a situation safe and only if I can not be confident that the situation is safe will I need to take steps to involve other people, constituting a breach of confidentiality.

I have received advice from Dr Janet Holt and Dr Kuldip Bharj on the question of how to handle disclosures from participant clients of their responsibility for criminal acts. The ordinary professional position amongst counsellors and psychotherapists is that confidentiality will not be breached in situations of criminal disclosure unless it was believed that the client themselves or somebody else may be at risk of harm. If a client disclosed that they were smoking cannabis or were shoplifting for example, we would encourage them to desist from these activities – stopping cannabis has health benefits – but the risk of harm to self or others would ordinarily not be considered serious enough to breach confidentiality. Drs Holt and Bharj confirmed that my policy on criminal disclosure would have to be different for research participants, with a broader consideration of disclosures that could potentially bring the university into

disrepute. For example current fraudulent activity might be considered to be a serious criminal disclosure justifying breaching confidentiality, whereas other disclosures, such as of a client watching a TV without a license might not justify such a breach. This policy is explained within the Participant Information Sheet so that the participant client understands the additional conditions of their confidentiality. Where disclosures are made that may fall into the category of a criminal disclosure these will be discussed within the research team e.g. myself and my three supervisors, to decide whether maintenance of confidentiality in this instance might have the potential to bring the university into disrepute and if we could not be satisfied about the appropriate way forward we would seek advice from the University Legal Advisor, without revealing information that may compromise the client's anonymity.

Anonymisation Data collected for the purposes of research will be anonymised using the following principles: replacing names with numbers or letters, substituting specific ages for age categories (e.g. client in their twenties), substituting specific locations for demographic types (e.g. post-industrial town in Northern England), and altering or omitting of any turns of phrase that may be idiosyncratic to the person or revelatory about their background. If a specific detail in a client's case is essential to appreciating the essence of the data e.g. the client is a nurse and is particularly distressed by an experience on his shift, other details will be altered to conceal identity, for example changing sex or age bracket or another factor that is not essential for appreciating the essence of the data. These same systems of anonymisation I plan to carry through the production of the thesis and further publications.

Withdrawal and destruction of data Clients will be informed that certain pieces of evidence can be destroyed at any time – for example any sound recordings or other materials that may be collected as identified earlier. If a client withdraws from the research, data collected for the research on their case will be destroyed in its entirety. I have decided that the client's opportunity to withdraw from the research will expire upon the deadline Friday, 30th November 2018 so that the thesis can be produced. * Please see earlier justification in section C12 for revision of this date.

C.20 How will you make your research data available to others in line with: the University's, funding bodies' and publishers' policies on making the results of publically funded research publically available. Explain the extent to which anonymity will be maintained. (max 200 words) Refer to <http://ris.leeds.ac.uk/ConfidentialityAnonymisation> and <http://ris.leeds.ac.uk/ResearchDataManagement> for guidance.

I believe I have already addressed the principles set out in the two websites identified via the hyperlinks. Please see my answers to section C19 as the most comprehensive review of my confidentiality, anonymisation and data management policies. The answers demonstrate that I will protect my clients' anonymity in all publications from the research project.

I have identified several forms of dissemination, these include: the thesis, related journal articles, conference presentations, University teaching, and CPD training. Where client data is referred to in any of these media, their confidentiality and anonymity will be protected as set out in previous sections. Clients that are interested in reading academic publications will receive manuscripts sent to them directly without any breach of copyright occurring. Wider public dissemination might include blogging or website articles for example, however in these media I do not envisage it being necessary to use client data directly but rather to focus in on particular findings from the present and future studies and elucidate these in more general terms accessible to the layman.

C.21 Will the research involve any of the following activities at any stage (including identification of potential research participants)? (Tick as appropriate)

- Examination of personal records by those who would not normally have access
- Access to research data on individuals by people from outside the research team
- Electronic surveys, please specify survey tool:
_____ ([further guidance](#))
- Other electronic transfer of data
- Use of personal addresses, postcodes, faxes, e-mails or telephone

numbers

- Use of audio/ visual recording devices (NB this should usually be mentioned in the information for participants)
- FLASH memory or other portable storage devices

Storage of personal data on, or including, any of the following:

- University approved cloud computing services ([Microsoft Office 365 for email](#) (Exchange online) and [Microsoft OneDrive for Business](#))
- Other cloud computing services
- Manual files
- Private company computers
- Laptop computers
- Home or other personal computers (not recommended; data should be stored on a University of Leeds server such as your M: or N: drive where it is secure and backed up regularly:
<http://ris.leeds.ac.uk/ResearchDataManagement>.)

C.22 How do you intend to share the research data? (Indicate with an 'X') Refer to <http://library.leeds.ac.uk/research-data-deposit> for guidance.

- Exporting data outside the European Union
- Sharing data with other organisations
- Publication of direct quotations from respondents
- Publication of data that might allow identification of individuals to be identified
- Submitting to a journal to support a publication

- Depositing in a self-archiving system or an institutional repository
- Dissemination via a project or institutional website
- Informal peer-to-peer exchange
- Depositing in a specialist data centre or archive
- Other, please state: In teaching and training settings it may be valuable to direct quotations of other data from client case work in order to illustrate themes. The principles of anonymity, as set out in section C19 will be observed, and the possibility of data used in this way is identified in the participant information sheet.
- No plans to report or disseminate the data

C.23 How do you intend to report and disseminate the results of the study? (Indicate with an 'X') Refer to <http://ris.leeds.ac.uk/ResearchDissemination> and <http://ris.leeds.ac.uk/Publication> for guidance.

- Conference presentation
- Peer reviewed journals
- Publication as an eThesis in the Institutional repository
- Publication on website
- Other publication or report, please state:

- Submission to regulatory authorities

Other, please state: ___ I am particularly interested in the possibilities of sharing themes from the research in teaching and training settings, for example delivering a Continuing Professional Development class on psychotherapy for people that present with somatic (physical) symptoms. Additionally the PhD research will inform class teaching that I provide at the University. In both these settings I may wish to use case vignettes to illustrate ideas, with all the ordinary principles of anonymity as set out in C19 will be observed, and the possibility of using data in this way is identified in the participant information sheet. _____.

No plans to report or disseminate the results

C.24 For how long will data from the study be stored? Please explain why this length of time has been chosen.³⁸ Refer to the [RCUK Common Principles on Data Policy](http://ris.leeds.ac.uk/info/71/good_research_practice/106/research_data_guidance/5) and http://ris.leeds.ac.uk/info/71/good_research_practice/106/research_data_guidance/5

Students: It would be reasonable to retain data for at least 2 years after publication or three years after the end of data collection, whichever is longer.

Where participants have remained in the study beyond the deadline of Friday, 30th November 2018 I envisage indefinite archiving of data (please see section A10, subheading **Retention of data beyond present research period**)

CONFLICTS OF INTEREST

C.25 Will any of the researchers or their institutions receive any other benefits or incentives for taking part in this research over and above normal salary or the costs of undertaking the research?³⁹

Yes No

If yes, indicate how much and on what basis this has been decided

C.26 Is there scope for any other conflict of interest?⁴⁰ *For example, could the research findings affect the any ongoing relationship between any of the individuals or organisations involved and the researcher(s)? Will the research funder have control of publication of research findings? Refer to <http://ris.leeds.ac.uk/ConflictsOfInterest>.*

Yes No

If so, please describe this potential conflict of interest, and outline what measures will be taken to address any ethical issues that might arise from the research.

C.27 Does the research involve external funding? (Tick as appropriate)

Yes No ***If yes, what is the source of this funding?*** ___ University Research Scholarship, University of Leeds

NB: If this research will be financially supported by the US Department of Health and Human Services or any of its divisions, agencies or programmes please ensure the additional funder requirements are complied with. Further guidance is available at <http://ris.leeds.ac.uk/FWAcompliance> and you may also contact your [FRIO](#) for advice.

PART D: Declarations

Declaration by Chief Investigators

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to abide by the University's ethical and health & safety guidelines, and the ethical principles underlying good practice guidelines appropriate to my discipline.
3. If the research is approved I undertake to adhere to the study protocol, the terms of this application and any conditions set out by the Research Ethics Committee.
4. I undertake to seek an ethical opinion from the REC before implementing substantial amendments to the protocol.
5. I undertake to submit progress reports if required.
6. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the University's Data Protection Controller (further information available via <http://ris.leeds.ac.uk/ResearchDataManagement>).
7. I understand that research records/ data may be subject to inspection for audit purposes if required in future.
8. I understand that personal data about me as a researcher in this application will be held by the relevant RECs and that this will be managed according to the principles established in the Data Protection Act.
9. I understand that the Ethics Committee may choose to audit this project at any point after approval.

Sharing information for training purposes: I would be content for members of other Research Ethics Committees to have access to the information in the application in confidence for training purposes. All personal identifiers and references to researchers, funders and research units would be removed. **YES**

Optional – please tick as appropriate:

Principal Investigator



Signature of Principal Investigator:

..... (This needs to be an actual signature rather than just typed.

Electronic signatures are acceptable)

Print name:John Hills..... Date: (dd/mm/yyyy):07/05/2017.....

Supervisor of student research: I have read, edited and agree with the form above.



Supervisor's signature: (This needs to be an actual signature rather than just typed. Electronic signatures are acceptable)

Print name:Jane Cahill..... Date: (dd/mm/yyyy):
..07/05/2017.....

Please submit your form **by email** to researchethics@leeds.ac.uk or if you are in the Faculty of Medicine and Health FMHUniEthics@leeds.ac.uk. **Remember to include any supporting material** such as your participant information sheet, consent form, interview questions and recruitment material with your application.

To help speed up the review of your application:

- Answer the questions in plain English, avoid using overly technical terms and acronyms not in common use.
- Answer all the questions on the form, including those with several parts (refer to the [guidance](#) if you're not sure how to answer a question or how much detail is required).
- Include any relevant supplementary materials such as
 - Recruitment material (posters, emails etc)
 - [Sample participant information sheet](#)
 - [Sample consent form](#). Include different versions for different groups of participants eg for children and adults, clearly indicating which is which.
 - Signed [risk assessment](#) (required for all activities taking place off-campus).

