CLIENTS' EXPERIENCE AND UNDERSTANDING OF CHANGE PROCESSES IN COGNITIVE ANALYTIC THERAPY

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DECLARATION

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

THESIS ABSTRACT

SECTION I: LITERATURE REVIEW

This paper reviews the qualitative literature exploring the experience of individual psychotherapy and counselling from the client's perspective. It considers the client's experience in three broad phases: pre-therapy feelings on becoming a client, the middle phase of therapy and the ending of therapy. It provides an updated synthesis of the available literature and presents a critique of that literature. The review demonstrates the rich diversity of experiences that are uncovered when exploring therapy from the clients' perspective.

SECTION II: RESEARCH REPORT

This paper reports the findings of a qualitative study exploring clients' experiences and understanding of change processes in Cognitive Analytic Therapy (CAT). Using grounded theory methodology the study utilised a three stage design to develop a 'bottom up' theoretical model allowing for constant member validation. Within this process, a total of 15 end of therapy interviews were conducted with nine clients who had received a course of individual CAT. The core conceptual framework, 'doing with' emerged from the analysis and was conceptualised to represent clients' subjective experience of CAT. This framework subsumed four main inter-related themes each interacting and influencing the other; 'being with the therapist', 'keeping it real', 'understanding and feeling' and 'CAT tools'.

SECTION III: CRITICAL APPRAISAL

The first part of this paper presents a synopsis, with personal reflections, of the research process from its origins to write up. The second part discusses the main learning experiences gained from the study.

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ACKNOWLEDGEMENTS

First I would like to thank the nine people who participated in this project for their time and for sharing their personal experiences with me.

I would like to thank my supervisors, Andrew Thompson and Sue Walsh for their support and advice throughout the whole research process.

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STRUCTURE AND WORD COUNTS

Literature Review
Prepared according to the guidance for the journal: Clinical Psychology Review
(See Appendix 14)

Research Report
Option A

	WORD COUNT
SECTION I	
Literature Review	7544
References	1936
Total	9480
SECTION II	
Research Report	11966
References	1491
Appendices	4322
Total	17779
SECTION III	
Critical Appraisal	3312
References	118
Total	3430
Total Word Count	**22822**
Total with References and Appendices	**30689**

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SECTION I

CLIENTS' EXPERIENCES OF INDIVIDUAL PSYCHOTHERAPY AND COUNSELLING:

A REVIEW OF THE QUALITATIVE LITERATURE

CLIENTS' EXPERIENCES OF INDIVIDUAL PSYCHOTHERAPY AND COUNSELLING: A REVIEW OF THE QUALITATIVE LITERATURE

ABSTRACT

This paper reviews the literature utilising qualitative methodologies to investigate the experience of individual psychotherapy and counselling from the client's perspective. It considers the client's experience of therapy in three broad phases: pre-therapy feelings on becoming a client, the middle phase of therapy (including experience of self, the experience of the therapist and the therapeutic relationship and the experience of significant helpful and unhelpful events) and the ending of therapy. It provides an updated synthesis of the available literature and presents a critique of that literature. The review demonstrates the rich diversity of experiences that are uncovered when exploring therapy from the clients' perspective. Researchers have employed many different qualitative methodologies in an attempt to capture a wide variety of client experiences ranging from the entire client experience of therapy to focusing specifically on one aspect of one particular individual session. The main findings are discussed and recommendations for further research are given.

CLIENTS' EXPERIENCES OF INDIVIDUAL PSYCHOTHERAPY AND COUNSELLING: A REVIEW OF THE QUALITATIVE LITERATURE

INTRODUCTION

Psychological process research concerns the assessment of the "content of psychological therapy sessions and the mechanisms through which client change is achieved" (Llewelyn & Hardy, 2001, p.2), whereas outcome research is concerned with the results and effectiveness of therapy. These two areas however cannot clearly be divided. In a recent review of the process research literature, Llewelyn and Hardy (2001) argue that research into the process of psychological therapies will advance our understanding of therapeutic change and facilitate theory development and therapeutic effectiveness. Clients' perspectives have received limited attention in psychotherapy process research and few exploratory studies exist (Elliott & James, 1989; Macran *et al.*, 1999; Messari & Hallam 2003). The function of this review therefore is to re-balance this debate by centralising clients' perspectives through the use of qualitative methodology.

Although instinctively one might think that seeking clients' views would be a natural avenue of research to undertake, there may be many reasons why there is an under-representation of clients' perspectives in the literature. McLeod (1990) feels there is a pressure for research to be 'scientific' and therefore clients' accounts may have been overlooked since they were not seen as objective and reliable. He also notes the influence of the dominant therapy models on the reliability of clients' experience. For example, psychoanalysts might argue that it is difficult to take clients' accounts at face value as they could be interpreted as evidence of transference or defensiveness. Furthermore behaviourists would customarily look at behaviour change as an outcome, putting less emphasis on internal accounts. Macran *et al.*, (1999) also highlight other traditional reasons, such as the client's impaired mental state or

lack of skills or insight influencing the perceived ability to make reliable or objective judgements on their therapy. This, together with some ethical and practical difficulties, (e.g. the risk of re-awakening unresolved issues or interrupting therapy progress) in conducting such research has meant that it is an area that has not received equal attention.

In contrast, there are now many strong arguments as to why clients' perspectives should be an integral part of psychotherapy research and be of equal importance and validity as any other researcher or clinician perspective (Macran *et al.*, 1999). Clients have 'privileged access' to their own private experiences (Elliott & Shapiro, 1992). They see themselves as significant contributors to successful therapy outcome and change (Dimcovic, 2001) and provide an important insight into change processes that occur in therapy (Helmeke & Sprenkle, 2000). In a recent review of the psychotherapy literature, Orlinsky *et al.,* (2004), suggested that the therapeutic alliance, particularly as viewed by the client, and the quality of client's participation in therapy are major determinants of therapy outcome. Entering in to the client's frame of reference would perhaps enable a more pragmatic picture of psychotherapy to emerge (Howe, 1993) which arguably might be preferable in its accessibility and utility, to some of the more complex and contradictory models proposed by 'expert' researchers of different persuasions. It is proposed that clinicians and researchers often "speak a variety of different tongues….but clients speak a common language" (Howe 1993, p.8). Furthermore this appears to remain relatively stable over time (Martin *et al.*, 2000), place and theoretical approach (Howe, 1993).

Together with evidence that client and therapist views on therapy can diverge greatly (for example, Bachelor, 1991; Halstead *et al.*, 1990; Llewelyn, 1988), these findings emphasise the continuing necessity and importance of exploring and understanding client's views on therapy and change to facilitate clinical practice and treatment effectiveness. In addition, such

research into seeking clients' views is consistent with the current NHS objective in involving users in planning and delivery of mental health services (Department of Health, 1999).

To date, the most comprehensive review of clients' experiences in therapy was conducted by Elliott and James in 1989. Reviewing studies with varied methodologies they presented the varieties of clients' experiences in nine domains which could be encapsulated into client's experiences of themselves, their therapist and the therapy itself. The review appears very comprehensive and systematic, however search terms or inclusion criteria are not made explicit so it is difficult to identify the criteria with which studies were reviewed. The authors themselves acknowledged that they blurred client and researcher perspectives, for example including studies that used observational measures of client experience, therefore limiting the degree to which one can guarantee correspondence with actual client experience. As a result of this study the authors made recommendations for future research, one of which was the need for more qualitative exploratory research on client's experiences.

Further reviews and book chapters detailing and explaining client's experiences of therapy (e.g. Howe, 1993; McLeod 1990; Elliott & Williams, 2003) are recognized as valuable information sources however they do not declare to be systematic or comprehensive in their coverage, and the vast majority of literature discussed is over ten years old. McLeod (1990) echoed the recommendations of Elliott and James (1989) for more qualitative research into client experiences.

Qualitative methods are particularly applicable and suited to exploring client experience. Applying a purely quantitative approach to process research may run the risk of reducing people to a construction of working parts that can be objectively observed and analysed (Howe 1993). This reductionist approach assumes that the way to understand how people

work is to observe the external presentation. Most therapies aim to work at both an intra and interpersonal level and therefore a purely expert defined 'outsider' approach may have limitations in describing and accounting for the complexities in therapeutic process. Only qualitative accounts from the clients would allow access to these changes and experiences as perceived by them. Such exploratory process methods in naturalistic research have demonstrated reliability and validity and, it is argued, have an equal and important role in furthering our knowledge about change processes in psychotherapy (Hill, 1990).

THE CURRENT REVIEW

Aims

Recommendations from earlier reviews (Elliott & James, 1989; McLeod, 1990) have stated the need for qualitative research into clients' experience of therapy. The current review therefore aims to provide an updated synthesis and critique of the available literature that has utilised qualitative methodologies to investigate the clients' experience of therapy.

Search Methodology

The electronic databases PsychInfo, Medline and Web of Knowledge were utilised in searching for appropriate literature. The searches were limited by the time period, 1990 to 2005 and to published articles in the English language. A range of search terms were used to optimise searching for qualitative evidence and to increase the precision of the search, the thesaurus facility on PsychInfo was employed (Shaw *et al.*, 2004).

Searching was carried out along four strands:

1. *Client* (including the terms client*, counselee*)

2. *Experience* (including the terms, experience*, perception*, understanding*, views*, perspective*, satisfaction*, attitude*, meaning*)
3. *Psychotherapy* (including the terms psychotherap*, therap*, counselling, counseling)
4. *Qualitative* (including the terms qualitative*, phenomenol*, grounded theor*)

These four strands were then combined in each database. For further identification of papers, references lists of pertinent articles were searched together with the Web of Knowledge 'times cited' function. Certain criteria were utilised to determine the inclusion and exclusion of articles for the purpose of this review. The terms 'patient' and 'treatment' were not used as keywords in the search as they were deemed too medical and would bring up an unmanageable and irrelevant amount of hits. This review aimed to focus on experiences of individual therapy therefore articles studying family, couple, child/adolescent psychotherapy and mental health services/treatment in general were excluded as were those which used simulated therapy sessions.

The qualitative and quantitative dichotomy has long been open to debate (Silverman, 1999) therefore identified articles using both quantitative and qualitative methods (for example open ended questions) were studied and included if the qualitative aspects received at least equal attention and were analysed separately using identified qualitative methods. Autobiographical and anecdotal accounts are not included as they are limited to purely individual descriptive stories and do not attempt to use recognised qualitative methodology.

This review centralised those studies that directly set out to investigate the clients' experience alone. Some studies looked at both therapist and clients' experiences but analysed and

addressed them separately (e.g. Lietaer, 1992) in these cases, in order to avoid losing valuable information, findings on the client's perspective were included.

Following this process a total of 36 articles were identified (marked with an asterix in the reference list).

Organisation of Review

The terms psychotherapy and counselling are used interchangeably throughout this review. Some may argue that there are inherent differences between the two practices and indeed it is important to acknowledge that diversity exists across the range of available talking therapies. This review has taken a generic stance in order to encompass as much of the available literature as possible.

This review considers the client's experience of therapy in three broad phases: pre-therapy feelings on becoming a client, the middle phase of therapy and the ending (McLeod, 1990). It seemed reasonable to adopt this natural progressive structure it follows the client's journey through therapy. Given the difficulties in synthesising qualitative data (Dixon-Woods *et al.*, 2004) in reality there is considerable overlap within these phases therefore these are only meant to be a framework for logically highlighting the therapeutic process rather than a definitive model.

PRE-THERAPY EXPERIENCES AND BECOMING A CLIENT

Client expectancies of therapy include beliefs about the duration, process and outcome of therapy (Joyce & Piper, 1998) and these expectations may consequently affect their experiences of therapy (Walborn, 1996). Clients' preconceptions also play a role in the perceived effectiveness of therapy, therapeutic alliance and the process of change

(Constantine, 2002; Joyce & Piper, 1998; Walborn, 1996). This review found little literature that has actually addressed this area directly from the clients' perspective.

In the only exploratory study found in this area, Taylor and Loewenthal (2001) interviewed eight clients and used discourse analysis of transcripts to describe their pre-conceptions of therapy. They found that expectations and preconceptions of therapy arise from images portrayed in the media and listening to friends and family. The words counselling and therapy already have meaning before any personal experience. First sessions, and leading up to them, were described as 'nerve-wracking', 'unnerving' and 'frightening'. Clients said they did not share these feelings with the therapist but they did dissipate on first meeting with the therapist, alluding that their expectations of how difficult it might be did not match reality. The researchers acknowledge that their findings are tentative as they did not analyse in detail all of the discourse in all of the transcripts and that interpretations are open to value judgements. Furthermore, this was a retrospective study where clients were asked to reflect back on their pre-conceptions of therapy whilst actually in therapy. Their current experience of therapy may have biased their views on their actual pre therapy feelings and expectations.

THERAPY EXPERIENCES

In a recent summary of psychotherapy outcome literature Lambert and Barley (2002) conclude that, in general, psychotherapy is successful and the average treated client is better off than 80% of untreated subjects. Moreover, many quantitative studies show that clients perceive therapy as a positive experience (e.g. Constantine, 2002; Dale *et al.*, 1998; Fava *et al.*, 2000). How can the recent qualitative literature enhance our understanding of the client's subjective meaning of why psychotherapy might be successful and viewed positively? As found in previous reviews (Elliot & James, 1989; McLeod, 1990) the literature appeared to

reflect three central aspects of clients' experiences in this middle phase of therapy: The experience of self, the experience of the therapist and the therapeutic relationship and the experience of significant events (helpful and unhelpful) in understanding their experience of change. Again it is worth highlighting that some overlap occurs in studies within this structure.

Experiences of Self

The client's experience of self within therapy is powerfully affected by the therapeutic relationship and nature of therapy (McLeod, 1990). However it also seems that clients use therapy as an opportunity to explore within themselves and reflect on internal experiences (Rennie, 1992). Connolly and Strupp (1996) found that client reported outcomes of psychotherapy can be clustered into four themes: improved symptoms, improved self understanding, improved self confidence and greater self definition. Experiences of self appear a central aspect of the therapy experience.

'Second order change' that is, a more permanent, fundamental change within the structure and system of the individual rather than purely first order changes in behaviour, cognitions and affect, are also part of client experiences of self in psychotherapy. Murray (2002) explored such experiences and concluded that clients in psychotherapy do experience important shifts in their experience of, and relating to, themselves and that these often then lead to other troubling aspects, such as first order difficulties to fall into place. However this study only interviewed clients who had 'at least two years' of ongoing therapy with the same therapist. Therefore, the findings may be limited when considering this phenomena in short term therapy.

In a multi-method study, which included analysis of semi-structured interviews, Farber *et al.*, (2004) explored the process and consequences, from the client's perspective, of client self-disclosure in psychotherapy. They found that clients often feel anxious and shameful before and during disclosure of intimate secret information but afterwards, despite sometimes a feeling of increased vulnerability, clients report more positive feelings of relief, pride, safety and a sense of authenticity. Most clients believe that therapy would be hindered if they withheld their thoughts and feelings and the process of disclosure is positively influenced by the quality of the therapeutic relationship. Given these therapeutic benefits of self disclosure, one might expect that clients engage readily in such activity. However there is a body of research that explored why this is not the case.

Using grounded theory to analyse transcripts of interpersonal process recall interviews of a single therapy session, Rennie (1992) proposed that reflexivity, described as an inner world of decision and action, is the most central quality of the clients' experience of therapy. Intrinsically this creates covertness within therapy and indeed Rennie (1992) also found that clients often decided not to share these processes and experiences with their therapist. In another study Regan and Hill (1992) investigated what clients did not share with their therapists. They found that most of the things left unsaid by clients in therapy were negative emotions, thoughts or behaviours that occurred to them during the session. The more thoughts and behaviours left unsaid were related to a poorer rating of satisfaction with treatment. However, this study only used clients from brief six session therapy and the authors hypothesised that this might not have been long enough to disclose more private issues. Furthermore the participants' presenting problem was lack of assertiveness, which in itself may have greatly influenced the process of disclosure within therapy and also in the research itself. The authors did not seek explanations as to why clients did not disclose, so inferences as to why and how non-disclosure influences satisfaction with treatment are limited.

Story telling in therapy could be one method clients use to overcome the difficulty they may have in disclosing or sharing internal experiences. Rennie (1994a) found that the clients' experience of telling a story in therapy was often more powerful and functional than its representation in discourse. He found clients used story telling to re-enter events, deal with deep feelings, tension and imagery, and to present themselves in a different light. Therefore client's internal worlds can be shared but not necessarily in an overt and explicit manner. This symbolic representation of experience has also been found in a study exploring clients' experience of problematic reactions in therapy (Watson & Rennie, 1994).

Saunders (1999) found another important experience during therapy was how clients feel and how they perceive their therapist to be feeling. Better outcomes were associated with the client not feeling inhibited or withdrawn and perceiving the therapist as interested and alert. The measurement of treatment outcome in this study was based on independent judges' ratings of medical cards. This would not necessarily be the most accurate method and client's subjective reports might have been more in line with the research aims.