Remember to include use [version control](#) and meaningful file names for the documents.

- If you are not going to be using participant information sheets or consent forms explain why not and how informed consent will be otherwise obtained.
- If you are a student it is essential that you discuss your application with your supervisor.
- Submit a [signed copy](#) of the application, preferably electronically. Students' applications need to be signed by their supervisors as well.

Appendix 3: Participant Information Sheet



UNIVERSITY OF LEEDS

School of Healthcare Studies

Participant Information Sheet (V3)

A multi-case study of psychotherapy for people who present with somatic symptoms: tracking patterns of change and facilitative elements in collaborative work with the client

Researcher: John Hills

Supervisors: Dr Jane Cahill, Dr John Lees & Professor Dawn Freshwater

I would like to invite you to take part in this study but before you decide, please read the following information.

What is the purpose of this study?

You've been invited to take part because you've mentioned having physical symptoms: these are known in psychotherapy as somatic symptoms. Whether or not you decide to take part in the study this won't affect the care you receive in any way. And if you did decide to take part in the study but then later changed your mind, you can leave the study without this affecting your care in any way: your therapy will continue as normal.

The purpose of the study is to identify:

- any changes that you experience in your symptoms or in your wider life during therapy
- any patterns that those changes followed
- what aspects of the therapy supported any changes that did occur, and
- what aspects of your life outside of your therapy might have supported those changes too.

I am very interested in your own views on these questions and will encourage you to give your views during your therapy.

Who is doing the study?

As well as being your therapist, I am the researcher, working towards a PhD qualification. I am supported by three experienced supervisors: Dr Jane Cahill and Dr John Lees, based at the University of Leeds, and Prof Dawn Freshwater, based at the University of Western Australia.

What will be involved if I take part in this study?

Your therapy will be just the same, week by week, whether or not you decide to take part. We will meet weekly for fifty minute sessions, and then approximately every six weeks we'll have a review session where we'll discuss how you feel the therapy's going and whether you're experiencing any changes. Usually in the review sessions we decide together whether it will be helpful to book more therapy and what would be helpful to work on in those sessions.

If you decide to take part in the study:

- Your therapy sessions will be recorded using an audio device. You will be able to request to stop the recorder at any point and will be able to request any recordings to be deleted.
- Your confidentiality will be protected in the same ways I explained to you when we met. However if you tell me about any serious criminal activity I may not be able to maintain confidentiality. Examples of serious criminal activity might include burglary, drug dealing or fraud. If I felt something you'd told me was so serious I could not maintain confidentiality I would explain my concerns to you first.
- One month after the end of your therapy you will be sent a report about your therapy by secure courier delivery and you will be invited to write a response letter or record a spoken response. This might take about an hour to do, but you could say as much or as little as you wanted. You'll also have the opportunity of a free therapy session to come back in and explore your thoughts and feelings about the report and have any questions answered. However you won't have to do anything if you don't want to.
- Three months after the end of your therapy I will make contact to ask you how things are for you at that point, about your symptoms and whether any changes we did identify in our work together have held. This phone call will take a maximum of twenty minutes. However you won't have to provide any information if you don't want to.

I will use the audio recordings, any other materials such as drawings or letters you shared with me, my own notes, and your response letter/recording as data. These will help to reveal any patterns your symptoms followed, any changes that occurred for you, and what factors helped these changes to come about.

Will I be anonymous?

Yes you will. In any writing I do about your therapy, I will remove all names and replace these with letters or numbers. Specific facts such as age, or any places or occupations that you talk about will be made less specific e.g. if you are 47 years old, you could be described as 'in your forties'. However if I think any of your information could mean you were identified I will change details, for example: an electrician could become a plumber, a holiday in Spain could become a holiday in Italy, and a distinct phrase used could be replaced with another.

Will the information I give be kept confidential?

Your consent form will be kept in your file in a locked filing cabinet in the administrative office of (text redacted). Any information I collect for the study, including the recordings, will be kept on a password protected computer at the University of Leeds, and will be encrypted so your data are secure. The data will be stored in no other place and the audio recorder's files will be deleted as soon as they are put onto the computer. During the study only I will have full access to these data, however some data will be shared with my three supervisors so they can help me develop ideas. Nobody else will have access to these data for the duration of the study.

At all times your information is protected under the Data Protection Act 1998.

What will happen to the results of the study?

I will write a large report – called a thesis – and will write about findings from the study in academic journals and explain these findings at conferences. The findings will also be delivered in training sessions to benefit other counsellors and psychotherapists, and in teaching situations to benefit students. You'll be anonymous at all times.

What are the advantages and disadvantages of taking part?

By taking part in this study you will help us to develop new theories on how we can better help people who come for psychotherapies suffering with physical symptoms. We intend for the findings of this study to be helpful to other therapists working with their own clients, as well as improving training in this area.

You may find the final report and publications interesting. Some clients say the publication of research they took part in helped them to see their therapy as an important milestone in their life.

However some clients are disappointed to read the final report as they believe they have been misunderstood or that important things have been missed. The six week reviews and the response letter or recording at the end are there to make sure your feelings and views are heard loud and clear.

Because the therapy is no different week by week whether or not you choose to take part, there's no extra time commitment. However writing or recording your response at the end of therapy, coming in for the free therapy session, and providing feedback over the phone three months after your therapy ends will take up some of your time if you decide to take these opportunities.

Can I withdraw from the study at any time?

If you decide in the 2nd session to take part in the study you have the opportunity of withdrawing from the study at any point up to Friday, 30th November 2018. This date is set so that I can produce the thesis. You can withdraw from the study either by telling me, or by informing the clinical manager (text redacted) or at (text redacted) and you don't need to provide a reason. If you decide to withdraw from the study all data we have gathered about you (recordings, notes etc.) for the study will be destroyed.

If you remain in the study, your data may also be of benefit to further research after the end of the present study. On the consent form you can state whether you're happy for your data to be used for further research or just for this study. Further research would continue to look at whether there was evidence of change, whether change followed any patterns and how your therapy and other events might have supported any changes.

After this study is completed your recordings and all other data would be transferred into a secure archive at the University of Leeds. Your data would be used for no other purposes and you would continue to remain anonymous at all times. I (John Hills) would continue to manage your data and they would not be passed to third parties.

Who has reviewed this study?

Ethical approval has been granted by the School of Healthcare Research Ethics Committee (*HREC16-043: Tuesday, 3rd October 2017*).

What happens now?

Please consider this information carefully. When I see you for your 2nd therapy session you'll have the chance to ask me any questions you have and once you're satisfied with the answers, I'll ask you whether you wish to take part in the study. If you do wish to take part we need to complete the consent form together in your 2nd session. If you decide not to take part this won't affect your therapy in any way.

If you would like more information or have any questions or concerns about the study please contact me, John Hills, on (text redacted), or at hc11j3wh@leeds.ac.uk.

Thank you for taking the time to read this information sheet (V3).

Appendix 4: Participant Consent Form



UNIVERSITY OF LEEDS

School of Healthcare Studies

Participant Consent Form

Project A multi-case study of psychotherapy for people who present with somatic symptoms: tracking patterns of change and facilitative elements in collaborative work with the client

| Please confirm agreement to the statements by putting your initials in the box below ▼ | |
|--|--|
| I have read and understood the participant information sheet (V3) | |
| I have had the opportunity to ask questions and discuss this study | |
| I have received satisfactory answers to all of my questions | |
| I have received enough information about the study | |
| I understand that I am free to withdraw from the study:- 1 At any time up to Friday, 30 th November 2018 2 Without having to give a reason for withdrawing 3 And as such all data collected about me for the purposes of this study will be destroyed. | |
| I understand that I will be asked at regular intervals whether I'm happy to continue to participate in the research. | |

| | |
|---|-------------|
| <p>I would like to be asked every: week / 2 weeks / 3 weeks / 6 weeks (please state)</p> <p>I would like to be asked: in session / by telephone / by email / other (please state)</p> <p>I understand I can ask questions about the research, or change these options, at any time.</p> | |
| <p>I understand that my therapy sessions will be audio-recorded, and that I can request for the audio-recorder to be stopped, or recordings to be deleted, without needing to provide a reason, at any point up to Friday, 30th November 2018.</p> | |
| <p>I understand that any information I provide, including personal details, will be kept confidential, stored securely and only accessed by those carrying out the study.</p> | |
| <p>I understand that any information I give may be included in published documents but all information will be anonymised: my anonymity will be protected at all times.</p> | |
| <p>I understand that following completion of the study my data may be of benefit for further research and publication as explained in the Participant Information Sheet (V3).</p> <p>I understand the aims of that further research, that my data will be used for no other purposes, that John Hills will continue to manage these data and they will not be passed to third-parties.</p> <p>I would be happy for my data to be retained for further research: yes / no (please state)</p> <p>I understand I can change this option at any time up to Friday, 30th November 2018.</p> | |
| <p>I agree to take part in this study</p> | |
| <p>Participant Signature</p> | <p>Date</p> |
| <p>Name of Participant</p> | |
| <p>Researcher Signature</p> | <p>Date</p> |
| <p>Name of Researcher</p> | |

Appendix 5: Case report example – Michael

Case report for Michael (m/40s)

Schedule of psychotherapy sessions



Presentation

Following complications at birth, Michael was born with a medical condition associated with spasms and tremors that limited coordination particularly in his hands and his arms. As Michael insisted throughout his therapy, he had a good childhood, and although had experienced some “name calling” at school was always able to “brush it off” and had not had problems making friends. Because of difficulties with more academic activities such as writing, Michael understood at school that as an adult he would have a “practical” job, and after leaving school trained as a plumber. Michael married in his twenties and became a father in his thirties.

However Michael came to counselling presenting with two significant difficulties:

- 1) For approximately ten years he had begun to become self-conscious when his arm and shoulder began to tremor and spasm. Michael had become anxious about how other people would perceive him and recognised a vicious cycle whereby the harder he tried to suppress tremors the more exaggerated they became. At the time of seeking counselling this problem was getting worse.

- 2) Throughout a similar timeframe Michael reported intimacy issues in his marriage. He and his wife had not had sexual relations in several years and Michael had started to use pornography – something he felt ashamed about. As he explained: since becoming parents life had increasingly revolved around the children leaving no time for one another.

The organisation that I provide counselling through uses the Patient Health Questionnaire-9 and the Generalised Anxiety Disorder-7 psychometrics for outcome measures. Michael's pre-therapy scores were 1 and 1 respectively. The statements he endorsed were 'feeling bad about yourself' and 'feeling nervous, anxious or on edge' (several days over the previous fortnight). In other circumstances one might look at these low scores and consider why the person had sought counselling, but as Michael himself explained: his experiences of anxiety were acute and intense, though limited to those moments where he felt exposed in his tremors – hence the low scores. (In the fifth session Michael's scores were 0 and 1 respectively, and in the final session 0 and 0).

Michael had had 12 sessions of Cognitive Behavioural Therapy approximately two years before beginning therapy with me to work on the first presenting problem and said that he learned some "relaxation techniques" but that had not found the therapy very useful.

In his assessment Michael recognised that he didn't expect a cure – the physical condition was something he would have throughout life, however he wanted to alleviate the anxiety he felt about the tremors. In the first session, which was not recorded, I made two suggestions to Michael in order to help manage his affect:

- To address the excessive self-consciousness he reported I suggested that he might in public situations become an observer of what other people were doing, as a way of shifting the attention away from himself.
- And to address situations of heightened anxiety I suggested some affect management techniques including breathing, posture and focusing.

Because Michael had identified physical symptoms in his assessment I invited him to take part in the study and in the second session he consented to join. Of the two suggestions I had made in the first session Michael evidently found the first to be useful, and referred to this in later sessions. The latter suggestion did not appear to have been particularly helpful, and indeed as I got to understand Michael's situation better I realised that his anxiety levels did not become intense enough to warrant the techniques I'd suggested.

Contents of the report that follows

Negotiation of a mutual formulation – Michael and I reach a consensus on the agenda for our work together, including the creation of a Hierarchy of Exposure, details of breakthrough experiences for Michael using this technique, and further revisions of Michael’s agenda for change.

Potential mechanisms of action

- 1) Greater openness
- 2) Developing reflective function in problematic situations
- 3) Greater compassion for ‘inner being’ including some thoughts on the ‘psychosomatic profiles’ of different voices that appeared to present in Michael’s narrative
- 4) Counselling as a symbolic ‘line in the sane’

A presenting problem not directly addressed, including some consideration of counter-transferential events, and my experience of our work together being ‘in a box’

Research effects – a consideration of potential mechanisms relating to Michael’s participation in the research

Timeline of Michael’s therapy in order to analyse the work longitudinally, including some thoughts on the trajectory that our work appeared to take

Questions I would like to ask Michael (in anticipation of our meeting to discuss the report)

Negotiation of a mutual formulation

The first three sessions involved a degree of uncertainty between us about how to make sense of Michael’s problem and thus the path our work together should take. In the second session, Michael described the time (of approx. 10 years ago) when he’d first been troubled by self-consciousness about his tremors (T = therapist):

T: And how did it first start to creep in, what did you notice?

Michael: Ahh ((high pitched)) I just (.) I noticed it (.) when I was working and people were (2.0) probably when my boss at the time was, sort of looking at me or telling me something, and I noticed myself sort of tensing up and I thought why (.) do I feel threatened with my boss when I’ve worked with him for (.) ten twelve years before that, so it’s not (.) it wasn’t like it was new situation [yes, yes].

Thus we tried to make sense of what it was that was going on for Michael. We went on in the session to try to understand the interpersonal ideas that may have been at work. In the following passage we consider what it’s like when Michael discusses his disability with someone:

T: I get the impression that one of the potential thoughts that went along with that before you start to talk about it is that sense of (.) are they noticing it [yeah yeah] are they aware of it, kind of thing, yeah?

Michael: That's it. How long have they noticed it and have they just decided to say something now or have they just (.) you know

T: I se:e ((said as though I finally get it)) so even when you start talking about it [yeah yeah] there's also that sense of how long have they been aware of it?

Michael: Yeah yeah have they just been polite and not said anything or, you know (.) obviously you don't know without asking ((said with a stifled laugh))

T: No that makes sense, that makes sense, absolutely [So, so]

Michael: So then you know you think in your head: 'God has it really been that (.) pronounced for the last, I don't know, (.) six months that I've been working for them or whatever (.) they've known me or whatever or is it just (.) the odd time that they've noticed it' [yes yes]. That's it ((said as though concluding))

T: And you don't know

Michael: No

T: And it's the unknown that ((inaudible as overlap with Michael))

Michael: Yeah yeah I think so (.) it's that (.) yeah sort of the unknown ((quieter as though trailing off))

By the end of the second session we had agreed between us that significant to the problem was Michael's discomfort with being perceived as "different". In that session I began to feel that perhaps a cognitive behavioural technique – known as the 'hierarchy of exposure' – may be useful to Michael and so explained how it would work. That in producing a hierarchy of exposure one lists certain acts or situations that are associated with a phobia and then these items are then ranked according to their difficulty. Then the idea is that the client is encouraged to begin with the least difficult as a behavioural goal for the week ahead and thus work up the hierarchy. Because the client is themselves actively deciding to expose themselves to their fear, they transition from being passive to active in the situation. However when I explained this concept to Michael he was initially not convinced – he specifically did not like the idea of having his tremors seen by others. To his mind he wanted to learn a technique so that nobody would ever see his tremors.

The third session did not break this impasse as given the structure of our calendar it was the last session before Christmas and so we reviewed Michael's therapeutic goals – essentially clarifying the initial aim of alleviating anxiety. I asked Michael in what areas he would like to see change, and we settled on the following:

Relaxation in certain scenarios – being able to stand back and see the bigger picture

'Standing tall' in company of people you don't know

Confrontation – assertiveness. Being able to when necessary.

Each of these therapeutic goals was relational in nature, and indexed back to the two presenting problems. The social nature of the goals reflected Michael's anxiety that he might be perceived as "less than" other people if they were to see his disability. The third area relates more directly to communication difficulties with his wife – Michael was anxious about disagreeing with his wife in case this led to an argument which made the problems between them worse.

The fourth session after the Christmas break was the session in which we agreed on a formulation. Michael endorsed my way of phrasing it that we were working on a 'phobia of having your disability seen'. Conceptualising the problem as a phobia reinvented the original suggestion of creating a hierarchy of exposure and during this session Michael was significantly more open to the idea.

There was another case also to be made for the use of a cognitive behavioural technique which was that by the fourth session I was acutely aware of the absence of emotional affect from the content of our discussions. Michael and I discussed this directly though Michael always explained this as simply not his style, that he didn't get emotional about things, however conceded that that "might be part of the problem". As a man with an engineer's brain I had the impression that Michael would appreciate a practical, technique-based approach rather than working on a more narrative or symbolic level. Use of the hierarchy would give our work a structure week by week in the absence of developing emotional content, and indeed I expected that emotional experience would be activated through Michael's practicing of the behavioural goal in the coming week.

Hierarchy of exposure as generated collaboratively in 4th session

I was impressed by Michael's pro-activity in generating the hierarchy of exposure in the fourth session. He took up my phrase about "small increments" and understood how he could introduce that into his design. So Michael recognised greater anxiety in holding a drink that was full as opposed to one that was empty for example. Follows is the hierarchy we generated:

LEAST DIFFICULT

Putting out plates for the kids, extending arm at home

Carrying a straight glass empty / half-full / full

Carrying a wine glass empty / half-full / full

Telling someone that your arm is a bit tight and you might need to stand up and free it up

Writing something down e.g. in front of a customer

Volunteering to do an intricate task in front of a customer [text redacted to protect anonymity]

MOST DIFFICULT

As Michael began to practice the exposures, we added a later amendment which recognised that different witnesses to his tremors invoked different levels of anxiety: younger people or older people invoked less anxiety for Michael than having people his own age witness his tremors. Michael attributed this to issues of status that were more intense around people his own age.

Breakthroughs applying the exposure technique

It is my belief that the hierarchy of exposure did deliver the desired structure and thus a sense of purpose to our work which Michael himself was increasingly motivated by. Whilst our progress was somewhat interrupted by a missed session due to heavy snow, Michael did gradually start to incorporate exposures into this week. By the seventh session Michael reported two very satisfying exposures. One in which he'd taken a cup of tea from a customer and explicitly referred to his tremors i.e. drew her attention to them; the second in which he wrote a quotation for a customer in front of them – something he would normally do out of eyeshot. That first exposure is captured in the following excerpt:

Michael: That (.) worked out because, you know, I (.) I (.) don't know when it was now – might have been last week some time – she gave me a cup of tea outside and I took it and just had a slight tremor because I had to take it [ok yes] so I forced myself, and I (.) said "sorry about that, I've got some problem with my arm", [yes, yes] I did actually tell her [yes] said "it's just a bit of nerve damage" you know. I didn't go into detail I just s-squirted over it [O↑:k], sort of thing, and she says "oh, not a problem". So, like I say, that made me feel (.) well why, you know, why have I got this problem when I can just say that when something does happen [yes, yes], you know, rather than (.) worrying what's going to happen [yes] you know, if I can just let it happen, and if it does happen it happens and I can just (.) deal with it then [yes, yeah] and I can just apologise or just think it's been alright – it's not been a problem.

As Michael reflected after the event: “what was I worried about?”. My belief is that by actively initiating his own exposure, Michael had discovered a degree of mastery over the problem he had not experienced before.