Experiences of the Therapist and the Therapeutic Relationship

There are many definitions and terms of what constitutes the nature of the relationship between therapist and client. But generally it is accepted that the construct has three common themes; 1) the collaborative nature of the relationship, 2) the affective bond and 3) the ability of both client and therapist to agree on treatment goals (Martin *et al.*, 2000). For the purposes of this review terms such as therapeutic relationship and working and therapeutic alliance will be used interchangeably. Meta analyses of process research have shown a moderate but reliable relationship between the working alliance and therapeutic outcome (Horvath & Symonds, 1991; Martin *et al.*, 2000) particularly as rated by the client (Horvath & Symonds,

1991; Whiston & Sexton, 1993). It is important therefore to further explore the client's perceptions and experiences of this relationship.

Surprisingly, there is only one qualitative open exploration of the clients' perception of the therapeutic alliance specifically. Bachelor (1995) asked 34 university counselling service clients to write down what they deemed to be a good client-therapist relationship and describe in detail a time in therapy when they experienced such a relationship. Phenomenological analysis of this data derived three relatively distinct types of perceived alliance; 1) *Nurturant*, emphasising trust, respect, non-judgemental, empathy, understanding and friendliness 2) *Insight-oriented*, emphasising improvement of client self understanding and therapist clarification activities and 3) *Collaborative*, emphasising active client involvement in the tasks of therapy. She found that these three core structures remained stable over the course of therapy. Interestingly, given previous findings of the client as an active participant in therapy (Rennie, 1992), Bachelor (1995) found the client viewed the quality of the alliance as primarily a function of the therapist contributions. Bachelor (1995) concludes that because the conceptualisation of the client is not taken into account, some crucial features of the perceived therapeutic working relationship (such as trust, insight and friendliness) are not accounted for in the literature.

Rather than such a general open exploration, the remainder of the studies identified in the current review investigated specific aspects of the client's experience and perspective of the therapist or relationship.

Bachelor's (1995) 'nurturant' alliance type, together with other facilitative therapist attitudes, encompasses the important factor of empathy. A more recent qualitative study echoes and expands on this finding. Myers (2000) explored the meaning of empathic listening from the

perspective of five female psychotherapy clients. Each person had an individual experience of being heard and often related this to their previous experiences of not being heard or misunderstood in other interpersonal relationships. They found the therapist was listening empathically when he/she appeared to be actively engaged in the dialogue characterised by paraphrasing, clarifying, questioning and remembering details. Myers concluded that empathic listening in itself is not reducible to a technique but rather a relational interactional variable unique to each therapeutic dyad.

Clients' experiences of other characteristics of the therapist have also received some research attention. Quantitative studies have reported that therapist level of experience is not uniquely associated to the client's perception of the therapeutic alliance (Dunkle & Friedlander, 1996; Hersoug *et al.*, 2001). However the qualitative research seems to have found that it is the *perceived* level of confidence, competence and professionalism of the therapist by the client that is important in session outcome and satisfaction (Thompson & Hill, 1993). In addition, the therapist, as a person, plays an important part of the client's therapy experience. The client's internal representation of them has been shown to benefit the therapy and therapeutic relationship (Knox *et al.*, 1999). Clients had a positive internal image of their therapist which they utilised in times of distress or when thinking about past or future sessions. These representations brought comfort and clients utilised them to introspect or influence therapy both within and outside of actual sessions. Together with internal representations, clients can find physical objects used in therapy a comfort. In a grounded theory study with six female participants, Arthern and Madill (2002), developed a model which illustrates how these 'transitional objects' work through a process of' 'holding'. The object represents the continuity of the therapist existence, connectedness with the therapist and eventually the development of a new sense of self.

As noted, collaboration is deemed by clients as characteristic of a good client-therapist relationship (Bachelor, 1995). However, Rennie (1994b) found that one major aspect of the client's experience of therapy was deference to the therapist, thus making it difficult to criticise or challenge the therapist. This might influence the true collaborative nature of the relationship. Rennie's (1994b) study showed that clients became resistant to their therapist if they were ambivalent to their approach. Due to the high regard that clients had for their therapist and wanting to make a good impression, this resistance was often shown in very subtle and veiled ways. Silence has traditionally been viewed as one way in which resistance is communicated but Levitt (2001) challenges this psychodynamic interpretation. She proposes that silences can have many different meanings that are sometimes under conscious control of the client. Cutting across different therapy models she explored the client's experience of obstructive silence in a single session of therapy. Her findings showed that clients described two types of obstructive pauses. The first being a 'disengaged' pause where the client was attempting to avoid difficult emotions and the second being an 'interactional' pause, where the client focuses on the disruptions in the processes of communication between therapist and client, most often reflecting confusion with the therapeutic task and therapist instructions.

There are differing perspectives on the ethical implications of the complex issue of therapist self disclosure and therapists are warned to take into account many ethical principles when considering disclosing personal information (Peterson, 2002). One exploratory research study into therapist self disclosure in long term therapy found that from the client's perspective, helpful therapist self disclosure can have positive consequences (Knox *et al.*, 1997). Disclosures were deemed helpful if they were perceived as intended to normalise or reassure the client and consisted of a disclosure of non-immediate information about the therapist. This

study aimed to investigate the effects of helpful therapist self disclosures therefore no conclusions can be drawn about the nature and consequences of unhelpful self disclosures.

Helpful and Unhelpful Events and Experiences of Change

Elliott and James' (1989) review summarised helpful aspects of therapy, as perceived by clients, into 5 categories; facilitative therapist characteristics, permission for client self expression, experiencing a supportive relationship, gaining insight and self understanding and the therapist encouraging the client to practice new skills outside of therapy. Given the majority of client reported change seems to be related to change within themselves (Connolly & Strupp, 1996), it will be useful to consider what the recent qualitative literature tells us about clients' understanding of these changes.

A recent qualitative study using grounded theory analysis has been able to develop a model of cognitive change processes in therapy from the client's perspective. Clarke *et al.*, (2004) investigated five clients' understandings of change processes in cognitive therapy for depression. Three 'clusters' were identified; 'The Listening Therapist' covering the non-specific treatment factors, 'The Big Idea' which contained specific factors from the cognitive therapy model and 'Feeling More Comfortable with Self' which centred on the outcomes of therapy. The ten categories within these could then be mapped on to the process of change explained by the assimilation model (Stiles *et al.*, 1990). Since the researchers used a prescribed interview schedule with no evidence of theoretical sampling, the strict application of a grounded theory approach could be questioned. Nevertheless these findings provide an interesting clinical and theoretical starting point from which to explore the process of change within therapy from the client's viewpoint. Notably, this model's clusters would encompass and account for the helpful aspects of an earlier study of client experience of cognitive therapy for depression (O'Leary & Rathus, 1993). Comparable results have also been found in

exploring client's experiences of different therapies. For example, traumatic incident reduction therapy (Valentine & Smith, 1998).

There is a body of research that specifically sets out to investigate helpful and unhelpful events as described by the client. Research into primary care counselling (Booth *et al.*, 1997) found that events deemed most helpful were reassurance, problem solution, insight and client involvement. Similar results were identified as common themes described by psychotherapy clients receiving both CBT and Interpersonal Therapy in the NIMH trial for treating depression (Gershefski *et al.*, 1996). Rennie (1996) however critiques this latter study highlighting methodological issues and possible researcher agenda limits the depth to which the participants' experience of therapy could truly be investigated. More specifically, Paulson and Worth (2002) uncovered three therapeutic processes that previously suicidal individuals found helpful for overcoming suicidal ideation; 1) validating relationships, 2) working with emotions and 3) developing autonomy and identity. A study combining qualitative and quantitative methods (Paulson *et al.*, 1999) found similar results to the above studies but also included four further categories of emotional relief, gaining knowledge, accessibility and client resolutions.

As part of an investigation into both client and therapist perceptions of helping and hindering events in client centred therapy, Lietaer (1992) content analysed 325 post session open ended questions. Methodologically, Lietaer states that the process was 'minimally theory driven' (p.139) and that she took a global view when presenting data, not accounting for individual differences. Nevertheless the results showed that the most helpful processes from the clients' perspective were again insight into oneself and situations and the chance for self exploration, both of these were facilitated by an involved, empathic, accepting therapist. Echoing Paulson *et al.*, (1999) findings, emotional relief was again identified as a helpful factor.

When considering the frequency and weighted importance of the categories and themes developed in each of these studies there seems to be a provisional difference between therapy models (e.g. Gershefski *et al.*, 1996). Clients involved in more prescriptive and directive therapy such as CBT appear to report more 'problem resolution' compared to more self insight and understanding in more exploratory therapy or counselling. It can also be inferred that this difference in clients' experience is influenced by variations in therapists' personal style within the same general model of therapy (Booth *et al.*, 1997).

Research studying client's recall of resolving 'misunderstanding' events in therapy (Rhodes *et al.*, 1994) emphasised the importance of the therapeutic alliance together with the client's willingness to assert negative reactions and the therapists' awareness of such feelings. This highlights the value of having an open and honest relationship to overcome difficulties in therapy. Qualitative investigations into unhelpful or hindering aspects of therapy indicate this is not always the case. A common pattern is apparent when reviewing articles investigating this area. Researchers have found that significantly less unhelpful events are reported compared to the reporting of helpful ones (Booth *et al.*, 1997; Levy *et al.*, 1996; Lietaer, 1992).This may be reflective of reality, given general client satisfaction with therapy (e.g. Constantine, 2002, Dale *et al.*, 1998; Fava *et al.*, 2000) or alternatively it may indicate that clients find it hard to reveal negative experiences after therapy as well as during sessions (Regan & Hill, 1992). Moreover, it is important when contextualising these findings to bear in mind clients' deference to therapists (Rennie, 1994b) and the possibility that clients are unwilling to criticise their therapist (Lietaer, 1992).

Hindering factors identified by Lietaer's (1992) client sample were split into two main categories. Firstly, therapist attitudes and interventions, such as being too intrusive, therapist

suggestions not feeing 'right' and lack of warmth, understanding and involvement. The second category was client processes, such as talking superficially, or feeling anxious and defensive. The majority of responses from clients were in the second category indicating that clients often attributed the negatives to themselves. The difficulty in distinguishing the person from the technique when analysing hindering aspects may again reflect that clients find it difficult to challenge therapist personally. Results from the NIMH study (Levy *et al.*, 1996) exploring hindering aspects in treatment for depression found very similar common overall themes (therapist techniques, therapist qualities and client processes) encompassing the categories found by Lietaer (1992). 'Disappointment' has also been found to have an unhelpful impact on primary care counselling (Booth *et al.*, 1997) but this study does not clarify whether this disappointment is with therapy, therapist or the client.

Therapeutic Needs and Experiences of Specific Client Groups

It became apparent when collating available research that several of the general exploratory studies of clients' experience of therapy sought the views of specific clients groups. In discussing what clients find helpful and unhelpful it is important not to categorise clients into one unitary group. Individuals have different needs and several studies have looked at specific subsets of clients. It was thought important to reflect this in the current review.

Dale and colleagues (1998) studied perceptions of therapy by adults who were abused as children. They found they faced particular issues or challenges in counselling including feeling inhibited in communicating openly, expressing dissatisfaction, tolerating silences and coping with therapist self disclosure. Although the therapeutic relationship is important in all psychotherapy it appears even more so in therapy with survivors of sexual abuse. Through content analysis of interviews with 19 male survivors of sexual abuse, Draucker and Petrovic (1997) found participants described therapy as a journey with their therapist as a guide. They

described six particular therapist traits as helpful; informed about male sexual abuse issues, informing the client about the therapeutic process, being connected to the client, respecting the client's process, going the distance with the client and letting the client go at the right time. A good relationship has also been found to aid retrieval of memories of childhood sexual abuse (Phelps *et al.*, 1997). The importance of relationship factors in this client group is further emphasised by negative therapeutic experiences mainly attributed to therapist reactions and qualities, such as perceiving the therapist as emotionally unavailable, prejudice or too academic (Draucker & Petrovic, 1997; Phelps *et al.*, 1997).

Exploratory studies of gay men's experiences of therapy have highlighted the need for gay affirmative attitudes from therapists. Discussions about sexuality are often reported to be unhelpful with clients feeling they were silenced or not adequately explored (Mair & Izzard, 2001). It is not necessary for the therapist to be the same sexuality but certain qualities, such as sensitivity, imagination and experience are essential (Lebolt, 1999).

Two studies explored the experience of counselling for cancer patients. In a combined quantitative and qualitative study, Boulton *et al.*, (1990) analysed open ended questions in 142 returned questionnaires. Almost all participants said they benefited from therapy. These benefits were achieved through processes characteristic of the generic helpful factors in psychotherapy with an additional factor particular to cancer patients situations, that of confronting the fear of death. A grounded theory study exploring experiences of CBT and relaxation (MacCormack *et al.*, 2001) also found the cancer patients' experience of the therapeutic relationship and having the opportunity to discuss their feelings and thoughts in safety with someone who appeared to genuinely care to be the most helpful.

People who experience psychosis may also have different therapeutic needs. Messari and Hallam (2003) conducted a study using discourse analysis of semi-structured interviews with five participants who had received CBT for psychosis. They found, in line with the general research findings, most participants emphasised the value of a trusting and respectful therapeutic relationship. In addition they highlighted, particular to the nature of psychosis, the difficult conflict between 'this is truly happening' and 'I am ill' discourses within therapy. Most participants found CBT a healing and educational process but one clear discourse from one participant viewed CBT participation as compliance with the powerful medical establishment. This highlights again that although clients may well be viewed as 'active agents of change' (Rennie, 1992) the notion of power within the relationship must be taken into account. This may be starker for people receiving therapy in a hospital setting where issues of motivation and personal choice might interact with their therapy experience of the 'collaborative' therapeutic relationship.

Although quantitative studies exist in the literature (e.g. Constantine, 2002; Wade and Bernstein, 1991) the search strategy utilised in this review only identified one study that began to explore the therapy experiences of people from different ethnic and cultural groups. A combined methods study by Shafi (1998) investigated the counselling experience of four Muslim Asian women. She aimed to explore the extent to which client and counsellor racial similarity affected the therapeutic alliance. Findings indicated that the majority of women did not feel racial similarity was an essential therapist quality. Given the small sample size, the lack of accepted qualitative analysis methods and the fact that the participants were all previous therapy clients of the researcher, the conclusions that can be drawn from this study are at best, limited and tentative.

ENDING THERAPY

The surprising lack of literature on client's experiences of ending therapy has been documented (Elliot & Williams, 2003; McLeod, 1990) and indeed the search strategy utilised for this review did not find any qualitative exploratory studies directly investigating the client's experience of ending therapy. The lack of quantity, breadth and depth of the literature in this area leaves many unanswered questions about client's experience of the one certainty of therapy, whether this is planned or not.

DISCUSSION

This review demonstrates the rich diversity of experiences that are uncovered when exploring therapy from the clients' perspective. Researchers have employed many different qualitative methodologies in an attempt to capture a wide variety of client experiences ranging from the entire client experience of therapy to focusing specifically on one aspect of one particular individual session.

The available qualitative literature within the timescale of this review does not reflect the variety of client experiences of self as found by the more extensive and inclusive review by Elliott and James (1989). They reviewed a total of 65 sources and categorised experiences of self into client intentions of tasks, client feelings or states, client style of self-relatedness, client style of relating to therapist and propositional experiences and concerns. Conclusions from this more limited qualitative literature can only be more tentative and less categorical but the findings do seem to reflect the main varieties of experiences identified by this earlier review. Furthermore, the qualitative research exploring helpful aspects of therapy conducted since Elliott and James' (1989) review appears to provide similar themes.

The similarities between the qualitative research findings from 1990 to 2005 and those of previous reviews of clients' therapy experiences support the view that the client's viewpoint does remain relatively stable and consistent over time (Howe, 1993; Martin *et al.*, 2000). This further strengthens the argument of listening to the client's voice.

Previous reviews of client experience and reviews of quantitative studies from different perspectives (e.g. Lambert & Barley, 2002; McLeod, 1990) conclude that what clients find helpful in therapy are the general processes, such as therapeutic relationships, rather than the specific techniques of a particular model. Overall this would be supported by the common themes identified in the recent qualitative literature. However there also appear to be some interesting differences. It has been demonstrated that different models of therapy have different impacts (Stiles *et al.*, 1988) and different perceived helpful aspects (O'Leary & Rathus, 1993). The literature exploring experiences of specific client groups particularly highlights the importance of being aware that everyone has individual needs, expectations and experiences of therapy. There may be common factors but they are just not as equally important to every person and situation (Wright & Davis, 1994). Therapy is not a technical procedure (Smail, 2001) but rather an individual, personal and relational experience set in a social context where many variables play a part in affecting change. Furthermore it has been argued that even the specific techniques of different therapeutic models could be viewed as a set of 'non specific' process factors since they are all an attempt to make sense and meaning of the clients' experiences (Howe, 1993). Some of the findings of the qualitative exploration of clients' experiences, where is has been difficult to distinguish between the person and technique, might support this view.