Throughout the rest of our work together Michael continued to practice the exposure techniques when he saw the opportunity. It is not possible to say at the time of writing this report whether Michael has experienced a reduction in symptom frequency e.g. the times when a spasm or tremor becomes amplified due to self-consciousness. This is due to sporadic nature of the times when self-consciousness could become an issue e.g. in social situations, nights out etc. However I hope to enquire with Michael at the three month follow-up as to whether he believes there has been any reduction in the frequency of these symptoms.

Further revision of the therapeutic goals

Also in the seventh session, following our celebration of progress being made, we returned to Michael’s identified therapeutic goals originally itemised in the third session. We discussed whether and to what extent he had experienced change in the different areas, what might have contributed to these changes, and whether we would seek to further clarify or rephrase the change agenda. The resultant statements we thus generated together:

Relaxation in certain scenarios – being able to stand back and see the bigger picture. Some sense of progress here e.g. being able to tell customer and realising: “what was I worried about?”

‘Standing tall’ in company of people your own age

Communication: saying what I want. Confrontation – assertiveness. Reporting increased confidence in this area.

Progress in the first statement was directly attributed to Michael’s practicing of the exposures. The second statement is focused more directly on people Michael’s own age, himself having recognised feeling more comfortable in the company of younger people and older people with whom issues of status are not as apparent. And although my own sense was that we did not adequately get to grips with Michael’s difficulties in communication with his wife, in the seventh session he was reporting greater confidence in being able to give his own opinions and not be afraid of how his wife would react.

In the following sections I explore the headline ideas that emerge from my understanding of Michael’s therapy.

Potential Mechanisms of Action

1) Greater openness

I believe there were four potential primary mechanisms of action underpinning the progress and change Michael reported during his therapy. The first of these I've described as "openness" – a word that Michael himself used - and this is more particularly with respect to Michael being more open about his feelings or vulnerabilities in relation to other people. Michael contrasted this openness with a baseline state of "keeping your head down", in which Michael would strive not for anyone to see his vulnerability and would attempt to solve all difficulties internally without seeking anyone else's support. My belief is that the very act of Michael coming for counselling has helped him to see the values in being more open with others. Whilst our work together was structured according to a cognitive behavioural technique there was nonetheless space for Michael to talk more generally about his experiences in an unconditionally positive way, as the following passage from the second session indicates:

Michael: Daft as it may sound I actually feel quite comfortable with you, you know it's (said while laughing) it's credit to you, it's not (.) it's not a threatening situation or anything like that. And (.) like I said, it's (.) comfortable talking about it [yes] because it's (.) you're not trying to (.) find fault with it [no no absolutely not] that's the...

T: Yeah I'm just (.) there's a real sense of getting to know your story at the moment. That feels to be (.) kind of, the, the nature of the session that we're having today [yeah yeah]. (said in a different, higher tone) I just wonder how you'd feel if ever I did notice a spasm, you know, [I don't...] how would that be for you?

Michael: Probably now, not as bad because you know why [yes yes] And that's the daft thing (.) if (.) if you could walk into a crowded room and say RIGHT EVERYBODY, I'VE GOT THIS PROBLEM WITH MY ARM, IF IT DOES THIS THEN THAT'S WHY [yes yes]. And then, that's it, done ((both laugh)) But you don't do you? You know, I don't shout from the roof tops. I've never have (.) I've never played (.) played that (.) that card [yeah yeah] you know.

T: If you were obviously disabled like if you were in a wheelchair or something like that

Michael: Yeah like I said last week, it's a bit different and people (.) look at you and sort of say, what's wrong with you? [mmm mmm as though in agreement]

In the fifth session, when Michael began to tremor in session which was the first time I had witnessed them first hand, he relayed that he felt he didn't need to fight against it as this was "not a stressful situation".

The exposure technique in a more tangible sense helped to foster a new mindset in which rather than Michael feeling he had to hide his vulnerabilities at all costs, that it could feel safe and even comfortable to have his vulnerabilities seen. Indeed in the tenth and final session Michael places the importance of openness as foremost in the value he derived from counselling:

T: If you finish tonight and you go forward into the months and maybe into the years you know, (.) what (.) will you remember as being (.) I guess, what will you take from the counselling sessions?

Michael: Erm ((breathes out)) probably(.) to be more open, not to keep things in to myself ((said slowly deliberately)). Erm (.) no matter what, what it is. Whether it's this or anything in my life. I've been a very (.) erm (2.0) sort of self (.) conscious person [yeah] and I've kept things just to myself and not really done anything else about them. Just dealt with it myself. Probably to (.) share it a bit more erm (.) sort of talk to other people, you know (.) erm (.) about (.) you know, say (.) "I've got this problem" [yes yes] sort of thing. Like I said, I've told you more than what I've probably told anyone ever and that's (.) just the way it is. Even your best friend, sort of thing, because you think well "they've got their own lives, it's not ...". (2.0) When you do get over that hurdle of telling them and actually they're not... "Yeah fine, it's not a problem" ((imitating higher, reassuring voice)).

2) Developing reflective function in problematic situations

The second mechanism of action I believe to have been influential for Michael I have described as 'developing reflective function'. This is partly attributed to the client acquiring the capacity to take a mental 'step back' and observe their affects and cognitions during key situations and thus realise they had different behavioural options in the situation i.e. they are not fated to play out the same distressful patterns.

By the fifth session in January, having created the hierarchy of exposure the previous session, Michael started to report a greater awareness at the end of his day. He was able to look back at his day and observe the situations in which he may have had difficulties with his tremors and heightened self-consciousness, and also observe that those situations had passed without the difficulties being realised. By the seventh session – the same session in which Michael was reporting significant process made with his exposures – he spoke about "stepping back after the event and assessing how it went". The following passage from the ninth session indicates a degree of consolidation of that new-found confidence and the capacity to reflect after the event:

Michael: The thing that's (.) helped me and what you, sort of said, it's like you, "you go away after the session and you do this". Well I, I sort of go away and at the end of the day, as I've said to you, I look back at that day as to what (.), what bothered me and

what didn't bother me, and what situation, because when you're actually doing it (.) you don't sort of clock it, and then you just think "well hang on a minute, no that was alright, that was a potential problem, but actually I was alright". So I've gone through it (.) totally (.) oblivious as to what could have possibly been ((said slowly deliberately)). Now (.) it's might have been that it was doing it and I didn't know or it might have been that it wasn't doing it. Either way it's not a problem ((said emphatically)).

Whilst Michael's description of the therapy reflects the directive nature of the exposure technique, what this passage also indicates is Michael's internalisation of the reflective work we had been doing in each session – reconsidering situations and the internal experiencing of them.

3) Greater compassion for "inner being"

The third mechanism of action that I believe to have been influential I have described as a greater compassion for what Michael described as his own "inner being". Interestingly the character of this internal voice, or perhaps these internal voices, shifted from the early to the late stages of Michael's therapy, with the more compassionate voice(s) becoming better defined towards the later stages. In the third session Michael introduced his own dialogism which he described as an "inner demon" as reported verbatim in the following passage:

Michael: There's that (.) inner demon [Yes ((emphatically)) yes] you're going to fail, you're going to fail, you're going to fail, you're going to, you know (.) It's the two shoulders

T: Yes. Definitely, definitely ((louder)), yeah! I re:ally feel that ((excited)). Two shoulders... So one shoulder as you say, you've got, this inner demon saying: you're going to fail, you're going to let (.) in this case ((wife's name)) down, you're going to spill some of her drink, you're going to beat yourself up about it (.) afterwards (.) Even though ((wife's name))'s already got over it, she's just enjoying her beer, you're beating yourself up about it. Who's sat on the other shoulder?

Michael: That's (.) sort of like the (.) person saying you could have done that, if you really pushed yourself you could have done it. [Mmm-hmm mmm-hmm ((encouraging))]

T: So someone who believes in you. [Yeah yeah, it's...] Someone who knows you can do it.

Michael: Yeah self belief it's not quite there on that aspect. You know, some aspects it is, like I've said, in the work and that. It's that (.) that belief (.) overcoming that (.) [yes] feeling.

My own enthusiasm for Michael's creativity in this passage from the third session is clearly evident. This may have partly reflected excitement that we might be 'dropping down' a level from therapeutic discussions that were more literal in nature. However also I was pleased that Michael was spontaneously introducing an internal dialogue, when I'd been taking a particular interest in the theoretical literature around this topic at that time.

The following passage from the eighth session demonstrates Michael's developed capacity to articulate what that kinder, more compassionate voice sounded like:

T: So (.) you've talked about a demon on your shoulder before, so there's this one demon that can be very sort of (.) critical I guess is one word for it [yeah yeah yeah] "come on get on with it, come on keep going" (.) and this is you being able to listen to the other voice [yeah yeah that's...] the 'inner being' you mentioned. So what's the other (.) what kind of tone has the other voice, or what attitude does the other voice have?

Michael: It's more calming now I think [Mmm-hmm, mmm-hmm ((encouraging))] "just (.) just calm down and don't be silly" (.) sort of thing (.) erm (.) sort of (.) [yeah] the sort of (.) daft as it sounds, the way you might address a child [yes, well yes ((considering it as though for the first time))] who's very upset or whatever, "hang on, just calm down, just take a step back, it's not as bad as what it..." [brilliant] it's more like that now [yeah] sort of (.) just calm myself down, just not (.) erm (.) rushing to get (.) Just (.) I'm not, I'm not getting any younger ((both begin to laugh)) you know, you (.) you know (.) you get wiser with age, so hopefully you know that's the (.) thing, it's not just learning to deal with the practical but also the emotional [yes ((emphatic))] as well.

Psychosomatic profiles of the different voices

As Michael and I reflected on these different voices they evidently corresponded to different psychosomatic profiles too. When the "inner demon" was in the ascendancy the vicious cycle of self-confidence had tangible physical aspects: as well as heightened tension in Michael's arm and shoulder, also an increased pace of activity, as though hurrying himself along. When Michael's internal dialogue was more of the quality of talking to a child Michael reported slowing his pace down, and noticing his muscles begin to relax.