The qualitative data also highlights that some client experiences are often, consciously or unconsciously hidden, or different to that of the therapist. This again accentuates the

importance of gaining access to client internal experiences to fully understand the therapeutic process. It has also drawn attention to some interesting caveats in this literature, particularly the lack of exploratory work on clients' experiences of endings and termination of therapy and therapeutic experiences of different ethnic and cultural groups.

Limitations of the current review, and indeed reviews of qualitative literature in general, need to be highlighted and borne in mind when interpreting the current findings and conclusions. Qualitative data is becoming more widely accepted as having a valuable contribution to the knowledge base (Hill, 1990) however it is by no means a homogenous or unitary concept (Smith, 2003). The measurements of all aspects of quality of qualitative research and integrating such rich and detailed findings remains difficult (Dixon-Woods, *et al.*, 2004).

The difficulty in assimilating different units of measurements of client experience has been noted (Elliott & James, 1989) and this was one of the challenges for this review. Relying on wholly retrospective accounts of therapy rely on clients' memories, which could be subject to bias, on the other hand this could gain a more significant impression of the client's perception of therapy and what they have taken away with them (Clarke *et al.*, 2004). Research accessing more immediate experiences, either within session (such as 'reliving' the session in IPR) or immediately after each session, may readily access more detailed and perhaps arguably more accurate, account of emotions and cognitions but provide too much detailed data (Hill, 1990). Clients' experiences may change from session to session, as they re-evaluate and consider more longer terms effects of certain aspects of therapy (Lietaer, 1992), therefore such methods may not access the clients' complete process of change. Furthermore, the articles considered in this review used both client verbal and written reports and each have their strengths and limitations. For example research interviews may allow participants to be more forthcoming (Rennie, 1996) whereas written accounts may be the purest account of client

experience (Howe, 1993). Utilising such varied methodologies needs to continue but consequently it will remain difficult to achieve a balance between synthesising this data and preserving the varied and rich information.

Not only are there different data collection methodologies to consider but many differences also emerge at the analysis stage. Some articles found in this review purport to use the same named technique but the way the analysis is performed is actually quite varied. Some studies lacked well-defined methodology and clarity when progressing from the analysis to interpretation and conclusions.

Macran and colleagues, (1999) identify four levels of client involvement in psychotherapy research. Although arguably more than quantitative methodologies, much of the qualitative research reviewed did not appear to be at the levels advocated for truly taking the client's perspective (i.e. involving clients in developing evaluation criteria and collaborating in the research question or agenda). The majority of the research still appears to be directed by researcher aims and hypotheses. Furthermore, interpretation of qualitative findings may often be influenced by researcher motives and agenda, known as the 'investigator allegiance' phenomena (Paley & Shapiro, 2002), whereby the conclusions are compromised by researchers' unwitting bias. To ensure credibility and validity, quality control recommendations for qualitative research (Paterson *et al.,* 2001) encourage a reflexive approach by the investigator in interpretation of data. This was not always adequately discussed in studies. Collectively, these issues make it difficult to gauge how accurate some studies' findings may be in accessing the authentic subjective client experience, It also highlights the current lack of genuine client led research.

There has been significant progress in both the quality and quantity of psychotherapy research in the last half decade (Imber, 1992). This growth is necessary and welcomed. However, one consequence of this is the generation of such vast and rich data, which can trigger a debate between positions and explanations of different researchers and theoreticians. This subsequently can create unresolved issues. For example, Kolden (1991) notes the lack of theoretical conceptualizations within psychotherapy research from which testable hypotheses can be derived. In their review of process research Llewelyn and Hardy (2001) comment that studies which seek to examine links between psychotherapy process and models of change are the most promising for theory development. With the exception of the Clarke *et al.*, (2004) study it appears that the literature studied in this review did not attempt to make such links with existing theoretical models. This was acknowledged by some authors (e.g. Lietaer, 1992) but ignored by others. However, potentially and somewhat ironically, theory based research could in fact limit theory development, as researchers may become constricted by theory and miss other potentially significant findings (Hill, 1990).

Given the above, there are arguments as to whether attempts should even be made to synthesise findings from such different methodologies (see Paterson *et al.*, 2001). However, in doing so one would jeopardize losing an indispensable contribution to the research knowledge base. The value of the unique and rich role qualitative data plays in understanding client processes far outweighs the difficulties. In addition, it is a particularly appropriate approach to reflect the individual nature of the therapy. Approaching the literature with a more tolerant, naturalistic philosophy, this diverse methodology could also be interpreted as strength of the research literature. Given that research has been critiqued to be too clinical and scientific and unrelated to the real world, these studies may be more identifiable with and reflective of therapy within different health setting and a true reflection of how services are delivered in the demanding and under resourced environments.

Despite the above limitations, the findings of this review emphasise the continuing necessity and importance of using qualitative methodology to explore and understand clients' views on therapy and change. However, it is important to ensure continuity so that these valuable qualitative findings are not dismissed, forgotten or ignored. This is where quantitative methods could have their place to potentially strengthen and validate qualitative findings. This may then give the client's experience the credit, significance and exposure in psychotherapy research that it deserves and proponents have been arguing for for decades. Information from clients' experiences are logically and empirically valid to influence and inform future research into psychotherapy processes and outcomes and consequently facilitate and enhance clinical practice and treatment effectiveness.

Recommendations for future research

Following this review a number of recommendations for further research can be made:

The lack of qualitative exploration of experiences of therapy from clients of different ethnic and cultural backgrounds is apparent. This is undoubtedly an area requiring further research attention and development.

The current review would echo previous recommendations that exploration into the variety of endings of therapy from the client's perspective would be a 'fertile area for further research'. (McLeod, 1990, pp 17). Moreover, given reports that change occurs outside of sessions and evolves after therapy has ended (Satran, 1995), this may well be a useful avenue to consider for future research as it could give more insight into continuing change processes and understandings of these from the client's perspective.

Furthermore, pre-therapy experiences are worthy of further qualitative exploration. This would be particularly important in understanding the often high rate of non-attendance at first appointments.

The studies of client experiences of self highlight the need to develop more encompassing outcome measures. Many researcher designed outcome measures focussing purely on symptom change may miss valuable self concept changes and lead to the underestimation of therapeutic effectiveness.

This review focused on adult clients' experiences of individual psychotherapy. Reviewing the available qualitative literature exploring clients' experiences and understanding of change within group, couples or family therapy would be worthwhile to develop a more thorough understanding of therapy processes.

Research in the future needs to ensure that we are truly getting the genuine client perspective and not just the researchers' perspective on the client perspective. More involvement of client and user groups in the development of the research agenda is required. Furthermore, qualitative researchers need to be careful about specifying and reflecting on their procedures and approaches to enhance quality and validity of such studies. Well-defined methodology and results are imperative, given that all research must be replicable.

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SECTION II

CLIENTS' EXPERIENCE AND UNDERSTANDING OF CHANGE PROCESSES IN COGNITIVE ANALYTIC THERAPY

CLIENTS' EXPERIENCES AND UNDERSTANDING OF CHANGE PROCESSES IN COGNITIVE ANALYTIC THERAPY

ABSTRACT

This study explored clients' experiences of Cognitive Analytic Therapy in order to gain an understanding of the use of reformulation and specific CAT therapeutic tools (e.g. letters and diagrams) and consider how these link to the clients' understanding of change. Using grounded theory methodology the study utilised a three stage design to develop a 'bottom up' theoretical model allowing for constant member validation. Within this process a total of 15 end of therapy interviews were conducted with nine clients who had received a course of individual CAT. The core conceptual framework, 'doing with' emerged from the analysis and was conceptualised to represent clients' subjective experience of Cognitive Analytic Therapy. This framework subsumed four main inter-related themes each interacting and influencing the other; 'being with the therapist', 'keeping it real', 'understanding and feeling' and 'CAT tools'. In sum, CAT from the clients' perspective is an active and emotional experience contextualised in a trusting and collaborative relationship with the therapist. Strengths and limitations of the study are discussed together with clinical implications and recommendations for future research.

INTRODUCTION

Client Experience of Therapy

Psychotherapy process research is concerned with the study of the interaction between client and therapist systems to identify the process of change (Milne *et al.*,, 2001). Clients' perspectives on psychotherapy however, have, in general, received limited attention in process research area and few exploratory studies are represented (Elliott & James, 1989; Macran *et al.*, 1999; Messari & Hallam, 2003). Previous reviews of the client experience literature (Elliott & James, 1989; McLeod, 1990) recommend and advocate the need for more qualitative exploratory research on client's experiences of psychotherapy. There appears to be many reasons for the paucity of research seeking client's views. McLeod (1990) feels there is a pressure for research to be 'scientific' and clients' accounts would not be seen as objective and reliable and he also notes the influence of the dominant therapy models on this way of thinking. This, together with some possible perceived ethical and practical difficulties, (e.g. the risk of re-awakening unresolved issues or interrupting therapy progress) may also account for the dearth of research in this area.

Conversely one may argue that clients' perspectives *should* be an integral part of psychotherapy research (Macran *et al.*, 1999). Clients have 'privileged access' to their own private experiences and therefore can provide a significant insight into the process (Elliott & Shapiro, 1992; Helmeke & Sprenkle, 2000). Furthermore, in a recent review of the psychotherapy literature, Orlinsky *et al.,* (2004), suggested that the therapeutic alliance, particularly as viewed by the client, and the quality of clients' participation in therapy are major determinants of therapy outcome. Client and therapist views of therapy can diverge greatly (for example see, Bachelor, 1991; Halstead *et al.*, 1990; Llewelyn, 1988) and such findings further emphasise the necessity and importance of exploring and understanding

clients' views in order to facilitate clinical practice. In addition, such research into seeking clients' views is consistent with the current NHS objective in involving users in planning and delivery of mental health services (Department of Health, 1999).

In 1989, Elliott and James reviewed studies that had investigated the client experience of therapy. They grouped their findings on what clients find helpful into five main categories; facilitative therapist characteristics, client self understanding/insight, client self expression, a supportive relationship and the therapist encouraging clients to practice new skills outside of therapy. However this review included studies that used observational measures of client experience, therefore limiting the degree to which one can guarantee correspondence with actual client experience.

Despite the demonstrated presence of these common helpful themes in the client experience literature there is still debate on the role of specific and non-specific factors in therapy. Some claim it is the 'general' processes in therapy that are deemed most helpful (Elliot & Williams, 2003; McLeod, 1990). Some studies have found clients' experience of the therapeutic relationship and having the opportunity to discuss their feelings and thoughts in safety carries the most therapeutic gain (For example, MacCormack *et al.*, 2001).

There is some evidence of a provisional difference between helpful aspects in different therapy models (e.g. Gershefski *et al.*, 1996). Client's involved in more prescriptive and directive therapy such as CBT appear to report more specific aspects of the particular treatment and 'problem resolution' outcomes compared to more self insight and understanding in more exploratory therapy or counselling. As part of an investigation into both client and therapist perceptions of helping and hindering events in client centred therapy, Lietaer (1992) content analysed 325 post session open ended questions. Analysis found the

most helpful processes from the clients' perspective were insight into oneself and situations and the chance for self exploration, both of these were facilitated by an involved, empathic, accepting therapist. Emotional relief was also identified as a helpful aspect, this has also been recognised as helpful in studies exploring clients experiences of counselling (Paulson *et al.*, 1999).

Findings from qualitative studies prioritising the client's perspective are beginning to provide an interesting clinical and theoretical starting point from which to explore the process of change within therapy from the client's viewpoint. Clarke *et al.*, (2004) investigated five clients' understandings of change processes in cognitive therapy for depression. Following a grounded theory analysis of post therapy interviews, 3 main clusters emerged; 'The Listening Therapist' covering the non-specific treatment factors, 'The Big Idea' which contained specific factors from the cognitive therapy model and 'Feeling More Comfortable with Self' which centred on the outcomes of therapy. The ten categories within these could then be mapped on to the process of change explained by the assimilation model (Stiles *et al.*, 1990). This study is commended for its generation of a theoretical model of change from the client's perspective but since the researchers used a prescribed interview schedule with no evidence of theoretical sampling, the strict application of a grounded theory methodology could be questioned.

Case Formulation

Irrespective of theoretical background, the majority of psychotherapeutic models advocate that a person's presenting problems be clearly defined and underlying psychological mechanisms be articulated (Eells, 1997). Fundamentally it is the idiosyncratic process of case formulation that performs this task. The case formulation aims to describe a person's presenting problems and to use psychological theory to explain and understand about causes

and maintaining factors that can inform interventions (Bieling & Kuyken, 2003). It is an ongoing process that is responsive and open to revision in the light of new information and is the result of a complex process of interaction between client and therapist (Westmeyer, 2003). This implicates the utility of formulation as a valuable tool for the therapist and hence as a consequence one might expect it to be helpful to the client and their progress in therapy.

Beard *et al.*, (1990) presented four clinical cases to illustrate how a jointly produced reformulation in Cognitive Analytic Therapy (CAT) is both helpful to client and clinician within therapy. They suggested that this process assisted patients in their own self-understanding and control. This study did not explicitly seek the clients' understanding of this but rather made these assumptions from the perspective of the therapist. In a quantitative study focussing more directly on the impact of CAT reformulation Evans and Parry (1996) found that reformulation did not have a short term bearing on session by session measures of perceived helpfulness, therapeutic alliance or individual problems. Interestingly though, through a semi structured end of therapy interview, the clients reported that the reformulation did have considerable impact on them, providing focus for therapy and cementing the therapeutic alliance. However this was not a systematic and qualitative exploration of the meaning and understanding of the reformulation and therapy experience of the clients.

It is argued that the primary criterion of the value of a case formulation is its treatment utility (Hayes *et al.*, 1987). It is difficult from the current research literature to confirm the value of case formulation in this way. In a recent review of the reliability and efficacy of case formulation, Tarrier and Calam (2002) concluded that the evidence is equivocal when comparing individualized approaches to treatment with standard protocols. Furthermore there is some evidence that clients have both positive and negative emotional reactions to the formal sharing of 'formulation' (Chadwick *et al.*, 2003), suggesting that the formulation may

be useful but also unhelpful. In sum, there is a paucity of valid research investigating the impact of case formulation on therapy outcome and hence it is difficult to identify the role that this may play in instigating change in clients.

Therapeutic Change

There are currently several models that conceptualise the process of therapeutic change (see for example, Prochaska & DiClemente, 1982; Stiles *et al.*, 1990; Tang & DeRubeis, 1999). Given the lack of a definitive relationship between formulation and outcome and the lack of exploratory studies examining clients' experiences of therapy, it would be useful to investigate the role which formulation plays in the process of change from the client perspective. Crucial questions include, how, or does, it fit in to established theoretical models of change? Does formulation instigate 'sudden gain' (Tang & DeRubeis, 1999)? Does it facilitate movement from contemplation to action in the stages of change model (Prochaska & DiClemente, 1982)? Does it assist in the process of assimilation (Stiles *et al.*, 1990)? Exploring these areas may shed light on the value of current psychotherapeutic practices.

Present Study

All psychotherapists make case formulations of their clients according to their preferred theoretical and clinical model of practice (Bieling & Kuyken, 2003). The CAT model stipulates that its unique process of reformulation sets it apart from other models (Ryle & Kerr, 2002). Therapist and client work collaboratively from the start to collect information in the assessment period with the explicit aim of achieving an agreed understanding (the reformulation) by session four. CAT makes use of writings and diagrams so the initial shared understanding is made clear. It offers a 'narrative reconstruction' in the format of a letter of the client's story to demonstrate how problems have been formed and maintained. This is supplemented with a diagrammatic summary (Sequential Diagrammatic Reformulation -

SDR). This reformulation provides a common agenda for therapy work and a conceptual tool for both therapist and client. This explicit and clear sharing of the formulation is not routinely utilised in all other therapies (Bieling & Kuyken, 2003) and yet the general under-representation of client experience in psychotherapy research is particularly apparent in the CAT literature. Despite the clinical emphasis on the collaborative nature of CAT, little is known about what client's actually think or understand about the therapy process. Although there has been some focus on the impact of reformulation in CAT therapy and it has been found to be "a powerful agent of containment and change" (Bennett, 1994), the studies, with the exception of Evans and Parry (1996), have not directly sought the client's perspective on this. CAT therefore seems a particularly appropriate choice of model to begin exploring further the general experience of receiving therapy, the client's subjective understanding of the formulation process and the role it plays in therapeutic change.

Aims

The aims of the present study are threefold:

1. To explore and describe the experience of receiving Cognitive Analytic Therapy.
2. To gain a better understanding of clients' experiences of the use of reformulation and specific CAT therapeutic tools (e.g. letters and diagrams)
3. To explore how the use of the reformulation and CAT tools link to clients' understanding of change.

METHOD

Choice of Methodology

The aims of this study were to gain an in depth understanding of the meaning and individual experiences of receiving Cognitive Analytic Therapy. To allow a full exploration into such complex psychological and social therapeutic processes, qualitative methodology was thought best suited. Such exploratory methods in naturalistic research have an important role in furthering our knowledge about change processes in psychotherapy (Hill, 1990). Furthermore, qualitative methods are useful in investigating areas where there has been previous little research. Quantitative methods, such as using standardised questionnaires, run the risk of narrowing the exploration of this experience and novel and idiosyncratic responses would be precluded. In addition, such methods would not be fully taking the client's perspective (Macran *et al.*, 1999) as these tools would be imposing the researcher's assumptive framework.

Grounded Theory

Grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1990) was chosen as the preferred methodology for several reasons. Firstly, therapy is a social interaction between two people (Kuhnlein, 1999) working at both inter and intra personal levels. Grounded theory methods can be used to study both individual process and interpersonal relations (Charmaz, 2003) and it provides an in depth way for the subjective experiences of clients to be explored and for these to be retained in the analysis and write up.

Secondly, the strength of grounded theory lies in its empirical foundation. Originally, grounded theory was designed to study social processes from the bottom up (Willig, 2003). This fits conceptually with the user focus of this study. It allows discovery of the client

experience without forcing that data into preconceived categories. Revisiting participants, checking out preliminary hypotheses and refining and exploring concepts are all inherent to the grounded theory methodology (Charmaz, 2003), rather than a 'bolted on' quality control method. This was particularly appealing as it meant participants take an active and collaborative role in the research process, not just providing data.

Thirdly, the simultaneous involvement in data gathering and analysis in grounded theory is explicitly aimed toward developing theory. Grounded theorists follow leads to develop their emerging theoretical categories. Other methodologies may produce a rich description of behaviour without extending or refining theoretical concepts or making theoretical connections. This emphasis on studying processes moves research away from static analyses and is particularly suited to this study's interest in the dynamic process of change. For these reasons other qualitative methodologies were considered but discounted as they would not allow sufficient exploration of the experience of receiving CAT. Although Interpretative Phenomenological Analysis (IPA, Smith & Osborn, 2003) would allow exploration of the meaning of clients' experiences it would not lend itself to the level of flexibility required to meet the aims of this study in terms of being able to generate a theoretical model. In template analysis the researcher has an initial coding template which is then verified or modified through data collection. This may hinder the emergence of spontaneous and novel data (Länsisalmi *et al.,* 2004). A method such as discourse analysis, which specifically analyses the language and discourse, would not lend itself to the aims of uncovering the phenomena and processes of change.

Ethical Issues

Although the research interview was not intended to cause undue distress, the material discussed was undoubtedly of a personal and emotional nature and may evoke distressing

memories. If this happened therapists collaborating in the study had agreed to see their clients and make appropriate arrangements within the relevant service. The research study gained ethical approval from North Sheffield Research Ethics Committee (see Appendix 1).

Design

The grounded theory approach utilised in this study largely followed guidelines by Charmaz, (2002) and aimed to develop a 'bottom up' theoretical model allowing for constant member validation. As such this study had a three stage design and utilised 15 interviews (see appendix 2 for diagram of study design). In line with grounded theory methodology stages are iterative.

Stage one: Symbiotic reflexive interviewing with inter and intra analysis of data

Within this stage, six participants were interviewed twice, giving a total of 12 interviews conducted. Each interview impacted on later ones as initial analysis allowed emergent themes to develop. Participants were revisited to elaborate on themes, both from their own original interview (intra-analysis) and themes from other participants interviews (inter-analysis). Revisiting participants allowed the researchers perspective and understanding to be challenged or validated. The interview schedule was amended to incorporate emergent themes and focus the data collection.

Stage two: Developing the model

This was the main stage of analysis. All collected data and initial codes were analysed through axial coding and then more theoretical selective coding (Charmaz, 2002). This led to the development of two hypothetical models. The first, a summary of the relationships between the axial codes and the second, a more conceptual model incorporating the axial codes.

Stage three: Testing the model and exploration of theoretical saturation

The function of this stage was to explore and validate the models that had emerged as a result of the first two stages. Theoretical saturation and theoretical sampling were sought. Interviews with three new participants were conducted to achieve this.

Participants

A purposive sample of nine clients, with a variety of presenting difficulties were recruited from a specialist CAT psychotherapy service and community mental health teams within the same NHS trust. In stage one, six participants were each interviewed twice, in stage three, three participants were interviewed once. There were eight female participants and one male, with an age range of 25-60years. Participant characteristics are shown in table 1.

All participants received a course of CAT with the basic tools (i.e. the therapeutic letters and SDR). A naturalistic stance was adopted therefore strict adherence by the therapists to the CAT model was not monitored. Duration of therapy ranged from 16 to 40 sessions. All clients had one follow up session as part of the contracted therapy and two people had returned to therapy for an additional six 'top up' sessions.

Recruitment

Six qualified therapists, five female clinical psychologists and one male psychiatrist, collaborated in the study. All adhered to a CAT model as their preferred orientation in therapy. At the time of recruiting clients, four of the therapists were qualified CAT practitioners, qualified for an average 11 years (range 7 to 17 years), and two were in the process of completing their CAT practitioner training.

TABLE 1: STAGE ONE PARTICIPANT CHARACTERISTICS

STAGE	Participant[1]	Gender M/F	Age	Ethnicity	Presenting Difficulties (Self report)	No of CAT Sessions	Duration between end of therapy and research interview
1	Sheila	F	46	White Irish	Depression Anxiety	16	10 months
1	Susan	F	35	White British	Depression	16 + 6	5 months
1	Margaret	F	56	White British	Low self esteem Reactive depression	16	2 months
1	Sarah	F	25	White British	Psychosis Not eating Depression	40	2 months
1	Elaine	F	47	White British	Depression	18	16 months
1	Dorothy	F	60	White British	PTSD from car accident Memory loss Depression	16	3 months
3	Alan	M	34	White British	Depression	36	4 months
3	Clare	F	43	White British	Psychotic Depression	16 + 6	4 months
3	Sam	F	29	White British	Low self esteem Depression Distorted self image	16	2 months

Therapists purposively selected clients from their current and prior caseload based on the following inclusion criteria; 1) the client reported some subjective change following therapy and 2) they had completed therapy within the last 18months. In addition, using clinical judgement regarding issues of risk or vulnerable mental health, therapists decided who to introduce the study to. Therapists introduced the research project either verbally at the end of the 3-month therapeutic follow up or in writing, after the follow up, by letter (appendix 3). The research information sheet (appendix 4) was given to clients at this point. Clients then

[1] Pseudonyms are used for all participants

self selected themselves into the study by returning an initial consent form (appendix 4) giving permission for the researcher to contact them. Participants were asked to sign the official study consent form (appendix 5) when they presented at interview.

DATA COLLECTION

The Interviews

End of therapy, semi-structured interviews were conducted. The original interview schedule (appendix 6) was guided directly by the aims of the research and followed the basic grounded theory interview concepts as outlined by Charmaz (2002). It was piloted with a therapist who had undergone personal CAT therapy. Amendments were made to the phrasing and some questions omitted as a result of feedback from this.

The interviews aimed to take the form of a 'directed conversation' (Lofland & Lofland, 1983), which generally began by asking how people had come into therapy and the schedule was used as a flexible guide to explore participants' experience. Some people told their story quite spontaneously and the main areas of research interest arose naturally, others needed more assistance with the prompts and questions.

Following grounded theory principles, data collection and the first stage of analysis were conducted simultaneously. Interviews lasted between 45 to 90 minutes. They were audio-taped and transcribed verbatim by an independent transcriber, who was required to sign and comply with a confidentiality form (appendix 7). Final stage interviews were audio-taped but not transcribed as time limits precluded detailed analysis of transcripts. All tapes were listened to by the researcher during analysis to allow the researcher to relive the interview,

immerse themselves in the participant's world and take detailed notes for those interviews not transcribed.

Analysis

The analytic process proceeded through three distinct phases as described below.

Phase 1: Simultaneous interviewing and initial open coding.

After conducting the first two interviews, initial open coding was utilised to generate descriptive categories from the transcripts. The transcripts were studied line by line and specific active terms, often using the participants' language, were used to describe what was happening in the data. See appendix 8 for an example of this process.

As a result of this initial coding, and in keeping with the grounded theory approach, the interview schedule was amended (Strauss & Corbin, 1990) to facilitate opening up additional avenues of interest that emerged from these first interviews. The same two participants were then re-interviewed to elaborate further and clarify the researchers understanding of the content of the first interview. Following up themes in this way strengthens the emerging analysis by sharpening and deepening the concepts (Charmaz, 2002). The same open coding was conducted on these second interviews and further comments incorporated to inform the next two participants' interviews. Subsequent participants were still encouraged to fully express their experience of therapy as limiting the interview schedule questions to generated open codes at this stage would not have ensured theoretical saturation was reached. This process was repeated until saturation occurred which was after interviewing the first six participants.

Memo writing was used during each phase of analysis to make the analysis progressively stronger, clearer and more theoretical (Charmaz, 2003) and to begin to develop ideas in narrative form. For example when participants made links between concepts this was noted to instigate the exploration of the relational aspects of the resultant categories and begin to understand therapeutic processes from the client's perspective.

Phase 2: Axial Coding

Once all interviews had been completed, the second stage of grounded theory analysis, axial coding, began. Axial coding uses the most significant or frequent initial codes to sort, synthesise and organise large amount of data (Charmaz, 2003). The initial codes were logged on separate index cards together with records of the transcript lines from which they originated. These codes were then organised into ideas for the axial codes. Employing the constant comparative method of grounded theory allowed the researcher to check the fit between these emerging analytic codes with initial codes and raw data. It also encouraged exploration of the depth and complexity of the data. Diagrams and memo writing were utilised to aid this process. Diagrammatic examples of the development of axial codes from the initial open codes, together with illustrative quotes[2] are provided in appendix 9.

Phase 3: Selective Coding

The aim of selective coding is to present findings as a set of inter-related concepts rather than a list of themes (Strauss & Corbin, 1990). In order to generate these concepts the axial codes were examined and explored and the transcripts and initial codes were revisited. Re-reading the narrative material allowed further searching for relationships and connections among the

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[2]All identifying information has been removed from the quotes used throughout the report. To preserve anonymity, 'T' is used to represent the therapist name and 't' replaces the gender pronoun of the therapist. All quotes have also been edited for readability. Long pauses and digressions have been removed and are indicated by……in the text. Repetition of words, and most utterances such as 'umm' and 'err' have also been removed.

categories. A process of both deconstruction and integration of the axial categories served to generate a theoretical model (Charmaz, 2002).

Validation of the Model

The developed conceptual model of themes, together with the more detailed axial codes, were presented to three new participants to explore their understanding of the model and how it fitted with their experience of therapy. As an opportunity to develop the concepts further, participants were encouraged to comment on the model's authenticity and any aspects of their experience they felt it did not accommodate. As a result of these interviews some very minor amendments were made to the dimensions of the codes, but primarily all three participants re-affirmed that the model was an accurate representation of their experience of therapy.

QUALITY CONTROL

In all research it is important to include measures to ensure quality, validity and credibility of the process and consequent results. This process was informed by following the guidelines and considering the issues presented in the following reviews: Elliott *et al.,* (1999) and Stiles (1993).

Elliott *et al.,* (1999) recommend that qualitative researchers clarify their values, interests and assumptions in order to help the reader to interpret the researchers understanding of the data and reflect on possible alternatives. The researcher was both sole interviewer and analyst of the data. She was a trainee clinical psychologist with several years experience of working within mental health services and had recent experience of working within a CAT model.

The first transcript and interview tape were examined by one supervisor to check the fit between initial coding and data and to feedback on interviewing style. The emerging themes were discussed with and monitored by both research supervisors who sought examples from the transcripts. A research journal was also kept to monitor the research process. This allowed a reflexive approach (Stiles 1993) and included influences upon data collection and analysis and what informed thinking in these areas.

Employing established grounded theory techniques to simultaneously analyse and collect data strengthened the methodological validity of the study (Charmaz, 2002). Multiple sequential interviews allowed member validation which ensured the researcher's interpretations were warrantable. The final stage in the research design of seeking model validation with three new participants was an additional strength.

For transparency, examples of open coding and axial coding development together with examples of quotes have been provided in the appendices to allow the reader to follow the process and judge the fit between the data and the resulting categories.

RESULTS

In total, seventeen categories resulted from the axial coding phase of analysis. It was recognised that participants often described their therapy as a 'journey';

" it was about, the journey I've had" Elaine

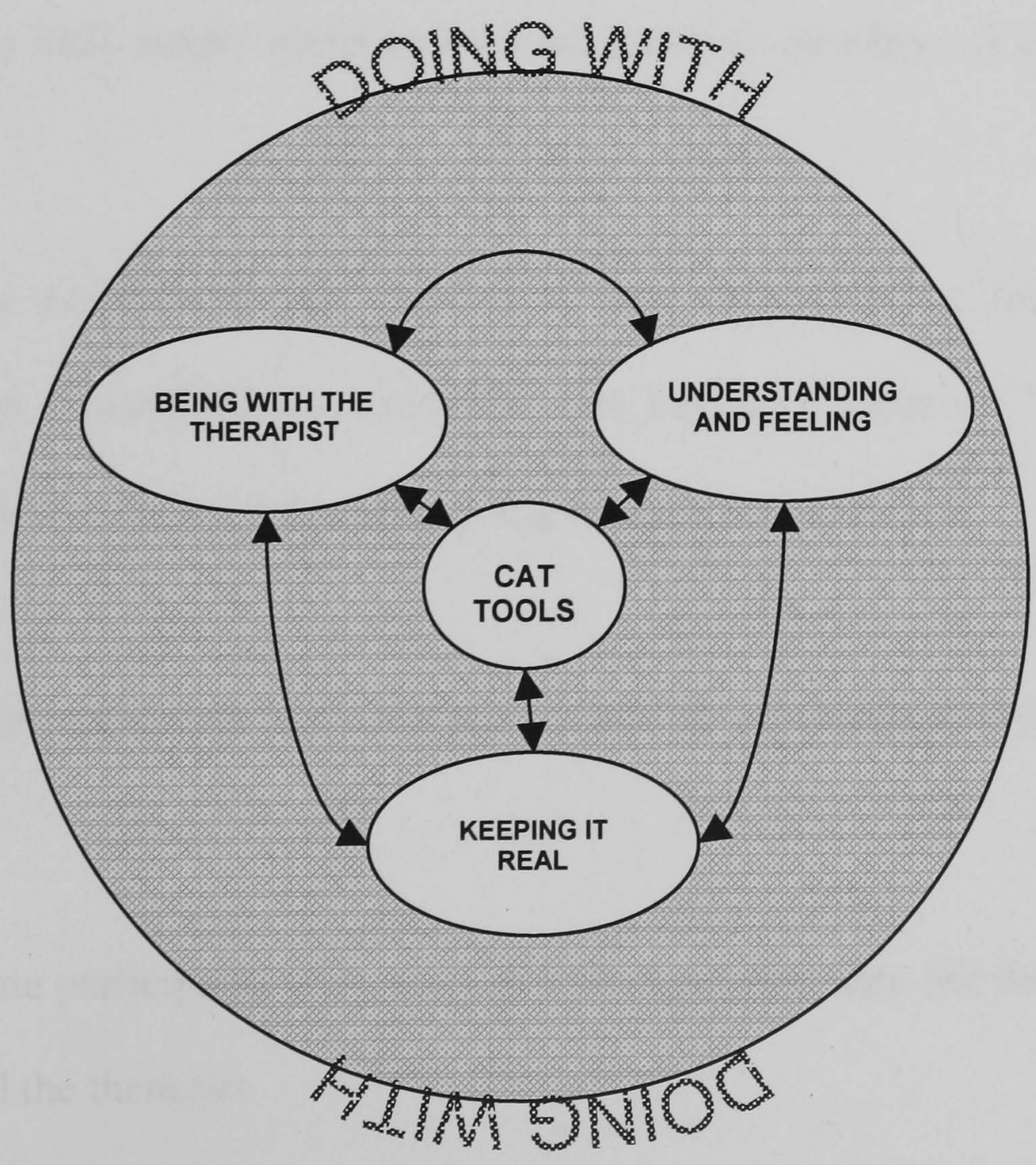
and this was reflected in the way they told their stories with a beginning, middle and end. This logical sequence was used to inform the representation of axial codes (Charmaz, 2002) and the hypothetical relationships between them. This is illustrated in Appendix 10. Exploring this notion of the journey with participants at stage three and revisiting the original transcripts highlighted that this was not a simple linear process. Participants appeared to move between different stages during therapy as they developed skills and awareness and some described being stuck in certain stages at times or having 'ebbs and flows'. Furthermore, there were a lot of complex inter-relationships between the axial codes together with overlapping dimensions within them. The process of selective coding developed a simpler conceptual model that accounted for all of the original axial codes, however, reflective of the interrelated processes, some of the axial codes could fit in different concepts (see appendix 11).

This results section will focus on presenting the theoretical model, validated by participants, which emerged from the analysis and integration of the more descriptive axial code journey model. It provides an understanding of the experience of Cognitive Analytic Therapy from the client's perspective and hypothesises how the specific CAT tools integrate into this.