Reflective back following the cessation of our therapy, I believe that the dialogical aspects might have developed further – e.g. more keenly articulating those different voices - if not for the frequent interruptions in our therapeutic work as is evident in the Schedule of Psychotherapy Sessions section.

4) *Counselling as a symbolic 'line in the sand'*

The fourth potential mechanism of action is one that I've not discussed with Michael at the time of writing this report. However reflecting on our work I suspect that Michael understood both implicitly within the structured, purposeful approach and explicitly in the creation of the therapeutic goals, that change was our agenda. Michael considers his previous counselling – a run of Cognitive Behavioural Therapy – to have been primarily about relaxation techniques, whereas our own techniques were based upon exposure and improved communication. Michael has had difficulties with self-consciousness with respect to his tremors over the previous decade and perhaps this period of counselling served as a symbolic line in the sand – this problem will be addressed and got to grips with.

In the third session Michael identified with the mental image that had been invoked in my mind of a barrier to push through in those situations where self-consciousness was becoming a problem. In my notes from the fourth session I noted my own sense of how important it was to retain a structure to the sessions. The exercise I suggested for the fourth session explored subtext in social scenarios. Though the exercise itself did not bear much fruit, I had the sense afterwards that Michael began to adopt what I described as a "let's do this" attitude in my notes – basically a belief that we really can make a difference in this work together. In the fifth session Michael appeared more motivated and mobilised than before as though mirroring my own belief:

T: What's exciting (.) for me, sat here (.) today is that I'm hearing (.) you're not just talking↑ about erm giving yourself a push, I can hear it in you somehow, I can hear that you're sounding pro-active, you're going for this, your attitude has (.) has shifted into a proactive role here

Michael: Yeah. Like I said I do feel more positive and comfortable, going forward now, (.) and trying to get out of that rut↑, that's been the (.) the comfort blanket [yes yes], keeping my head down, sort of thing [mmm mmm]. Sort of just (.) standing up a bit more. And like you said: standing a bit (.) taller, just, when things are (.) sort of, starting to get to that point, just sort of taking a deep breath and looking around (.) seeing what else is going on in the world [hmm yes], instead of my world.

In our final, tenth session, Michael appears most strongly to provide evidence for counselling as a line in the sand in the following passage:

Michael: I spoke to my doctor a few weeks ago, regarding (.) because they'd, they'd offered at the beginning of these sessions, they'd offered medications, and one of them was (.) erm (.) diazepam [mmm-hmm]. And I thought: "No way, I'm not going down that road [mmm] even". So you know that was the only one that they could say may help [may help] and then there was all the side effects which obviously he'd listed [absolutely]. And I rang him up, you know, because he said "just make a telephone

appointment just to discuss it if you want...". And I rang him up and said "Look, I've found a way with these sessions" – you know, because he'd referred me to this, redirection to... [yes yes] – "that I'm actually dealing with it (.) erm from a mental point of view [yes yes] rather than from a medication and physical and that is actually better for me (.) than becoming reliant on a medical that might not even work [yes yes] that might (.) erm take... All these things do, I think, is take the edge off [mmm-mmm] you know, I think it's it's better (.) for me, it might be different for other people, you know, but for me (.) that in my mind, that I know I'm dealing with and not reliant upon (.) a medical substance to do it [yeah]. And I feel happier that way.

A presenting problem not directly addressed

Whilst up to this point I have considered the things that worked well during Michael's therapy, in one important respect I believe things did not go as well as they might have otherwise. Michael reported two key presenting problems in his assessment, though in our work together we focused on the anxiety and self-consciousness associated with having his tremors observed by others. Despite several attempts during our ten sessions to ignite discussion on the other key presenting problem – Michael's intimacy issues with his wife – we did not do any substantial work in this area. My feeling during our time together was that as we worked on the first problem that we would discover natural points of contact with the second. For example, we worked on how Michael communicated his needs to his wife about his tremors in public situations and I expected that these discussions would then explore the bigger picture of Michael's communication with his wife, though this did not happen.

It is important to state that Michael himself on several occasions endorsed better communication with his wife – not just on issues relating to his tremors but also more generally around areas of disagreement and/or asserting his own views and feelings. In the seventh session we recognised that work on the first presenting problem was assisting with the second problem without us working on it or addressing it directly.

Counter-transference

As is demonstrated in the timeline, I experienced difficulty with the lack of emotive content in our sessions. In the early stages of our work I searched for a way to 'drop down' a level in our discussions and noticed feelings of anxiety on my part when we did not. Indeed I also experienced somatic symptoms in the counter-transference – my own body felt to be tensing up, the pace of our discussions remained relatively fast with no significant pauses, and listening back to the recordings I noticed the tone of my voice was subtly at a higher pitch in work with Michael, perhaps reflecting physical constriction in my throat.

The experience of our work being 'in a box'

I experienced our sessions as though we were working within a 'box' with clearly defined edges. As long as we were working within the box – e.g. working on issues around Michael's tremors being seen by others – we worked fluently together. However when the discussion may have naturally have led beyond those limits, or indeed when I attempted to initiate a discussion beyond those limits, we seemed to hit a wall.

I reflected back to Michael on several occasions about the feeling of a lack of emotive content in our work and he insisted that was his style – he just wasn't an emotional person. The organisation that I provide counselling through uses the Patient Health Questionnaire-9 and the Generalised Anxiety Disorder-7 psychometrics for outcome measures. Michael's pre-therapy scores were 1 and 1 respectively. The statements he endorsed were 'feeling bad about yourself' and 'feeling nervous, anxious or on edge' (several days over the previous fortnight). In other circumstances one might look at these low scores and consider why the person had sought counselling, but as Michael himself explained: his experiences of anxiety were acute and intense, though limited to those moments where he felt exposed in his tremors – hence the low scores. (In the fifth session Michael's scores were 0 and 1 respectively, and in the final session 0 and 0).

One question that I struggled with was whether Michael was exhibiting alexithymia – the inability to access or to articulate one's own feelings which is often apparent with clients who present with somatic symptoms – or whether to take Michael's description of himself as not an emotional person at face value. As our work progressed I came to believe that implicitly it had been established between us that Michael and I would not work on the second presenting problem.

In recognition of the effect of research participation on the course of therapy, Michael remarked in an early session that "you seem to be more interested in the physical side". I clocked that as an early sign that maybe Michael then expected that we would not be doing any work on the second problem and so said explicitly that our work was not just limited to the physical side. In hindsight I have come to believe it was a mistake on my part to think that we could tackle both the core presenting problems simultaneously. Michael was clearly more comfortable talking about difficulties with his tremors than discussing intimacy problems, and now I believe I should have been satisfied to do the work we were doing rather than feeling as though we *ought* to be working on a different level.

Indeed in the fifth session, Michael began to introduce motifs that may well have led to work on the second presenting problem later in our work together. In this session he was most articulate about how he communicated with his wife and the difficulties

he faced. In the following passage he describes how the contrasting positions between being relatively avoidant and relatively open applied to his relationship with his wife:

T: I know last week we very much pitched it in terms of communication [yeh yeh ((short punctuated))], you know, and how you communicate with ((wife's name)) and is it possible perhaps that you're noticing some movement then in terms of your communication with ((wife's name))

Michael: Yeah yeah I think so, we're talking a lot more, and I don't mean about this and all the issues, but just general talking about things (.) erm (.) because (.) again I was (.) bad at dealing with the kids' (.) day to day stuff, you know like (.) packed lunches, [yes yes] their homework, all that. She'd do it, and me being me I'd let her do it, you know, because I don't like (.) to get involved (.) erm (.) in something that she's got (.) streamlined in the way she wants it. I don't want to come along and upset the applecart [mmm]. But she's said to me, she says: "I'd rather you did (.) I'd rather you would (.) put your input in and then.." [mmm^]. But then I'd say "Well what if you disagreed with it" and (.) that to me was (.) was a big issue [yes, yes] if she disagreed with something that I'm you know, trying to say (.) for example I just said "what about doing his homework this way" you know, and I'd be scared of her saying "well we've been doing it this way for the last twelve months" or whatever so why, you know, [yes] so then I'd just think, just keep quiet [I see]. So it was just keeping myself back a bit

T: Mmmm so when you said to ((wife's name)) what if you disagree, what did she say to that then, what was her view on that?

Michael: Erm (.) she said that's fine to disagree because she's (.) she's said to me before, over this period of time, you know, "it's not bad to get angry, and argue, because it does solve the problem sometimes, you know, instead of just walking away" [yes yes]. And that's why as I said to you before, it's about confrontation not conflict [mmm] – confronting things [yes, yeah] So I tend to think 'oh well hang on this might cause...', so I just won't say anything [mmm mmm ((short, punctuated))]

T: So in your avoidance of conflict [yeah] it's created a bit of space between you [that's right yeah] whereas if you a:re able to communicate that bit more, even^ if you disagree there's more of a closeness about it [yeah that's it].

What feels important in retrospect is that on the day of the next session, what would have been the sixth session, I had felt anxiety which I understood at the time to be about being able to keep our precious momentum going. As the day progressed snow fell very heavy and we made a mutual decision to cancel our session given the problems we might have encountered getting home afterwards. I noticed a feeling of relief for my part about our not having that session. Then when we did have the sixth session the following week I found it to be drained of energy, nothing we were really working on seemed to connect or have any momentum about it. It is possible that Michael was affected by my own internal dialogue of feeling that we *ought* to be

working on the second presenting problem and so subtly withdrew somewhat from the therapeutic work. Whilst the seventh session brought with it very positive developments in terms of the exposure techniques and a mutual experience of motivation about the work we were doing together, I noted in the eighth session a continued sense of there being a “box” around our work.

By the ninth session my feeling was that Michael was communicating already that he’d got as much as he’d wanted from counselling i.e. to work on the first presenting problem and that we’d already reached a plateau. In that session Michael spoke about his childhood and mentioned his mother and father’s separation, but when he mentioned what his Dad “did” he said that he “wouldn’t go into detail”. In the counselling session that felt like an indicator that limits had been drawn up about what would and wouldn’t be discussed.