CORE CONCEPTUAL FRAMEWORK: DOING WITH

The core conceptual framework, 'doing with' emerged from the analysis and was conceptualised to represent clients' subjective experience of Cognitive Analytic Therapy. It was chosen as the concept appeared in all interviews and had the greatest links with the other categories (Strauss & Corbin, 1990). It seemed to grasp the essence of what clients were conveying about their experience of therapy and understanding of change. This framework subsumes four main inter-related themes each interacting and influencing the other. The first three are 'being with the therapist', 'keeping it real' and 'understanding and feeling'. Participants described many different ways in which the fourth theme 'CAT tools' integrated in all of these prior themes. A diagrammatic representation of the model is given in Figure 1.

FIGURE 1: 'DOING WITH': A THEORETICAL MODEL OF THE CLIENT'S EXPERIENCE OF COGNITIVE ANALYTIC THERAPY



'Doing with' conceptualises the strong sense of the working bond between client and therapist in CAT. Participants felt they couldn't have made changes on their own and the support of the therapist was crucial.

"I couldn't have done that on my own, there is absolutely no way could I have done the work that I needed to do, without having somebody so skilled and so able to go with me and help me on that journey. And that to me is so, so incredibly brilliant" Elaine

The conceptual framework acknowledges that therapy from the clients' perspective was often described as very hard work. Participants talked about the role they had in actively working together with their therapist.

"... [Therapists] are not going to change you, they got to sort of trigger the things within your self and I think one of the things that I think probably came out at the onset is that you have got to work on it. You don't just sit back and let it all happen you know your therapist isn't going to wave a little magic wand and it's all going to be okay. It's working alongside" Sheila

All participants recognised they needed to take responsibility for change and many commented that determination, motivation and having a focus on 'getting better' were personal qualities that helped them keep going through the hard work.

"I was very clear, right from the word go, I would do absolutely everything in my power to change" Elaine

Despite this, some participants were wary of how dependent they felt they were becoming on therapy time and the therapist.

"There was a sense of dependency and that was quite scary" Alan

Some described therapy as 'a crutch' and were apprehensive, if not frightened, of how they would manage on their own when therapy ended. The intensity of this feeling varied greatly between participants and fluctuated over the course of therapy. Most were more accepting of this than others.

"....there's a danger [of]using the therapist as a prop isn't there? its no good because, I've got to live my own life, cant have a prop to prop me up all the time, so I've got to learn how to, deal with it myself really, that's how I see it" Margaret

Each sub theme is first described below, and then the experience of the CAT tools, and how they interlink with each of these themes, will be presented.

BEING WITH THE THERAPIST

This theme conceptualises the emphasis and importance clients placed on the qualities of and their relationship with the therapist. Participants' first impression of therapist appeared fundamental. People described making very immediate automatic decisions about whether they were going to 'get on' with their therapist.

"...you will make a decision about somebody within, you know, sort of a couple of minutes of being there. And that is incredibly almost automatic response" Elaine

Many described their therapist's manner as very calm, quiet, friendly, truthful, reassuring, sympathetic, personal, kind, caring and encouraging. Participants stressed how important it was to feel understood, listened to and valued as a person.

"...T said well 'you must absolutely furious, of course you were furious' You know? I thought, hang on this is somebody who understands that, you know, why I feel like I do" Margaret

"That's a big thing. If you feel that the person, is interested in, in what you've got to say. That ... validates you, you are valid as a person, and then that helps enormously I think." Dorothy

Participants described feeling confident, comfortable and at ease within this relationship and professional qualities such as the perceived competence and experience of the therapist contributed to this together with the confidentiality clauses.

"...[therapists have] got your qualifications, so, so there's a certain standard that reassures the client" Margaret

Furthermore, many talked about the importance of having a trusting relationship. They needed to feel safe and secure in order to divulge personal and painful information in the confidence that the therapist would be able to contain their emotions.

"it's about developing that trust. I think for me the...the testing out was, if I fell apart, could T bring me back up, because I was frightened I couldn't do it myself." Elaine

Clients compared this relationship to others outside of therapy and described feeling free to talk and explore their thoughts and feelings.

"it was having somebody to talk to, that you didn't know. There was no, previous relationship with that person, so you were free to say what you wanted, without any sort of repercussions coming up again..." Margaret

Being given permission to own and express emotions was also talked about. This way of being in a relationship then appeared to be a mechanism of change in itself as some participants used it as a model to transfer to the outside world.

Therapist actions that participants described as pertinent to being supportive in change were challenging unhelpful thoughts, explaining and recognising patterns, questioning and helping clients think for themselves.

"T gave me confidence that if I was doing something wrong t would tell me. As in, if I was thinking you know, in an unhelpful way then T would tell me" Sarah

Two participants talked about not wanting to let the therapist down. For one this encouraged her to work hard in therapy whilst for the other it meant she sometimes found herself saying what she thought her therapist wanted to hear in order to please them.

" when I came away sometimes, I thought... 'I think I said that because that's what she wanted me to say'" Dorothy

In sum, the supportive environment created by just being in a therapeutic relationship facilitated aspects of change and added greatly to the positive experience of therapy that participants described. The relationship alone however did not appear sufficient.

UNDERSTANDING AND FEELING

This theme refers to the ways in which participants said they felt better about themselves after therapy and their understanding of this change process. Change, from the clients' perspective, seemed implicit in becoming aware of and developing an understanding of their feelings. This development of insight then leads on to recognising their behaviour and making attempts to do things differently.

Being unaware of certain feelings or issues or actively pushing them away were more prominent at the beginning of therapy.

"... people bury so much stuff because it's too painful to bring out in the open" Sheila

Participants then talked about issues 'surfacing' in therapy that they had not shared with anyone before or not wanted to deal with.

"I thought I'd got them taped and stuck away...and in the therapy they all came back" Elaine

Participants described therapy as a very emotional experience. Everybody talked about getting very upset when reliving these difficult painful memories and acknowledging their existence. There was an awareness of needing to go through this pain to make sense and understand themselves. Some described it as a 'necessary evil'.

"..it's not something you particularly want to go through because its very difficult, but yet you know that.... you have to go through [it... to use a common phrase feel the fear and do it anyway" Susan

Many talked about feeling relieved once they were able to open up and release and express these emotions and repressed memories.

"...I felt relieved about giving it away. Like giving it to another person and keep it..." Sarah

Accessing and exploring childhood experiences appeared to be useful to all participants and seemed a key feature in beginning to understand the origins and development of their behaviours. It appeared to be one of the first and necessary stages of change from the participants' perspective.

"It's suddenly having somebody who explains where you learnt that and why you learnt it. And it was part of, for me a defence mechanism, it was part of, of survival when I was a little one, that was the only way I got through" Elaine

Following on from the concept of understanding, participants talked about becoming aware of and recognising their behaviours and thought patterns.

"T made me realise how many times I was saying should, 'I should.'..... each time I said it, t just had to look at me and I knew that I was, I just thought 'god I said it again.'" Dorothy

Next were comments about beginning to re-assess situations and questioning themselves, their behaviour and recognised thought patterns.

"certain talk patterns have emerged during my psychotherapy and you sort of you know if you are going to behave in a situation somewhere were you think 'well why am I doing that that's not true' So you are questioning yeah, yeah and more analysing why you react in a certain way" Sheila

Participants then talked about taking a different perspective or taking a step back, to help them open up more choices about doing things differently.

"there are certain thought patterns, that I have, and what I am doing, is learning to change those thought patterns. Block them when I've discovered that I'm using them [description of patterns] I stop myself and say, hang on, stop that, think of something positive" Margaret

In the main this appeared to be something that participants began to actively look into themselves whereas at times others relied more on therapist suggestions.

" T taught me or, I don't know if that the right word, taught, help me sort things out...[details of difficult relationships] and how I could change my behaviour to improve the situation" Sarah

Clients reported therapy as a positive experience and described themselves in new ways in comparison to their past selves indicating recognition of unhelpful prior aspects. Most people reported quite general positive changes within themselves and not specific symptom relief and attributed these changes to therapy. Learning to be kind to oneself were comments made by nearly all the participants. They no longer criticised themselves and some said they knew themselves better.

"...more comfortable in my own skin, not depressed, not like hating myself, not frightened about what career, what job... I don't feel like a failure" Sarah

Participants also talked about general improvements in their self-confidence, self esteem and assertiveness.

" I'm getting better at going 'no no no I want to do that for me.'" Elaine

In addition most, but not all, talked about improvements in their relationships with others. Some of these changes appeared to be a consequence of the general improvements in self whereas with others there had been a more specific focus on relationships in therapy.

"I think if you start understanding, how you're functioning, then you can, sort of appreciate how other people are functioning as well" Margaret

All participants talked about change being a very gradual process and not an immediate, sudden change. Some described 'ups and downs' in therapy but with a gradual trend of improvement. Becoming aware of their thought and behaviour patterns took time and practice and the new skills they were learning took time to develop.

"... it's actually been a gradual [understanding], a big light didn't come on, it sort of seeped through as time went on" Margaret

All participants commented that therapy was not 'a cure' and acknowledged that their patterns and feelings were still there. No-one was distressed or frustrated by this but rather accepting that longstanding behaviours were difficult to change.

"I don't blame T... or anybody else, for that matter, for not coming up, with a quick a solution, probably after sixty years of feeling guilty it takes a long time to, to alter the patterns," Dorothy

Participants acknowledged the fragility of change and normalised the unpredictability of the future and the impact external events or other people could have on their mental health and achieved changes.

"I have no illusions that I'm now cured forever. No way. And I'm sure there's major crises that are around some corner or other" Elaine

All participants made comments about how they felt that change is ongoing and continuous and once therapy ended there was a responsibility of oneself to keep practicing the techniques learnt.

"[therapy is] not an end in itself. It's like there's, a door is open to give you a model of trying to manage your life if you like. But...but it's a process and as you build you'll move forward" Elaine

Some even commented that this was where the real learning took place and noted more improvements since therapy ended.

"In fact I think, its [my changing behaviour is] probably coming more to the forefront since I've finished therapy, and I've had time to reflect..." Margaret

KEEPING IT REAL

This theme represents comments people made about the critical importance of 'doing' and not just talking in therapy. Those that had had previous counselling would compare their experience of this with CAT. Being able to 'offload' feelings and thoughts did not appear to be sufficient.

"...and that's what I liked about the therapy it wasn't sort of up in the clouds you know, it was real in terms of your day to day activities" Sheila

Everyone appreciated that practical tasks to do outside of therapy were given and discussed.

"T would suggest things that might help and I'd go away and try them and come back and say how it had gone" Sarah

Two participants could link doing tasks outside of therapy specifically to an improved sense of self, for example;

" if you can achieve, a task, you know and get something done, you feel better ...., you know feeling worthwhile and feeling a sense of some achievement really" Sheila

Specific discussions linked directly to their particular issues and using real situations as examples to work with within therapy were deemed very useful.

"...doing bits of scenarios that have happened, not just made up, things that have happened while your having therapy" Susan

Continuity between sessions was also commented on. Participants found it valuable when the therapist followed up things talked about previously. Specific metaphors or techniques seemed to help keep things grounded in reality and were important and useful 'tools' that were remembered and accessed easily.

"....there are certain things that T said that really really stuck in my mind that have helped an awful lot .....one was 'what would your best friend say to you?' Or 'if this was your best friend what would you be saying to her?'" Dorothy

CAT TOOLS

CAT tools are; the reformulation and goodbye letter (the letters), the sequential diagrammatic reformulation (the diagram) and the time limited structure of CAT.

The majority of participants found the time limited structure comforting and useful. It helped them know what to expect and keep them focussed in sessions. However, one person found it frustrating and rigid and felt they did not have much control over the continuation of therapy. Feelings about the structure seemed to influence emotional reactions towards ending therapy.

Those who found the structure useful were prepared and more accepting of the ending, however when it was experienced as restricting, this led to feelings of dread, fear, and anger. Knowledge of the follow up appointment was comforting and for some the therapist had 'left the door open' to come back if needed which participants noted as really important describing it as a 'safety net'.

The letters were also described as part of the 'professionalism' and structure of therapy. Participants had a variety of reactions to the letters ranging from ambivalence to powerful emotional pain. There were also different reactions to the diagram. Two people in particular didn't find the diagrams helpful. They found them hard to remember and didn't feel they were a major part of their therapy experience. One because she found it too complex and hard to grasp and another felt she was dismissive of them as it just didn't fit with her way of working. Some were more ambivalent and accepting of the diagrams as part of therapy whilst others again found it very emotional.

WHAT ROLE DO THE SPECIFIC CAT TOOLS PLAY IN CLIENTS' EXPERIENCE OF THERAPY AND THEIR UNDERSTANDING OF CHANGE PROCESSES?

Being with Therapist

Both the letters and diagrams appeared to contribute and cement the therapeutic relationship.

Most appreciated the process of negotiation and collaboration in the development of the letter and diagram and this made some clients feel empowered.

" ...[I was] given the draft letter, take it home, go through it and think... that itself is was very powering for me" Susan

It also appeared for some to be an agreement of the working bond and helped clients know what to expect from therapy.

"...confirming, and making sure that you're both, understanding, talking, singing from the same hymn sheet, kind of thing or you know, but making sure, that I understand things the way T was, understanding them and, making sure we were sort of, going down the same path really" Margaret

After the reformulation letter some talked about their feelings toward the therapist. They felt the therapist was insightful and had listened and understood them.

"I felt as though there was an incredible powerful working bond there. I was staggered at the insight and how what I'd said had led T to write the letter in the way that t did. It was like 'ah, my god,' you know" Elaine

"Like an active demonstration of listening,[the letter], made me think that T was thinking about me and thinking about ways to help me" Sarah

The reformulation letter seemed to evoke the strongest emotional reactions ranging from sadness, pain and shock to ambivalence and acceptance to feeling positive and hopeful that things could move on. The importance of the therapeutic relationship being containing and trusting at this point was commented on as being crucial.

The goodbye letter appeared to have a slightly different function. People said they found it useful to write to the therapist as a way of documenting their progress and an opportunity to say thank you. Not everyone wrote a letter to the therapist at the end, one person intended to write to her therapist but wanted to wait and see how she managed after therapy. People tended to feel and hope that the goodbye letter was of benefit to the therapist.

" [the goodbye letter was] sort of giving an occasion to finishing it and to thanking the person which I felt was quite important and to feedback to them what it has meant for you" Sheila

Keeping it Real

Both the letters and diagrams contributed to making things real and tangible. With both the reformulation letter and goodbye letter, there was a sense of being able to see things written down in black and white that made their issues and memories more real and stark for people.

"...seeing all the like, so many like sad things all written together, hand written and they were, they were me or about me or mine, something, yeah"

R: Yeah, so there's something about seeing it there –

"Yeah, all condensed and a bit like, a bit like it's real, and you can't take it back" Sarah

For those that found the diagrams useful, they found it an accurate visual tool and one person described feeling amazed at seeing her behaviours mapped out in this way, finding it very different experience of thinking about herself. By naming and labelling thought processes and behaviour on a piece of paper made issues tangible and aided self awareness.

"When T did [the diagram] the first time, it was quite amazing just to actually look at it and just to see.... that diagram with all the, the aspects and everything there was, that's what I did....that's right, that's exactly right." Susan

By using real live examples in the diagrams helped again to ground therapy and have a more practical use.

"...doing bits of scenarios that have happened, not just made up, things that have happened while your having therapy" Susan

Understanding and Feeling

The reformulation letter appeared to facilitate the first client identified change process of understanding. Participants could clearly link their current difficulties to their earlier childhood experiences. The diagram also aided understanding for some but this appeared to be more on the level of understanding patterns rather than the historical explanation.

"...the understanding of why I was feeling like I was, was very helpful"

R: How was the understanding achieved?

P: [T] drew diagrams of how I was powerless, belittled, felt wronged, was angry, couldn't express it, kept it inside myself, and so it was a vicious circle. So T sort of explained, that aspect to me and so that, it sort of showed up a pattern" Margaret

The diagram seemed to play a more important part in the learning process of becoming aware of behaviours, questioning themselves and trying to do things differently. This was part of the gradual process of change as participants commented it was initially hard to see and recognise patterns but they gradually gained insight with practice and therapist assistance.

"I could practise it, and that's what I did, I went home and I practised my bubble. And I would think something, and I'd think 'that's, yeah, of course it is, that's how I've always thought....right, so I've always thought, right, what is another way of doing that.'" Elaine

Some found the diagrams annoying and limiting at times as they questioned how they could apply to all situations and emotions whereas others seemed to say the opposite and commented how they used it to apply to many different situations.

Both the reformulation letter and diagram helped people step back and take a different perspective on themselves. Participants talked about how seeing things written on paper helped them develop a more empathic and anon-blaming position.