In hindsight I could have taken a note of the motifs that Michael had introduced in the fifth session and accepted in myself that now was not the time to do that work. I believe Michael's answers to the PHQ9/GAD7s were accurate for each of the times he produced them. Though I suspect that if our work had continued and we’d begun to address the second presenting problem that there would be a great deal of emotion that may well have been activated both within and between sessions. As to what prevented us from moving into that different territory two possibilities may both have had influence. Firstly, the ninth session which already felt like a plateau was followed by my bereavement, meaning that the three sessions that we would have had in the run up to the next review were cancelled – what would we have discussed in those three sessions? Secondly, Michael may have been aware that the sessions were being recorded for the purposes of the research and in that context not felt confident to talk about that other matter. Indeed Michael opted to have the collect the case report from our building rather than have it securely delivered to his home.

Following the long break due to my bereavement, the session we organised, our tenth session was understood mutually to have been a final, wrap-up session. In that session Michael reported a breakthrough idea that seemed to have been generated with his wife – the idea of “acceptance” of physical limitations in some scenarios. This idea in its turn appeared to have been particularly beneficial for Michael and appears to have arisen as a consequence of him having counselling and thus him and his wife talking more directly about his vulnerabilities. As such then it appears reasonable to propose that subtle progress was made in the second presenting problem to the extent that Michael and his wife are communicating more explicitly and directly than they were before.

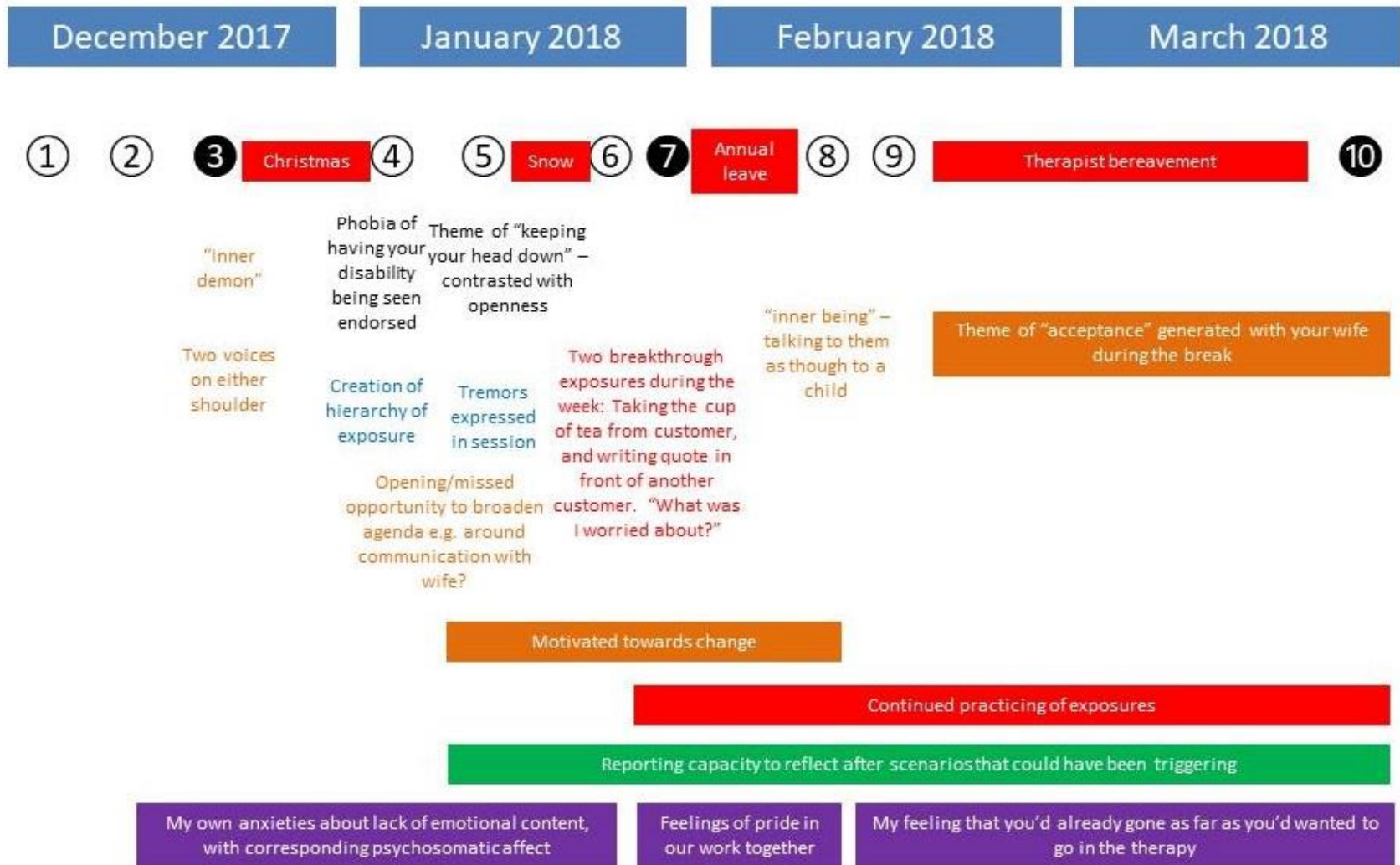
Research effects

I have already touched upon what I suspect to be the primary influence of Michael's participation in the research over his therapy: namely that it perhaps contributed to his limiting of the content and scope of our work together. I've also highlighted a remark from early in Michael's therapy that is clearly indexed back to Michael's awareness of the research: that "you seem to be more interested in the physical side". That this was in Michael's awareness almost certainly influenced the content of our work.

Other considerations also suggest at research effects. In the fourth session I noticed that Michael's eyes frequently glanced towards the audio recorder. My awareness (and anxiety) was that we were not discussing the other presenting problem however the times in which Michael's eyes glanced at the recorder didn't seem to correspond to any particular theme. In the next session as part of ordinary continuous consent I asked Michael explicitly whether he was aware of the audio recorder and he said he was not.

I'm also mindful that one aspect of Michael's presenting problems was the fear of confrontation and discomfort in asserting himself. This may have made Michael less comfortable generally in questioning aspects of this therapeutic process, and indeed may have made him feel he wanted to present a picture of progress for me to write about as he wouldn't want to let me down as I conducted my studies.

Returning however to the theme of counselling being a line in the sand, the research effects may not necessarily have been detrimental to the quality of Michael's therapy. Participation in the research may have bolstered Michael's sense that we were going to achieve something substantial together. One warning sign that a participant client is telling the researcher what they think they want to hear is when the client gives scripted answers based on common perceptions of counselling, such as 'it was important to talk to someone who wasn't part of my life', or 'counselling helped me to untangle all my worries'. However Michael's remarks in the wake of his successful exposures: "what was I worried about", for example, or his reports of being able to reflect on potentially distressing situations and realise "actually I was alright" appear to be authentic and personally meaningful revelations.



Timeline

Thoughts on trajectory (longitudinal analysis)

It is clear that thoughts on the longitudinal trajectory of Michael's therapy must include recognition of the frequent interruptions which meant we were not able to build up a sense of momentum in the way that is possible in an ordinary run of six sessions between one review and the next, which is what I plan for in my counselling practice. Following the Christmas break I had anticipated us having a run of five sessions until my planned annual leave but this was interrupted by the snow. Additionally, we had contracted for another run of five sessions after my annual leave which was then interrupted by my bereavement.

However some patterns can nonetheless be observed in this timeline. I had often attempted within my weekly note-taking to anticipate what trajectory our work together would take. I anticipated a sigmoidal form of progress: a period of establishment in which little change was observed would be followed by a period of substantial and rapid progress, which would be followed in turn by a plateau in which the gains would be consolidated. With respect to Michael's first presenting problem I believe we do see such a sigmoidal trajectory, with the period between the 4th and the 8th sessions accounting for Michael's gains. Such a 'sudden gain' would not be reflected in a PHQ9/GAD7 scoring as Michael's scores were so very low at baseline, and yet it is evident from the qualitative data. Because this sigmoidal form was in my mind this might be attributable to either a correct assessment of the potential of our work together, or a kind of self-fulfilling prophecy in which my expectations were implicitly communicated to Michael. My understanding of Michael's expectations of therapy is that he only imagined a short run of psychotherapy sessions so it may be indeed that the trajectory I anticipated was already influenced by that. In which case then it may be truer to say that the expectation of the trajectory our work would take was implicitly co-produced.

There are other patterns suggested by the timeline. I represent what I experienced as a surge of motivation from the fourth session that just preceded the gains that began to be endorsed strongly in the seventh session. One interpretation of this is that Michael (and I) had to first believe we could achieve something substantial together before that substantial progress could indeed be made. In that respect then the motivation might be considered to be a 'fuel' providing the energy of the subsequent gains.

As previously observed, the fifth session featured the opening of more extended discussions on the difficulties Michael experienced communicating with his wife, and the subsequent session felt drained of energy. This itself may have been fuelled by a sense of confidence and purpose in our work established in the fourth session just after Christmas. However it is often the case in counselling practice that a session in which the client begins to explore territory that feels 'riskier' is followed by a session in which the client withdraws again. In this case Michael had implicitly established the

boundaries of our work together and the sixth session may have represented an unconscious reassertion of those boundaries.

As previously observed, I note Michael's keener articulation of his "inner being" voice between the third and eighth sessions. Had our work continued, this work on his inner dialogue may have developed further. I would be interested to know whether Michael has continued to access that more calming voice at the three-month follow up.

In keeping with the sigmoidal pattern, Michael's eighth session took the form of consolidation of the ideas emerging since the fourth session:

T: So if we characterise that, you know, what is was, you know, before (.) or in the past [yep], you know, as a fear of having your disability seen ((spoken slowly in a deliberate way)) [yeah yeah yeah] (.) how do we describe this differently, what are you doing instead when you're taking the c-cup of coffee and...?