"...like reading a very sad book. You have empathy for that person even though that person is actually you" Clare

With regard to the continuity of change participants reflected back on therapy in slightly different ways. Some appeared to use the general concepts of 'thinking things through' whereas others used the actual materials from therapy. All participants kept both their letters and diagrams however those that did not find the diagrams particularly helpful were unsure as to the whereabouts of the diagrams.

"...they [diagrams] are not something I have got back and delved into a lot you know I probably don't even know where they are now" Sheila

The letter and diagrams appeared to have slightly different use after therapy. People tended to use the letter as a record of how they felt before they went in to therapy and to reflect on progress. One person found reading the letter a way of maintaining a connection with the therapist.

" [I read the letters] when I was upset or missing T or something. [I] felt comforted by reading T's words" Sarah

Diagrams appeared to be used and referred to more frequently in a practical way than the letters. People used them when they felt upset, as a reminder of how to deal with things and to re-emphasise what they had learnt. Some described it as a way of keeping therapy alive and have found that the techniques have become more automatic as time passes.

"...if I have a big dip, or I feel, I start to feel a bit shaky, I'll go back to [the diagram]and try and 'right, what's this about, what's happening here?'" Elaine

People commented that CAT gave them a set of management tools, and the techniques learnt in therapy could be adapted and generalised to many situations to manage their emotions, cognition and behaviours.

"But, its managing it again, being able to control the way you think about those issues, because CAT therapy is doing that with other specific things, I think it reflects and it bounces off on to others as well. Cos you know you are changing the way, your core thinking" Susan

It was acknowledged by some that these tools do have limits and cannot always be accessed as sometimes extreme emotions or physical tiredness take over. They appear to require a certain level of functioning to utilise them beneficially.

"And I can't, can't do the distraction, can't do the breathing, because [fear] tends to take over completely" Dorothy

DISCUSSION

This study set out to explore and describe the experience of receiving Cognitive Analytic Therapy and to gain a better understanding of clients' experiences of the use of reformulation and specific CAT therapeutic tools. It also aimed to explore how the use of the reformulation and CAT tools link to clients' understanding of change.

The model, generated directly from the interview data, proposes a representation of these aims. From the clients' perspective, the experience of CAT is characterised by a strong feeling of actively working together with the therapist. The emergent themes had reciprocal relationships and not one theme alone appeared to be sufficient to instigate the changes clients reported. These changes were facilitated by being in a collaborative trusting relationship with the therapist where the client felt understood and safe to explore deep emotional and painful issues. Keeping the therapy real by using real situations and having practical tasks to do, enhanced the relationship and allowed clients to feel they were actively doing something to achieve change. The experience and use of the CAT tools were contextualised within these processes. It was significant that while the themes, and relationships between them, represent common experiences there was some variation within them. For example, those who had the greatest emotional reactions to the letters and diagrams and took an active role in constructing them appeared to gain most benefit from them. With the exception of the two people who did not connect with the diagram, those who were more ambivalent to the tools did find them useful, but gave more importance to the therapeutic relationship. These findings are discussed in the context of the current related literature.

The changes participants attributed to therapy were more general shifts in their experience of, and relationship with, themselves. These are reflective of 'second order changes' that Murray

(2002) describes. She proposes it is these that often then lead to other troubling aspects, such as first order difficulties in behaviour, cognitions and affect to fall into place. Murray's study interviewed clients who had 'at least two years' of ongoing therapy. This study has demonstrated that more fundamental changes within the structure of self can be achieved with a time limited therapy such as CAT.

The proposed model's themes do appear to capture the general categories of 'helpful aspects' of therapy summarised by Elliott and James' (1989) in their review. Facilitative therapist characteristics, permission for client self expression and experiencing a supportive relationship are encompassed in 'being with the therapist', gaining insight and self understanding are represented in the 'understanding and feeling' theme and the therapist encouraging the client to practice new skills outside of therapy is reflective of the 'keeping it real' theme. It is the experience of the CAT specific tools and the role they play in all of these that gives CAT an additional helpful aspect.

Previous claims that clients are not interested in techniques and it is the therapeutic relationship which carries therapeutic gain (for example; Elliot & Williams, 2003; MacCormack *et al.,* 2001; McLeod, 1990) are not substantiated by this study. The relationship is indeed of significant importance but all participants spoke of the usefulness of actually being able to do things and translate therapy to the real world. Many talked about having 'tools' to manage day to day situations although it was difficult to distinguish at times, due to the close symbiotic relationships between concepts, whether these were general suggestions from the therapist or specific to the CAT model. Some described useful therapist actions or therapeutic techniques that would be common to other therapy models, for example challenging thoughts and using the 'best friend' compassionate role play to gain a different

perspective and generate alternative thoughts would also be utilised in a Cognitive Behavioural Model (Fennell, 1989).

Much of the model generated from this exploration of client experiences, appears consistent with the basic tenets of the CAT model itself. The notion that the CAT therapist is good at 'doing with' (Kerr, 1998) and that CAT involves hard work and much of that hard work is done by therapist and client together (Ryle & Kerr, 2002) are overwhelmingly upheld by the findings. It reinforces Rennie's (1992) claims that clients do and can influence what goes on in therapy and are indeed 'agents as well as patients'. The active role clients described taking confirms that they see themselves as significant contributors to successful therapy outcome and change (Dimcovic, 2001).

However within this collaboration there were instances of what Rennie (1994) calls client deference. Participants spoke about wanting to make a good impression on their therapist, not wanting to let them down and not questioning their judgement even if they doubted it. Some clients did feel able to openly challenge their therapist whilst others sat back and accepted the therapist must 'know what they were doing'. 'Unspoken rules' about the therapeutic relationship were known to all participants. Therefore, despite best collaborative efforts participants are all too aware of the inherent power imbalance within the therapeutic relationship however this did not seem to have a detrimental effect, rather the 'professional' aspect of therapy, with warmth and friendliness, gave people comfort and confidence.

One striking feature of the model is the role 'feelings' play in CAT, participants described therapy as a painful emotional experience. Participants' sense of accepting this as a 'necessary evil' to gain maximum benefit from therapy is in line with Saunders (1999) findings that clients' affective experience has a fairly strong relationship with treatment effectiveness.

Further more it supports the notion that cognitive insight alone may not be sufficient to instigate change and problem resolution but affective arousal is needed too (Watson & Rennie, 1994). The experience of this emotional release was cathartic and helpful, supporting previous claims that self disclosure, positively influenced by the quality of the therapeutic relationship, is therapeutically beneficial (Farber *et al.,* 2004). This emotional experience of CAT corresponds more with previous research on clients' experiences of more exploratory therapy or counselling (Lietaer, 1992; Paulson *et al.,*, 1999) rather than cognitive or cognitive behavioural therapies (Clarke *et al.,* 2004; Gershefski *et al.,* 1996).

Aspects of the 'understanding and feeling' process are similar to the three Rs of CAT; reformulation, recognition and revision (Ryle & Kerr, 2002). Confirming previous findings, the reformulation letter and diagram appeared to cement the therapeutic relationship (Evans & Parry, 1996) and the clients' perspective also concurs that the reformulation provides a common agenda and focus for therapy (Evans & Parry, 1996; Ryle & Kerr, 2002). The reformulation process as an educational intervention (Ryle, 1994) is reflective of the current findings. Through the letters and diagrams, understanding, becoming self-aware and learning how to do things differently were achieved. Inherent in this was *seeing* things on paper. This appeared to instigate a shift in perspective. Gaining this distance enabled the client to build a different relationship with themselves, one with less self-blame and more understanding and empathy.

The debate continues in the wider therapy forum with regard to the value and treatment utility of the case formulation (Tarrier & Callam, 2002), for most participants in this study aspects of the reformulation were indeed powerful and useful tools, but it is important not to forget that clients are individuals and that this process may not make sense or be of as much use to all. The conceptual model demonstrates that the impact and use of the reformulation is

contextualised within a supportive and collaborative therapeutic relationship and therefore it is difficult to tease apart the active agents of containment and change in their own right. In line with previous findings (Chadwick *et al.*, 2003), this study found evidence that clients have both positive and negative emotional reactions to the formal sharing of 'formulation' in both prose and diagrammatic form. However, this is not to suggest that the shared formulation was unhelpful. For those who were more ambivalent to the both reformulation and goodbye letters they were just accepted as part of therapy, and those who did not find the diagrams useful just minimised their role in therapy and found other aspects helpful. It did not seem to have a negative impact on therapeutic progress or hinder the relationship with the therapist greatly. Further investigation into 'what works for whom' with regard to case formulation is warranted.

Participants talked about the gradual and often difficult process of recognition. Frequent client references to 'avoiding loops' or 'vicious circles', 'finding ways out' of patterns and 'stopping cycles' are all consistent with the cognitive analytic approach to 'revision' of target problem procedures (Ryle & Kerr, 2002). Referring to the diagram either physically or mentally aided both these processes for most and therefore supports Beard *et al.*, (1990) claims that the diagram assists in self understanding and control. The accuracy of the diagrammatic reformulation was commented on by some but again this was not the case for all clients either because they were found to be 'too complex' and 'hard to grasp' or egodystonic, it just didn't fit with the persons way of working. Comments that the diagram was frustrating or limiting at times may indicate that that they are not always as accurate from the client's perspective as the professional or theoretical point of view (Bennett & Parry, 1998).

A significant part of the clients' experience of therapy is not represented in the three Rs of CAT. The process of accessing, and then releasing and exploring, previously repressed or unconscious difficult memories or emotions was something pertinent to all participants and often preceded the reformulation. To accommodate this, comparisons of the processes within the 'understanding and feeling' concept can be made with current theoretical models of change. Similar to the client experience of cognitive therapy (Clarke *et al.*, 2004), the clients' description of their change process in CAT could be likened to the processes of the assimilation model (Stiles *et al.*, 1990). Clients do indeed appear to begin with 'warded off' thoughts that resurface ('vague awareness') through therapy, facilitated by feeling safe and understood in the therapeutic relationship. The stages of 'problem clarification' and 'understanding/insight' were also described by clients and this is where the reformulation letter and diagrams appeared to play their role. Clarke *et al.*, (2004) proposed that cognitive therapy focussed on these two stages, together with the final 'problem solution' stage. This appears true for CAT therapy but it also seems to focus more explicitly on the emotional processes of moving between 'warded off' and 'vague awareness'. The notion that change is fragile and continuous does not necessarily lead one to be believe that, from the client's perspective, problems have been fully 'mastered' at the end of therapy in accordance with the assimilation model. Furthermore, as emphasised by several clients, this is not a simple linear process and gaining one level of change does not necessarily guarantee successful and fluid movement onto the next stage.

It could also be proposed that these client derived change processes reflect the more simple pre-contemplation, contemplation and action stages in the stages of change model (Prochaska & DiClemente, 1982). The cyclical nature of this model could also better accommodate the non-linear journey of therapy and the notions of continuous and fragile change. It was not

apparent from the interviews and subsequent analysis that participants experienced any 'sudden gain' sessions (Tang & DeRubeis, 1999).

The ongoing and continuous nature of change, and the use of the therapeutic materials by most after therapy ended was interesting. One person felt comforted by reading the letters as it felt she still had a connection with the therapist and others used the letters to reflect on the progress and the development of themselves. The diagrams were used to continue to change and practice skills, a way of 'keeping the therapy alive'. In a grounded theory study, Arthern and Madill (2002), developed a model illustrating how 'transitional objects' used in therapy work through a process of' 'holding'. Transitional objects represent the continuity of the therapist existence, connectedness with the therapist and eventually the development of a new sense of self. One hypothesised role of the materials used in CAT therefore could be similar to that of a transitional object.

CLINICAL IMPLICATIONS

Having a better understanding of client's experiences and their understanding of change may potentially help inform therapist practice in many ways.

The concept of 'doing with' highlights the active role clients take in therapy and the value this has for them. Those who took a more active involvement in developing the letters and diagrams appeared to benefit more from them. Therapists should actively encourage and facilitate as much client input in to these as the client can offer to influence successful outcome (Duncan & Moynihan, 1994; Orlinsky *et al.*, 2004).

When working with the specific CAT tools it is important for therapists to be aware of the possible range of emotions and reactions they evoke. Clients have demonstrated they are aware of what they find useful and by asking them their opinions would reinforce the notion of working together. For example working with diagrams just sometimes might not fit with the client. It might not necessarily be an enactment of a reciprocal role or problem procedure.

Most participants did not expect therapy to be so emotionally hard and tiring and there were times that it was so difficult that some did not want to return. Clinicians need to be mindful of this and prepare clients for the emotional pain. By explaining and reinforcing that pain is part of the change process would support clients through difficult times and perhaps discourage early drop outs. In addition, there is a need for the therapist to 'keep it real' and ensure clients have adequate practical coping strategies to deal with difficult emotions when they leave each session.

Participants talked about therapy being a journey and change being a very gradual and somewhat erratic process. Some people felt 'stuck' at points in their therapy leaving them with feelings of frustration that some were unable to voice to their therapist. However, with retrospect all clients acknowledged that change was actually occurring at these times and progress was being made. Therapists need to be aware of this and encourage comparisons to how people were when they first accessed therapy to facilitate recognition of small changes.

STRENGTHS AND LIMITATIONS

This study is the first qualitative exploration of the experience of CAT from the perspective of the client. The proposed theoretical model offers a valuable contribution to understanding the process of change from the client's perspective. The *actual* relevance and use of the CAT

specific tools from the client's perspective has been discovered rather than the assumed use from the clinician or theoretical perspective.

Some may argue that because adherence to the CAT model was not monitored, or all therapists were not fully qualified CAT practitioners, this might not reflect the experience of true CAT. Conversely this naturalistic approach utilised in the study is one of its strengths. Research has been critiqued for being too clinical and scientific (Kühnlein, 1999) and unrelated to the real world. The results therefore may be more identifiable with therapy within different health settings and a true reflection of how services are delivered in the demanding and under resourced NHS environments.

A limitation of this study is it focussed on positive change. No-one was interviewed who had reported negative or no change. Another may be a sampling bias due to the nature of the therapist and then self selection into the study. Therapists may have selected participants with whom they had a positive relationship. Furthermore some participants clearly stated they wanted to partake in the research to 'give something back' to the therapist or service.

"I wanted to use the experience I'd gained in any way to help the service if I could" Elaine

The willingness to participate may have been indicative of the strength of the therapeutic relationship and influence and account for the theme 'being with therapist'. Consequently the developed model may not represent the experience of clients who did not experience a positive therapeutic relationship or indicate positive change. It would therefore be of use to explore this further and perhaps investigate the applicability of the model with such clients.

Participants could be reluctant to disclose any negative feelings about their therapist (Rennie, 1994). Two people were able to voice their anger and frustration at the therapist but this seemed to be related to aspects of therapy rather than the therapist themselves. This meant unhelpful characteristics of the therapist could not be assumed.

This study adopted a constructivist approach to grounded theory, as recommended by Charmaz (2002). Therefore the theoretical model provides an interpretative representation of the studied phenomena, not an exact account of it and should be viewed as an attempt to explain the experiences of the participants interviewed (Willig, 2003). The initial model emerged from analysis of six participants' stories, but through testing the model it could explain the experiences of three different participants. This highlights common experiences and adds strength to the model. However, there are some limitations with regard to the sample used in this study. Although the participants spanned a wide age range, all participants were of white British or Irish origin and eight of them were female. No major revisions occurred as a result of interviewing the male participant at stage three but further exploration of male client experiences and different cultural groups is warranted. The variety and co-morbidity of client presenting problems again reflects the naturalistic approach of the study and is viewed as a strength. Future research might want to focus on specific disorders however for more detailed exploration.

The analysis and data collection were performed by one person. In grounded theory, teamwork in categorising data is not insisted upon (Glaser & Strauss, 1967). Qualitative approaches can never be objective (Rennie, 1992) and a sole analyst can become the expert on the data achieving a depth of analysis that can be difficult to reach with a research team (Levitt, 2001). It is acknowledged that there will always be another perspective on the meaning of a text (Taylor & Loewenthal, 2001) but the engagement of participants throughout

the analysis attempted to keep the interpretations as close to the intended meaning as possible. It is possible the researchers' clinical training and experience of using the CAT model may have influenced both the interviews and analysis. Clinical skills may have facilitated rapport and encouraged participants to talk about their experiences but also it is possible that the awareness of the researcher's clinical and professional status might lead to the chance of the participant deferring to the interviewer in the same way they are inclined to defer to the therapist (Rennie, 1994). The researcher's experience of the CAT model similarly might have biased or facilitated interpretations. Grounded theory acknowledges the possible influence of researcher prior knowledge and this should be bracketed away during analysis. The credibility checks outlined in the method section were employed to minimise such influence. The model has been grounded in the data by providing examples of quotes to highlight the origins of the coding to help the reader judge interpretations. Furthermore, transparency is hoped to have been achieved by detailed diagrammatic and prose explanation of the analysis process.

FURTHER RESEARCH

Specific sub-groups of clients may have different individual needs and face particular issues in therapy (e.g. Boulton *et al.*, 1990; Lebolt, 1999; Mair & Izzard, 2001; Shafi, 1998). Further testing of this contextual model is worthwhile and necessary to continue developing understanding of the change process from the perspective of the client. It would be interesting to explore the experience of CAT with different client groups, such as those who experience negative or no change, different cultural and ethnic groups or sexuality, to compare and contrast findings.

This study did not focus on developing the pre-therapy experience. All participants talked about the processes leading up to therapy including what led them to seek therapy, their

thoughts, feelings and expectations of it. This appeared to be an important part of the therapy journey and is worthy of further exploration to help understand the full client experience.

One major finding of this study was that all participants felt that change continues after therapy ends. A more detailed exploration is recommended. For example, longitudinal studies following up clients at regular intervals after therapy could investigate their understanding of longer term impacts and how these may or may not have been maintained or achieved. Comparisons between models of within therapy change and post therapy change could perhaps give valuable insight into continuing change and external helpful or unhelpful factors that could be capitalised on within therapy for therapeutic gain.

CONCLUSIONS

This study explored the experience of Cognitive Analytic Therapy from the perspective of the client. Grounded theory methodology allowed the development of a conceptual model that proposed to explain the clients understanding of change and the integration of the specific CAT tools within this. The core conceptual framework of this model was labelled 'doing with'. This characterises the client experience of CAT as actively working together with the therapist. This framework subsumed four main inter-related themes each interacting and influencing the other. 'Being with the therapist' refers to the qualities of and the relationship with the therapist. A collaborative trusting relationship with the therapist where the client felt understood and safe to explore deep emotional and painful issues was important. 'Keeping it real' refers to the critical importance of 'doing' and not just talking in therapy and 'understanding and feeling' highlights that change, from the clients' perspective, seemed implicit in becoming aware of and developing an understanding of their feelings. This development of insight then led to recognising behaviour patterns and making attempts to do things differently. Participants described many different ways in which the fourth theme 'CAT tools' played a role in all of these themes. Clients talked about achieving more general changes in the way they related to themselves as a result of therapy and not one theme alone appeared to be sufficient to instigate this. The processes of change described by the client are not simple linear stages and this process continues after therapy ends.

It was significant that while the themes represent common experiences there was variation within them. Individuals placed different emphasis and importance on each theme and a range of different emotions and reactions to the CAT tools were observed. Much of the model generated from this exploration of client experiences, appears consistent with the basic tenets of the CAT model itself. The findings that clients take an active role in therapy contributing to

successful therapy outcome, reiterate the importance of continuing to investigate therapy from the clients' perspective.

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SECTION III

CRITICAL APPRAISAL

INTRODUCTION

This paper will appraise and critique the research study and process from the perspective of the researcher. It will be divided into two main sections. First, it will present a synopsis, with personal reflections, of the research process from its origins to write up and second it will discuss the main learning experiences gained from the study.

THE RESEARCH PROCESS

Planning of the Research Study

Origins of the project

My interest in this project arose following the research fair at the Clinical Psychology Unit and subsequent discussions with Andrew Thompson. Initially the research was proposed to focus on the client experience of the reformulation in CAT. I had a genuine interest in user involvement and therefore investigating the client experience was particularly appealing. Furthermore, as part of my first year adult mental health placement I had some experience of working in the CAT model and from that perspective found the reformulation sessions and diagrams powerful and emotional aspects of the therapy. I was intrigued about the client's perspective on this. I was surprised there had not been any research within this area and pleased as it is seemed the ideal project for me to tie together my two interests. I thought it would be a very clinically relevant project to undertake and looked forward to see how this would influence and develop my own clinical work.

Further Development and Clarification of the Research Project

Following these initial discussions, Andrew Thompson and I met with Glenys Parry at ScHARR to develop our ideas further. As a result of this a slightly different approach to the research began to materialize. Instead of presuming that reformulation was a key process, it was thought exploring client's general experience of CAT and seeing whether reformulation emerged as important would be valid.

Using CCAT competency ratings to ensure that therapy adhered to the CAT model was suggested. This would involve having to tape all of the participants' therapy sessions. This process would impact greatly on the tight timescale for the project since participants would have to be prospective not retrospective clients. It might have also aroused some suspicion about evaluating competencies. This might threaten the number of therapists willing to participate and consequently reduce the pool of participants. This was a key concern given previous trainee experience of difficulties in recruitment. Furthermore my intention of maintaining a naturalistic approach to the research meant using a more 'sterile' version of CAT would not be necessarily representative of CAT as it is routinely delivered in the NHS.

In a similar vein, the measurement of change was discussed. Clinically significant and statistically reliable change using standardised measures such as the BDI and CORE was considered. This again had practical and logistic implications on the research process and timescale. All therapists would have to ensure that all new clients were given measures as they entered therapy and as this was not routine practice in all services it couldn't be guaranteed. Furthermore it didn't fit with the user focus of the study. It would assume that change could be measured objectively, it was decided that a subjective report of change would be as valid as any other measure within this study.

The identification of an NHS liaison supervisor was made at this stage. Sue Walsh agreed to be involved in the study as she was Clinical Lead of the specialist CAT service and had experience in supervising grounded theory theses. Many different ideas followed (too many to document in detail!), including expanding the project to comparing experience of the formulation processes of CAT with CBT and psychodynamic therapies. It became confusing and I had feelings of uncertainty about the direction of the research. It felt it was drifting further away from my original interests. Having confidence in my focus and needs I felt able to express these concerns to my supervisors and we negotiated settling on the original idea of exploring the client's general experience of CAT with a focus on their understanding of the specific CAT tools and process of change.

Liaison with the CAT therapists

Arrangements were made to attend and present at both the specialist and community CAT service meetings to discuss the study. An information sheet was developed and distributed to therapists to describe the research and the nature of their potential involvement (Appendix 12). My research protocol and research information sheets were also made available. All of the therapists were very interested, enthusiastic and motivated about the research. This was comforting and appeased my initial apprehension of how they would respond.

There was some initial concern from some therapists about informed consent. Some felt uncomfortable contacting clients after discharge if clients had not been forewarned this might happen. I fully understood and agreed with the reasoning behind this although again it did cause concern and anxieties about how this would impact on the process of the research and the availability of participants. After discussing this, amendments were made to the general information leaflet given to people referred to a clinical psychologist. It now informed them

they may be asked to participate in routine evaluations, audit or research. I also said I would make it very explicit in the COREC form about contacting people post discharge. As the ethics committee had no concerns about this method the therapists felt more comfortable doing this.

Choosing a methodology

As documented in the research report, IPA (Smith & Osborn, 2003) was first considered as a method of analysis. However as the project evolved it was thought grounded theory (Strauss & Corbin, 1990) would be better suited to its aims and focus. It allowed the same exploration of subjective meaning but since the study was interested in understanding the dynamic process of therapeutic change, taking the analysis further to develop a theoretical explanatory model would be more appropriate than a presentation of different themes. I was apprehensive and excited about this for the same reasons. With the exception of basic content analysis I had never conducted a thorough qualitative analysis before and I was unsure as to what it would actually entail. Furthermore I was concerned that I might lack peer supervision since no-one else in my year group was utilising this methodology. My anxieties were allayed somewhat as I knew I had an experienced supervisor in this method and discussions with peers about general approaches to qualitative analysis proved useful and further allowed me to differentiate between IPA and grounded theory and feel confident that I had chosen the correct method for my research.

Initial Research Proposal Process

There was a delay in completing the initial research proposal for health reasons, so it was submitted to the Clinical Psychology Unit Research Sub-Committee for peer review in July 2004. Following the review meeting in September 2004, with only minor changes recommended, approval was granted. I found this a useful process to go through as it helped

clarify my thoughts and reasoning behind the project and the constructive feedback prepared me for the next stages of the ethics committee review.

Ethical Approval, Research Governance and Indemnity

I was keen to progress as soon as possible and application for ethical approval, research governance and indemnity were all simultaneous. Once I had got my head around who, what, where, when and how, all processes were more straightforward than I had expected. Attendance at the North Sheffield Ethics Committee in October 2004 was a daunting but valuable experience. It made me realise that my research was 'official' in a sense and something more than just part of my doctoral qualification. Minor amendments were suggested as a result of this and full ethical approval, and consequently research governance and indemnity from the university, were granted in January 2005.

Funding

Since the study design involved interviewing the participants involved in stage one twice transcribing costs alone exceeded the university allowance of £500. In total the estimated research budget was £1003 and an application to the Sheffield Health and Social Research Consortium for additional £603 was made. This process again was relatively trouble-free and I was granted the extra funds in November 2004.

The Research Study

Literature Review

Initially I chose to review the literature on the experience of therapy from the clients' perspective. However, this generated so many articles that it became very overwhelming. Studying this literature further and with the assistance of supervision it was decided that this

would be too ambitious a project. Narrowing the scope of the review to qualitative studies made it more manageable and relieved my frustrations and stresses.

I found the literature review process itself very time consuming. 'Client experience of psychotherapy' was an extensive area to conduct a literature search and it generated many false positive to wade through. Trips to the university and hospital libraries, waiting for Inter-library loans and trips to the British Library to obtain articles added to the stress of time 'ticking away'.

A strict application of grounded theory (Strauss & Corbin, 1990) does not advocate conducting a literature review before analysis as it could contaminate interpretations of data. However, due to time restrictions this was not possible. I was constantly aware of this during analysis and made notes and attempts to minimise the influence of my knowledge of the client experience literature.

Interviews

Interviews began in February 2005 and the final one took place very close to the deadline in mid July. I found it challenging in the first two interviews to switch between my 'clinical hat' and 'researcher hat'. I didn't want to do to too much reflection and put words into the participant's mouth. Furthermore I was conscious, with my knowledge of CAT, not to presume understanding and meaning of what participants were talking about. Further enquiry elicited their personal meanings. I enjoyed conducting all of the interviews. It was fascinating to hear client stories and I was genuinely inquisitive which I think helped to elicit more valuable information. The nature of the interviews obviously touched on emotional and personal material and all participants became upset at some point. I found my clinical skills were of use in managing these situations and participants were given a choice about whether

they wanted to continue. Some people gesticulated, or used facial expressions to convey emotions or meaning, verbal clarification of this was encouraged for the benefit of tape. It highlighted that it is not just what people say but how they say it.

As King (2004) comments, I felt that after the first few interviews my interviewing skills were improving quite rapidly and having my supervisor listen to my first interview provided useful feedback. Conducting simultaneous analysis meant I felt the interviews became more fruitful and efficient as I knew what to look out for and explore meaning there and then.

Transcripts

Due to the methodology of this project, where interviews relied on the analysis of the preceding ones, transcribing had to have a relatively quick turn around time. Several technical difficulties with transcribing machines and availability of transcribers meant the transcripts of the first two interviews were completed five weeks after the interviews. This was very frustrating and stressful, as it obviously meant delaying revisiting the first two participants and subsequent interviews. I tried to allay my anxieties by concentrating on beginning my literature review. Employing three different transcribers speeded up the process and return of transcripts.

Analysis

Overall I found the process of analysis simultaneously challenging, confusing, exhausting frustrating, interesting and enjoyable. I found listening to the interview tapes whilst conducting the line by line coding invaluable. It allowed me to alter often vital inaccuracies in the transcript, fill in the inaudible gaps and attend to the intonation of the participants. At first I found line by line coding quite surprisingly difficult, I was conscious of how much interpretation I was using at this stage. I often questioned myself if I was 'doing it right'.

Consulting the qualitative textbooks and discussing this in supervision allowed me not to be too strict with myself. By asking 'what is this person trying to say?' and using client terms helped me feel more confident in this. I found the memo writing aspect of grounded theory, personal reflection and my organisation skills also useful in reducing my anxieties about this process. Documenting thoughts, feelings, sensitising concepts (Charmaz, 2002) and practical processes was a useful audit trail so I had confidence in knowing what stage I was at and where my ideas had come from.

When developing the theoretical model it felt at times I couldn't see the woods for the trees. Again I felt I wasn't sure exactly how to do this. I referred to many published grounded theory papers which only added to my confusion and frustration as they had all different methodologies. This was confirmed when I read Dey (1999) who stated there were probably as many versions of grounded theory as there were grounded theorists. This helped me relax and gave me confidence that there is not one absolute way of analysis. There was conflict between wanting to keep all the complex and rich data and reducing it to more conceptual categories. I felt the need to encompass everything. After lots of scrunched up and binned paper and several attempts that didn't seem quite right it eventually came together. This clarity was again aided by supervision.

Working with and relying on others

From the beginning I was aware that recruiting and liaising with the CAT therapists was largely my responsibility. Having this control was quite liberating and enjoyable, it made the whole process more 'real' and personable. The CAT therapists played a vital role in this research and maintaining good relationships with them were crucial to its success. I was aware that this was my research project and obviously might not have such a high priority within the very busy and pressured work schedules of therapists. Regular formal and informal

contact was maintained via e mail and attendance at meetings. I ensured they had all my different contact details so I was constantly available for any queries. Working with and relying on three different transcribers also proved frustrating at times when they were unable to meet deadlines. Sometimes this was for unforeseen reasons (e.g. sickness) but I made sure that before giving tapes to them that they had the choice about whether they were able to commit to the necessary timescale.

Write up

I found the actual process of writing up the research report quite refreshing after being bogged down in the minutae of data at the analysis stage. I sometimes felt I had lost sight of the overall picture, and it was reassuring to set the study back into context. However I found that I was still immersed in the detail of the interviews. I felt a degree of conflict between wanting to do each participants' story justice and the reality of trying to do this for all nine participants in about 4000 words. All quotes appeared equally valuable and I had trouble in choosing what to leave in and out. There were so many overlapping and interrelated areas and it was difficult to know how to convey and express this in a logical and clear way. Again supervision was imperative to assist in this process by offering more objective and concrete advice. Originally I chose the shorter 'Option B', for writing up my research but once I began writing up the results I realised that the richness and complexity of the data required a more liberal word count and changed to the longer 'Option A' to accommodate this.

Supervision

My natural approach to writing and way of working is often very thorough and over inclusive, for fear of missing something of importance, before gradually honing it down. As a result this frequently leaves me feeling overwhelmed and lost by the amount of information. My supervisors were very talented at helping me at these times. I felt comfortable enough to

splurge out my thoughts, ideas, difficulties, frustrations and anxieties in a sometimes incoherent manner. With their assistance and direction I could re-gather them, take a different perspective and find my way again. Supervision was containing both theoretically and emotionally.

Having two different supervisors, both with more of an academic role, often meant amalgamating different approaches and suggestions about the direction of the project. At times, meetings often generated more ideas than it resolved, which on one hand encouraged wider thinking but on the other could feel overwhelming. With time however I felt this was an important learning experience for me. It allowed me to digest and process all of this information and discover with more confidence, more about my own position and thought and ideas.

LEARNING EXPERIENCES

This final section will be unable to do justice to the tremendous learning experiences I have gained from conducting this final year research project –as a researcher, clinician, student and human! Furthermore I still feel very much within that learning process, just as found in therapy, I am believing that change is indeed a continuous process and my skills and reflections will continue to evolve as the thesis deadline comes and goes. Some learning experiences have been highlighted in the first section and I will try and summarise a few further points here.

- The balancing of the different roles of a qualified psychologist has been emphasised. I feel I have gained insightful knowledge into the processes and procedures involved in

conducting research in the NHS. I feel confident to take more research on in the future in tandem with clinical work.

- I have learnt that research and clinical work are not separate entities. I drew on clinical skills during the research process, for example establishing rapport in the interviews, and have utilised my research knowledge to inform clinical practice. For example, in my interactions with clients I have learnt not to assume anything. I am now checking out more explicitly their understanding and thought and feelings of the therapy process and encouraging their active involvement. Making a safe and comfortable environment to facilitate this is paramount.

- Theoretically I feel I have learnt much about the research base on client experience and the processes of change. The literature review again emphasised the value of theoretical and clinical practical links. Furthermore I feel I have developed my skills in critically appraising research studies.

- This study has really enforced my belief in the power of the client voice and strengthened my motivation to continue user involvement projects when qualified.

- The necessity of good supervision has been highlighted for me. The assets of critical review for generating ideas, preventing bias, validity checks and clarifying ideas, not to mention the containment of anxiety have been invaluable.

- I have learned that looking after yourself during stressful times is paramount. Going out and doing something to escape the confines of my study allowed me to come back with a fresher mind. Giving myself 'time off' was often (if not always) accompanied by guilt but

it was definitely needed and I reframed it as part of the process itself. I also found that often some of my more insightful ideas often occurred when I was out riding my bike or walking and not necessarily thinking about work.

- Working closely with other professionals, working between teams and co-ordinating different aspects of this research has enabled me to develop my negotiation, organisation and diplomacy skills. I feel more prepared to for undertaking such roles as a qualified psychologist.

- I feel my time management skills have further developed as a result of breaking daunting and overwhelmingly large pieces of work into smaller more controllable sections. Setting target deadlines for these made the process more manageable.

- Finally, completing this research has given me a great sense of personal achievement and developed my confidence in my ability. At times when I thought I couldn't, I actually could and did!