Michael: I don't know [it becomes a smooth movement]. I don't think I'm as conscious it's like more (.) back of the mind [aha] it's still there but as (.) as though this is a feat [ye:s yes yes] got to try and do it, it's more of a (.) smooth erm thing (.) erm (.) for me to, to, to do [mmm-hmm] (.) and it's not like (.) erm (.) euphoria after I done [yes] you know ((both slightly chuckling)) it's it's it's just starting to (.) not normal, not become normal but it is mo:re (.) normal than, you know, than it was.

By the ninth session I had the strong sense that Michael felt he had had as much as he wanted to get from counselling at this time. We had been scheduled to have a further three sessions in the 'block'. It is possible that in those sessions we might have returned to motifs relating to Michael's second presenting problem. Or alternatively those three sessions may have been light on therapeutically useful content as Michael implicitly withdrew.

Michael's therapy was a short 'piece of work' in which some promising behavioural blueprints were established. The difficulties that Michael has experienced with self-consciousness in relation to his tremors are c. 10 years old, and in the brief time we worked together it is not possible to make any conclusions about whether the behavioural principles we established together would 'take hold' and continue to be practiced in the months and years to come. Indeed Michael continued to recognise a distinction between situations in which anxiety was more intense with people his own age. Here too the three-month follow up may provide some valuable insights into what extent the work we did together did have lasting value for Michael.

Questions for Michael

- What's it been like to read through this report?
- Is there anything in the report that you didn't understand or that troubled you?
- Have I got anything wrong and/or is there anything you would change?

- How did you find out about this counselling service? E.g. were you referred?
- Did you experience this counselling as different to your CBT and if so how?
- How did you feel on the evening that we had to cancel the counselling because of the snow?
- From the sessions themselves, can you think of anything that was particularly helpful, and what made it so?
- From the sessions themselves, can you think of anything that was particularly hindering/unhelpful, and what made it so?
- Have other people noticed any changes in you?
- Are you continuing to dialogue with that “inner being” and/or that calming voice?

Appendix 6: Data as generated through case notes and reflective journaling

The thesis as delivered represents the conversion of my reflective process – as captured through my case notes, reflective journaling, use of supervision and personal therapy – into the formal development of theory. In this appendix item I provide some windows into the relatively raw data as collected through my journaling and the case notes I made following each session with participant clients. These relatively raw, unprocessed data indicate the emergence of themes which are formalised in the resultant thesis. Each section of this appendix offers some examples of those data arranged according to theme with brief commentary on each.

Indications in early case notes of the work we would go on to do

I note that early on in my work with Lou, indeed when first analysing the session we had on the 5th December 2017, Lou's second session, that I anticipated work that would only come to full fruition much later in our work together, over the summer of the following year.

'I have a burgeoning sense that there is an important and insecure attachment dynamic between [Lou] and her Mum [...] I have a sense that the potential for development is in the area of the dynamic of [Lou]'s relationships with her Mum and Dad - what has been silenced for so long that needs to be heard?'

These notes anticipate not just Lou's increasing competence in asserting her own position within the family, but moreover the later work we would do in addressing Lou's roles within a drama triangle that involved her Mum and her sister. Her relationship with her father received less of our attention although we recognised intense anger directed towards him that would manifest in her dream (as reported in section 3.1 of the thesis).

In a slightly later session, Lou's sixth on the 9th January 2018 I anticipated further developments:

'I have the sense listening back to this that [Lou] may be in danger of greater weight gain during this period of instability - being able to control diet and lose weight may be

an important indicator that you are moving in the right direction. It may be that us drawing attention to the question of why you dropped off the diet and why you didn't care can help you to take better control of it in the future.'

We did indeed come to a greater clarity on why Lou dropped off her diet which we situated within a greater relational context about control vs being controlled. By the end of our work together Lou reported a shift away from fixation with her weight and body image towards a positive promotion of fitness and health. Note that a couple of times in this passage I address the second person. At this point I was starting to get into the habit of writing my therapeutic notes as though written to the client – an approach congruent with the 'over the shoulder' approach to note-taking. It also reflects my growing interest in dialogical theory over this period.

Somatic theorising

Likewise there are examples in my note-taking of where I attempt to develop theories as to the meaning of certain somatic presentations in session. This passage is taken from notes following Lou's 11th session on 10th April 2018:

'You describe picking [husband] up drunk and it is another example of your anxiety that he might vomit which is triggering for you. And naturally this reminds me that we have a lot of tummy themed ideas here - from literally thoughts about your weight, and the original presenting difficulty that involved vomiting, the anxieties you have about other people vomiting, to the liberating idea of "fire in my belly".'

It is as though in passages like these I am attempting to fantasise about my client's somatic experience so as to model something that they are struggling to do for themselves. I continued to do this throughout our time together as this passage from Lou's 20th session on 3rd July 2018 indicates:

'I recognise that you've done well to get out tonight however as you will go on to explain, you needed to come tonight to get some things off your chest (interesting use of pun there given chest infection). Interestingly I start to feel a kind of aching in my chest as we talk as though I might be coming down with one too. I share this with you.'

However Lou never learned to fantasise about her somatic experience in the way that McDougall (1989) prescribed in her psychoanalytic work. Ultimately my sense was that this invitation to fantasise flat however might have been more successful with a different client.

Subtext and implicit communications

I also notice within my case notes passages in which I am attempting to make contact with implicit communications which might have been exchanged between my client and I in the subtext. For example in these notes from Myrtle's second session on the 19th June 2018, I am trying to make sense of Myrtle's laughter, which I would later explicitly draw her attention to because to me it was curious:

'Your laughter when you say things that are compelling or even potentially emotional - sort of incongruent. As in, but don't think I think I should be taken seriously. It's almost a self-deprecating laughter.'

Following Myrtle's third session on 3rd July 2018 I make some further observations about the meanings underpinning what is being communicated:

'You describe a situation in the cafe where your Mum is punishing you by behaving outrageously [...] Sometimes it feels more like you enjoy just talking about your Mum to me, a stranger, because you know what an impression it will make on me, and it allows you to get it off your chest by turning it into an amusing story.'

When Jane, John and I went on to perform a hermeneutic analysis of my work with Myrtle – to appraise claims of change and causality – we considered explicitly the question of whether Myrtle sought to entertain me through these stories, however our determination was that nonetheless there was sufficient evidence to support the relational context of some of Myrtle's somatic experience and that relief from her ectopic heartbeats did appear to correspond to a shift in Myrtle's relationship with her mother.

Returning to work with Lou, there was an incident involving her husband which I found shocking, in which he had been in a city with Lou and had boarded a train home without her, leaving her stranded there, later offering the reason that he thought she

was trailing behind him. Whilst I tried to remain non-judgemental in my stance, my implicit communication betrayed my true feelings as this exert from 10th April 2018 (Lou's 11th session) indicates:

'I didn't comment on this at the time but you seemed to notice my silence at that point when you said "I was just like eh" - it was as though you wanted to communicate back that you understood the seriousness that I perceived in that event.'

The following session we returned to discussion on that incident and afterwards I made the following notes about the impact of my implicit communication upon Lou. The passage is also interesting because it offers a glimpse into my awareness of use of self:

'I immediately noticed that I betrayed too much of my own incredulity about the idea that [husband] could have got onto the train and not realised you were there. This was too judgemental of me, but I suppose in a way we're looking at a continuum between the implicit and the explicit. I don't want to put words in your mouth, and nor do I want to sow seeds of doubt.'

Notes from a slightly later session on 15th May 2018 (Lou's 15th) also indicate the subtle communications that were taking place between us following a conversation about sex which was somewhat exposing and associated with shame:

'You tell me: "I've never known you be so lost for words" and we have a laugh. I actually don't feel lost for words but that we're lingering on a very personal topic for you and that the experience of that is dropping down a level. But I also suspect you feel a bit more vulnerable talking about such a topic and so when I was quiet, although I felt relaxed, you might have needed to be reassured that I was on your side and didn't think any the worse of you.'

Parallels between personal process and client process

Throughout the data collection there are also some interesting examples of parallels between my client's process and my own as the therapist, and perhaps that my own personal processes shaped my attitudes towards what my client told me. A couple of examples from my notes on working with Lou appear to indicate the influence of my

own personal therapy (I was seeing a therapist called Mick at this time) over how I went on to relate to my own clients.

This passage of notes comments upon Lou's 22nd session on the 17th July 2018:

'When you describe times when your Mum says it was better when you were there, how you used to cook together etc. it's kind of like your Mum has trouble separating (individuating) from you, and thus you from her [...] Note how I'm picking this emphasis up from working with Mick and then it's informing my client work.'

This coincided with the period of sessions in which I believe Lou and I did our most effective work together. Two sessions later on the 31st July 2018 I perceive the influence of my personal therapy again over work with Lou:

'I'm mindful at this stage of the stock that Mick puts on separation. You demonstrate all the signs of not being able to peel away from the dynamic of your Mum and [sister] - you even said how you put them before [husband]. And because you're so embroiled in that dynamic how can you possibly realise a new transitional identity? Something about the swimming suggests a way.'

Mick's emphasis on attachment and separation anxiety – given our work on the loss of my Dad – is here informing my own theorising of Lou's realisation of a transitional identity: the 'fire in my belly' motif described in section 4.1 of the thesis.

Modelling my theory in therapeutic process

One thing that made an impression upon me in the regular weekly work of listening back through audio recordings of the sessions was the way in which the tone of my voice appeared to shift. In this diary entry from 4th January 2018, following the first sessions for Michael and Lou after that Christmas, I offer some further thoughts on this which link to my developing theory of the situation of psychosomatic experience within wider I-positions.

'But what is also noteworthy is that my imposter syndrome has a psychosomatic profile – my jaw pain flares up, and as observed from one or two of the recordings so far, my

tone of voice changes – it becomes higher pitched and I use more “sort of thing / kind of thing” statements. When I’m feeling like the session has its own momentum I feel physically more relaxed, warmer to the client, my voice deepens and my words are bolder and more certain.’

From that first session back after Christmas, Lou’s fifth, we can see evidence of my developing thesis as directly informed by work with the participant clients, but also perhaps as directly informing I made sense of the work:

‘My sense of the cognitive stuff about catching the negative thoughts and considering alternatives: ‘could that be true’, seems more like creating a scaffolding in the hope that a new voice will emerge.’

Clearly my expectation of chance here is that the ‘cognitive stuff’ isn’t the end result of successful working with Lou but rather creates the platform for dialogical change to occur. In my diary entry from the 1st February 2018 I observe my growing confidence as a therapist given the explicit and coherent model of change I was referring to at that time:

‘Noticing in terms of my professional development that whilst in the past I might have been floored by something that a client said [...] now I always have a way of taking the conversation forward, reassuring the client that we can contain this here. This seems to be down to the fact that I have an increasingly coherent higher reference point that I can always reorientate back to - dialogism in the shorthand.’

In this session from Lou – her seventh - on 23rd January 2018 I am using the language of my emergent thesis to make sense of the work in real time, and indeed hearing Lou’s different ‘voices’ in the audio 533recording:

‘I noticed the appearance of a different voice in the session, [Lou] talking not as a peacemaker but as someone more defiant, interestingly I thought of a defiance when she talked about [friend]’s diet breaking down.’

This same voice-hearing process is observed again in my notes following Lou’s session on the 27th March 2018 which represents to me between where we were presently to where we had been just a couple of months previously:

'I'm hearing you speak with "fire in your belly", I'm not encountering the peacemaker in sessions any more. And this process seems to be a reaction to [husband]'s controllingness or attempt to control.'

Somewhat later I made an interesting observation about a way that I was non-verbally modelling my own framework for change, as indicated in this diary entry from the 15th May 2018:

'One thing I realised today is that I talk with my hands in therapy in a structured way. Most notably my hands move along an invisible timeline running left to right in the client's field of view, therefore right to left in my field of view. I have previously automated the understanding that I need to reverse physical representations of time so that the client sees them as they expect which is left to right. As a consequence I often represent past/old/problematic i-position with my right hand, and future/new/alternative i-position with my left hand. This communicates implicitly an expectation of change as realised over time – from where I was to where I am.'

The timeline is a relatively universal symbol with left indicating the past and right the future, and it appears that I was, mostly unconsciously, communicating a linear concept of change to my clients at that time and thus letting them see the purposefulness that I perceived in the work.

Influence of research process – listening to and coding the sessions each week – on therapist understanding

As just noted listening to the audio recordings as an additional experience for me as the therapist for each of the four participant clients helped to enrich my understanding and appreciation of the work we were currently doing. At times also I was able to observe my own development as a practitioner in a way I might have missed had I not had the audio recordings, as these notes from the 19th December 2017 elucidate:

'Noting that already I'm holding my tongue when I might have otherwise intervened, and also not giving the client more than one point at a time to consider - deciding for myself which is the most important to relay to them. These are both influenced by listening back to the recordings from previous sessions [...] Interestingly the tone of my voice is different - subtly a tone deeper, subtly sharper and more confident, compared

with other client work where I'm still feeling I need to make something happen and thus my tone of voice betrays an anxiety (associated with jaw pain).'

Elsewhere the audio recordings enabled me to identify important details that I missed in the real-time of the session, as in this entry following Lou's fifth session on 2nd January 2018:

'I missed an opportunity to say to you that it's still ok to be angry.'

Nonetheless this listening back and catching those details probably enhanced the quality of what I took back into the room in coming sessions, a phenomenon observed by counselling students who typically are recording sessions during their training.

Scrutinising my understandings of change process – anticipating hermeneutic analysis

I was familiar with and an admirer of Elliott's (2002) and Bohart et al.'s (2011) protocols for qualitatively appraising claims of therapeutic change from the beginning of the data collection window. Here are some data from my case notes that demonstrate the way I was guided by these protocols in scrutinising my understanding of the therapeutic process and the change that appeared to be taking place in the initial analyses that followed each session.

This passage is taken from notes following Michael's fifth session on 9th January 2018:

'You also appear more motivated and mobilised than ever before, and I feel this is associated with my 'Let's do this' attitude. However I also wonder whether sometimes your positive appraisals of the work so far are scripted - you're telling me what you think I expect to hear from you.'

The notes reflect my appreciation of the complex idea of the placebo effect in psychotherapy, as I go onto explore in section 6.7.9 in the thesis. However I also note here, as elsewhere the possibility of client's offering 'scripted' appraisals of their therapy, an expectancy effect as warned by Elliott (2002).

I suspected expectancy effects in work with Jennifer too, as reflected in these notes following her third session on 1st May 2018:

'You are endorsing a huge amount of mental clarity all of a sudden. It is possible that these early sessions have been a big revelation to you, I also wonder whether there is expectancy effect here which is amplified by the therapy - you feel you are expected to respond emphatically to the ideas. I also wonder whether this will be followed by a period of disillusionment.'

Later from notes in the same session I make more direct reference to the themes invoked in the Elliott (2002) and Bohart et al. (2011) protocols:

'I am left with a niggling sense of my own power of suggestion - that I seem to be implanting these ideas for [you] and you are taking them on so enthusiastically. This may simply be a continuation of the placebo effect (or however I ultimately describe it). However I am left with a deeper wondering: if the placebo effect takes hold and my clients run with that, modelling the change I have proposed they will model, will this prevent deeper, more unexpected therapeutic change from taking place?'

I raised these thoughts explicitly with Jennifer and consider the question as to what extent expectancy effects may have influenced Jennifer's own reporting of change in the mini-study in section 6.7 of the thesis.

I was also particularly mindful of the possibility of expectancy effects in work with Myrtle, as the following passage following our second session on 19th June 2018 indicates:

'You begin session by explaining how you "gave myself a talking to" on holiday. Recognising that your Mum is a grown-up and is responsible for her own life. I have the feeling that on the one hand this rush to clarity and resolution may be as a consequence of our first session and counselling being a line in the sand. However also this may be about you giving something concrete as you're really not sure what to make of counselling - this may even be about you attempting to generate what you think is expected to happen in counselling. The authenticity of the resolution may be in how much you really do shift in position to your mother. Also in line with today's thinking, I'm cautious about you taking a position that you feel may be expected of you in order to get better, as it sounds alienating.'

I explore the apparent ‘crystallisation of discontent’ and subsequent sudden gain that Myrtle appeared to demonstrate in section 6.7.3 of the thesis having raised this explicitly with Myrtle through my communication of the case report to her. However the passage also indicates the way in which I would continue to ‘test out’ theories about how much expectancy effects might be set off against evidence of ‘real’ change – here looking out for evidence that Myrtle’s relationship with her Mum has genuinely shifted.

The emergence of the parallel thesis – the autoethnographic strand – as tracked through diary entries

Although much of this evolution is already captured in the thesis itself, some additional data – exerts from my reflective journaling – also provide glimpses into the development of my dialogical concept of research, the emergence of an uncomfortable dialectic between constructivist and positivistic positions – which primarily played out through my dialogue with supervisor John Lees – and then ultimately to the emergence of the ‘thesis beneath a thesis’.

This diary from the 28th July 2017 immediately follows my ‘transfer viva’ – progression from year one to year two of my PhD:

‘After the Viva Jane told me that I wear my theory like a skin and she’s right – it’s not something I have to recall like a student recalling content for an exam, the theory is much more personal and immediate than that.’

The idea that theory is personal to me, or that theory generation is rooted in personal experience, is of course a core idea in my thesis. It is interesting to observe the signs of the uncomfortable dialectic – two very different theses – emerging relatively early on in my PhD journey, as this diary entry on 13th August 2017, six months before the death of my father, illustrates:

‘I can caricature this by recognising how uncomfortable it is for me [...] to be faced with two contradictory theories – uncomfortable, giggling, I need harmony and purity and what I have is an awkward half-way house. [...] It is like having children that don’t get on – I love them both, I see both their qualities and it is so uncomfortable to see them disagree. Perhaps I am very intolerant of difference; perhaps I am impatient for a

synthesis that will arrive eventually. [...] I am in my laboratory faced with two beautiful but incompatible prototypes and I am unsure which to develop.'

About the same time I had been counselling in a hospice and attended a funeral for one of my clients. The following diary entry captured a seminal moment in the development of my thesis. On 25th August 2017 the idea of a linkage between psychosomatic experience and subjective competence, as explored in section 1.3 of the thesis began to sink in following my experience at that funeral:

'Interestingly, yesterday when I was about to walk over to [client name]'s funeral, my jaw pain flared up tangibly. In retrospect, the best understanding I have of what was going on was that I just didn't know what role I was going to play in that ritual. I know that I meant a lot to [client] and I was one of the few positive aspects of the final chapter of his life, but I couldn't grasp that strongly enough to participate confidently. I remembered the paper that I read some time ago about chronic pain being associated with a lack of competency e.g. how am I going to navigate through this one?'

In the month following my Dad's death I recorded a succession of diary entries that appeared to track the conscious acceptance that the thesis as I had originally envisaged it would have to change in shape and complexion – my experience as a researcher was moving before the event of losing my Dad and afterwards it seemed hollow and impersonal. This entry, from 14th March 2018, captures something of the personal meaning and significance that dialogical theory was coming to have for me:

'I feel flat and cold, sort of like I'm bruised all over. I'm battling with feelings of meaninglessness and senselessness. [...] Stephen Hawkins (who died today) said "it would not be much of a universe if it wasn't home to the people you love". [...] The universe only takes on any meaning through an 'I-Thou' type of relating. This seems to me, in the light of losing a loved one, the only 'saving grace' we have [...] This morning William [my son, who was three at that time] woke early and I was working at the computer. Before what happened I would have done everything I could to have carried on working, justified by the responsibilities that I have. But when William walked into our bedroom, I stopped immediately what I was doing and we played together. We lied on the bed, we pretended we were in a rocket going up into space and that the pillow was our controls. I could tell it meant so much to him to have his Daddy's (rare) undivided attention.'