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APPENDICES

APPENDIX 1

North Sheffield Ethics Office
1st Floor Vickers Corridor

Direct Line: 0114 271 4894 or 271 4011
Fax: 0114 256 2469
Email: sue.rose@sth.nhs.uk

Northern General Hospital
Herries Road
Sheffield
S5 7AU

08 December 2004

Dr Andrew Thompson
Clinical Psychologist
University of Sheffield
Clinical Psychology Unit, Dept. of Psychology
Western Bank
Sheffield
S10 2TP

Dear Dr Thompson

Full title of study: *Clients' experience and understanding of change processes in cognitive analytic therapy.*
REC reference number: *04/Q2308/96*
Protocol number:

Thank you for your letter of 19 November 2004, responding to the Committee's request for further information on the above research and submitting revised documentation.

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

Confirmation of ethical opinion

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

The favourable opinion applies to the research sites listed on the attached form. Confirmation of approval for other sites listed in the application will be issued as soon as local assessors have confirmed that they have no objection.

Conditions of approval

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

The following is also a condition of approval: The standard insurance statement (see Guides) has not been included, please provide an updated information sheet with this statement included under the heading "What if something goes wrong?"
The consent form should be on letterhead.

Approved documents

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

Document Type:	Version	Dated:	Date Received:
Application	2	19/11/2004	25/11/2004

Investigator CV (student and supervisor)		14/09/2004	17/09/2004
Protocol	2	15/10/2004	25/11/2004
Summary/Synopsis	1	08/09/2004	17/09/2004
Copy of indemnity arrangements		09/11/2004	25/11/2004
Interview Schedules/Topic Guides		08/09/2004	17/09/2004
Information for Clinicians	2	15/10/2004	25/11/2004
Letter of Invitation to Participants (form therapist)	1	08/09/2004	17/09/2004
Participant Information Sheet	2	15/10/2004	25/11/2004
Participant Consent Form (consent to be contacted)	2	15/10/2004	25/11/2004
Participant Consent Form	1	08/09/2004	17/09/2004
Response to Request for Further Information		19/11/2004	25/11/2004

Management approval

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

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the sheet enclosed with your provisional approval letter.

Notification of other bodies

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

Statement of compliance

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

04/Q2308/96 **Please quote this number on all correspondence**

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

Yours sincerely

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

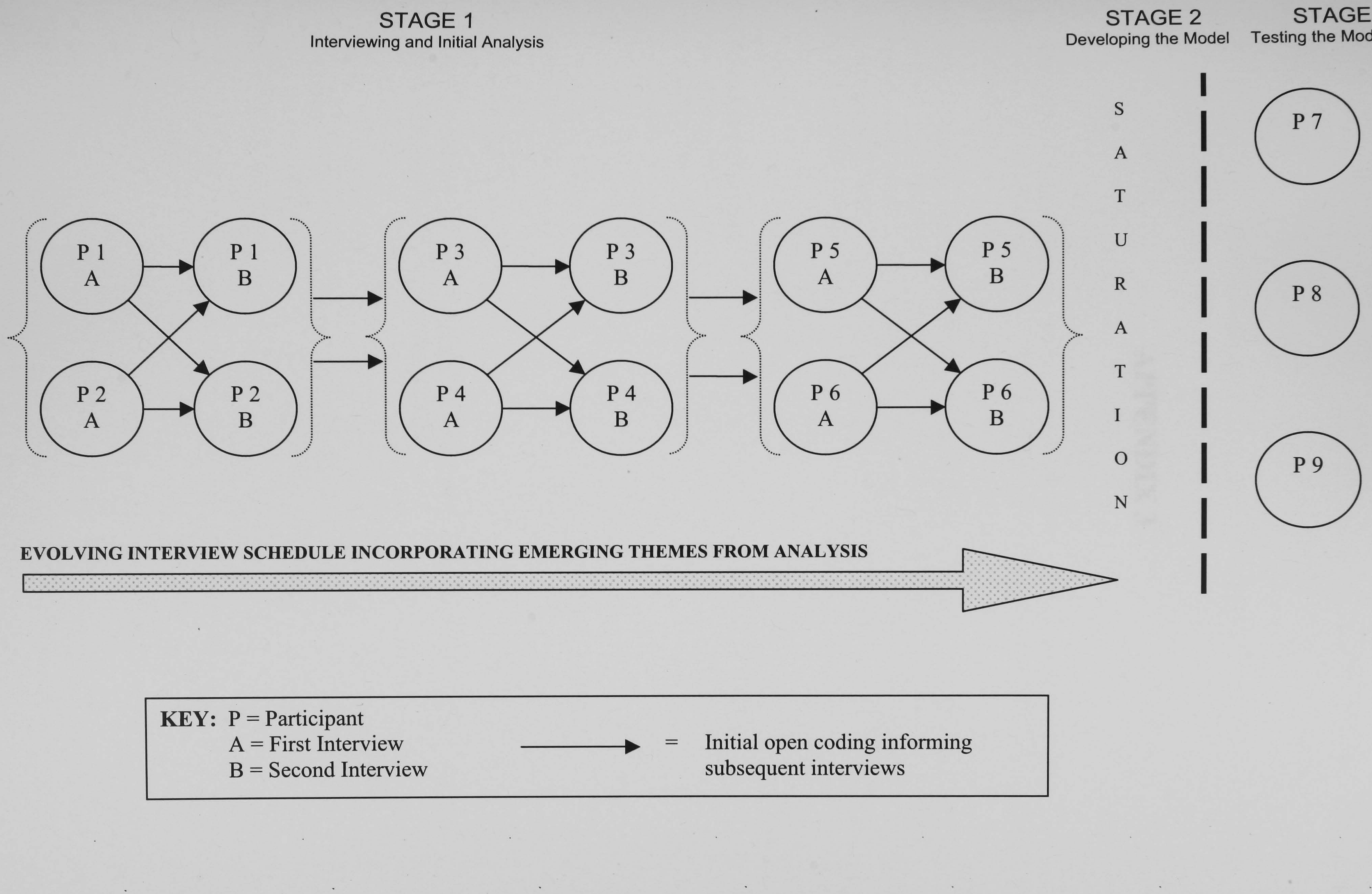
Copy to: Ms C Rayner

Standard approval conditions

Site approval form (SF1)

APPENDIX 2

DIAGRAM TO SHOW STUDY DESIGN: INTERVIEW PROCESS AND CONCURRENT ANALYSIS



KEY: P = Participant
A = First Interview
B = Second Interview

→ = Initial open coding informing subsequent interviews

APPENDIX 3

Sheffield City Council

Sheffield Care Trust

Mental Health and Wellbeing

NHS

INDIVIDUAL NHS COMMUNITY HEALTH CENTRE ADDRESS

DATE

Dear.....

Please find enclosed some details of a research study currently being conducted in Sheffield Care Trust. It is interested in client's perspectives and experiences of the therapy they have received.

Please read through the information sheet for more details before you decide if you would like to take part. If you are interested in participating further with this research or just wish to find out a bit more about it please complete the attached form and return it in the envelope provided. Alternatively you can contact the researcher directly by telephone. Below are her contact details:

Kate Rayner
Trainee Clinical Psychologist,
Clinical Psychology Unit,
University of Sheffield,
302 Western Bank,
Sheffield
S10 2TP

Tel: (0114) 222 6570

E mail: pcp02cdr@shef.ac.uk

You are under no obligation to participate in this research and it has no bearing on any future or current NHS treatment you may receive.

Thank you

Yours sincerely,

Individual Therapist Name

APPENDIX 4

Sheffield City Council

Sheffield Care Trust NHS

Mental Health and Wellbeing

RESEARCH INFORMATION SHEET

Study Title: **Client's Experience and Understanding of Change Processes in Cognitive Analytic Therapy**

Researcher: Kate Rayner, Trainee Clinical Psychologist, University of Sheffield, Clinical Psychology Unit, 302 Western Bank, Sheffield, S10 2HP. Tel: (0114) 222 6570

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

What is the purpose of the study?

To find out more about what it is like to receive Cognitive Analytic Therapy (CAT) and to gain a better understanding of what people think about any personal changes that may have happened as a result of the therapy. CAT also uses some unique therapeutic tools such as letters and diagrams. The study will also look at what people thought of these and how they were used in therapy. There haven't been any studies in this area and I believe it is important for future psychologists and therapists to hear client's experiences so we can learn from them.

Why have I been chosen?

You have been chosen as you have recently completed a number of sessions of Cognitive Analytic Therapy with a psychologist, psychiatrist or therapist in Sheffield. In total I am hoping to interview about 8 people, all who have received CAT in the last 18 months.

Do I have to take part?

No, your participation is purely voluntary and it is up to you to decide if you wish to take part. If you do decide to take part then you can keep a copy of this sheet and the consent form you will be asked to sign. However, you can choose to withdraw from the study at anytime, without giving any reason. Whether you choose to take part won't affect any NHS treatment you have now or in the future.

What is involved in taking part?

Spending some time talking to me in a tape recorded interview. I am mostly interested in your experiences, views and understanding of the therapy you have received. This interview should take about an hour and will take place at the NHS centre where you received therapy. We can arrange a time and day that suits you.

After each interview is completed, the tapes will be transcribed and I will begin to look for common themes in what people have said. At the end of this first interview we will arrange a time and date for a second interview. This is to ask for your comments and suggestions on the themes I have developed to make sure I have understood you correctly. Themes may also have emerged from other interviews that I did not ask you about in your first interview I may ask you if these are relevant to you too. This interview will be shorter than the first and will probably last about half an hour. You will be paid £10 for your time and any out of pocket expenses including travel costs.

Will my taking part in this study be kept confidential?

Your therapist will be aware that you are taking part in this research and a copy of this information sheet together with your consent form will be sent to him/her to be kept in your file. However, what you talk about in the interview will not be fed back to your therapist.

Because we will be talking about things that are private to you, the tape recording of our interview is confidential. You will be issued with a code number and the tape recording will not have your name

on it, just this code number. Any personal details you give me will be kept away from the tape recordings and the tapes of our interview will be kept safe, locked in a filing cabinet when I am not using them. When I have finished with the tapes, I will erase them. Any personal details you give me will be kept away from the tape recordings.

I will be employing professional transcribers to help me type out the taped interviews. All the transcribers sign a confidentiality agreement to say they will keep the tapes and what people say private and not discuss the content of the tapes with anyone apart from the researcher. When I am writing up the research project all names and other details will be changed so no one can identify you or your therapist.

There are certain circumstances however in which confidentiality may be broken. Such circumstances might be, for example, if you disclosed intent to harm yourself or others. If this did occur in the interview I would openly discuss this with you and inform you of the action I would need to take as appropriate.

What are the potential benefits of taking part?

This study is not part of your therapy or any other part of your healthcare. You are not set to gain anything by taking part, other than the experience of putting your opinions across so we can understand the therapy process better.

What are the potential disadvantages or risks of taking part?

Some people find talking about their experiences helpful, but others might find that this upsets them. You have the choice to refuse to answer any questions asked in the interview or withdraw your consent to take part at any time. If you do become upset during the interview, we could talk about it at the time or you can contact me afterwards on the number above. You may have to leave a message and I will call you back. Alternatively, you might like the researcher to contact your GP, your therapist or a personal friend on your behalf. If you would like to talk to someone different you could contact The Samaritans on 2767277.

What if something goes wrong?

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study you can use the normal NHS complaints procedure by contacting the complaints manager, Wendy Hedland, on 2716706.

Alternatively you could get in contact with the research project supervisors, Dr Sue Walsh or Dr Andrew Thompson on 2226570 or write to them at: Clinical Psychology Unit, Department of Psychology, The University of Sheffield, Western Bank, Sheffield. S10 2TP.

What will happen to the research when it is done?

I aim to write up the research for my thesis that will contribute to my Doctorial qualification in Clinical Psychology. This means that the thesis will be available within the University of Sheffield library. I also hope to have the research published in an academic journal, in order that your experiences can be understood better by psychologists and other therapists who deliver this type of therapy.

What next?

If you are interested in knowing more, you can telephone me at the University of Sheffield Clinical Psychology Department on 222 6570. You might need to leave a message and a telephone number so I can get back to you. If you are interested in taking part, please complete and return the attached form in the envelope provided and I will contact you so we can talk more and arrange to meet. If you are not interested in taking part, I would like to thank for you time in thinking about this.

Thank you for reading this information.

Sheffield City Council

Sheffield Care Trust

Mental Health and Wellbeing

NHS

Consent form to be contacted about the research project entitled:

Client's Experience and Understanding of Change Processes in Cognitive Analytic Therapy

Name:

Address:

*Home Telephone Number:

*Mobile Telephone Number:

*E mail Address:

*You do not need to complete all of these fields if you do not wish but I will need at least one contact number. Please underline your preferred method of contact.

I agree to be contacted by Kate Rayner to talk more about taking part in this study

Signature: _____

Date: _____

Please complete this form and return in the envelope provided. Thank you.

APPENDIX 5

Sheffield City Council

Sheffield Care Trust

Mental Health and Wellbeing

NHS

CONSENT FORM

Title of Project: **Client's Experiences and Understanding of Change Processes in Cognitive Analytic Therapy**

Name of Researcher: Kate Rayner, Trainee Clinical Psychologist, University of Sheffield

Please initial box:

1. I confirm that I have read and understood the information sheet dated..... ☐
2. I have had the opportunity to ask questions and these have been adequately answered ☐
3. I understand that the interview will be tape recorded ☐
4. I understand that I am free to withdraw from the study at anytime, without giving any reason, and without my health care being affected in any way. ☐
5. I agree to take part in the above study ☐
6. I agree to take part in an additional interview to add further comments or suggestions to the themes developed from the interviews. ☐
7. I agree that the annonymised transcript of my interview may be used for teaching purposes ☐

Name of Participant	Date	Signature
Name of Researcher.	Date	Signature

APPENDIX 6

INTERVIEW SCHEDULE

1. General Experience of Therapy

- Can you tell me about how you came into therapy?

How would you describe the person you were then?
What did you expect from therapy?
What did you want from therapy?
Did you know what Cognitive Analytic Therapy was? What did you call you therapy?

- Tell me about what happened during therapy. Could you describe what you thought about it?

What has therapy been like for you?
How did it feel to be in therapy?

- How did you feel therapy went?

Did you get out of it what you hoped?

2. Use of reformulation and tools

- Did your therapist use any letters or diagrams in therapy?

What was your experience of getting the letter?
What did you do with it?
When you first received your letter how did you feel about yourself? Your therapist? Your therapy?
What was your experience of the diagrams used?
When you first received your diagram how did you feel about yourself? Your therapist? Your therapy?
How did the letter/diagrams impact on you?
How did you use them in therapy? Outside of therapy?
Have you kept them? Do you still use them?

3. Change

- How would you describe the person you are now?

How, if at all, has your view of yourself and your circumstances changed at all as a result of therapy? How do you explain this?

- Did coming to see your therapist make a difference to you in anyway?

Do you think you have changed as a result of therapy? In what way?
What did you learn about yourself?

- *How do you understand these changes?*

What do you think might have brought these changes about? (outside and inside therapy)

4. Difficult Aspects

Was there anything in therapy which was difficult for you?

5. Ending

- What was ending therapy like?

Did your therapist write a letter?

Did you write a letter?
What was your experience of writing a letter?

- How have you thought about therapy now it has finished?

As you look back on therapy are there any other events that stand out in your mind?
Can you describe that? How did this event affect what happened to you /therapy?

- Was there anything missing from your therapy?
- Would you have liked to have done things differently? How?
- Is there anything you might not have thought about before that occurred to you during this interview?

Is there anything you wish to add which hasn't been covered?
Anything that I haven't asked that you might think useful for future interviews?

APPENDIX 7

Sheffield City Council

Sheffield Care Trust

Mental Health and Wellbeing

NHS

TRANSCRIBER CONFIDENTIALITY FORM

Title of the Project: Client's Experience and Understanding of Change Processes in Cognitive Analytic Therapy

Name of the Researcher: Kate Rayner, Trainee Clinical Psychologist, University of Sheffield.

The tape you are transcribing has been collected as part of the above named research project. Tapes may contain information of a very personal and private nature and we would like you to agree not to disclose any information you may hear on the tape to others. Maintaining this confidentiality is of the utmost importance.

Declaration

1. I agree to treat the transcription of the tape as confidential information and discuss the content of the tape only with the researcher.

2. I will keep the tape in a secure place where others cannot gain access to it.

3. I will ensure that no information relating to the tape contents or transcripts remains on the hard disk of any computer I have used.

4. I will ensure that no copies of the tapes or typed transcripts are made other than those needed for the researcher.

5. If the person being interviewed on the tape is known to me (or I recognise any person who is mentioned in the interview) I will undertake no further transcription work on the tape.

Should you find the content of the interviews distressing or upsetting in any way, please contact the researcher to discuss these issues.

I agree to the above terms and conditions.

_____	_____	_____
Name of Transcriber.	Date	Signature
_____	_____	_____
Name of Researcher.	Date	Signature

APPENDIX 8

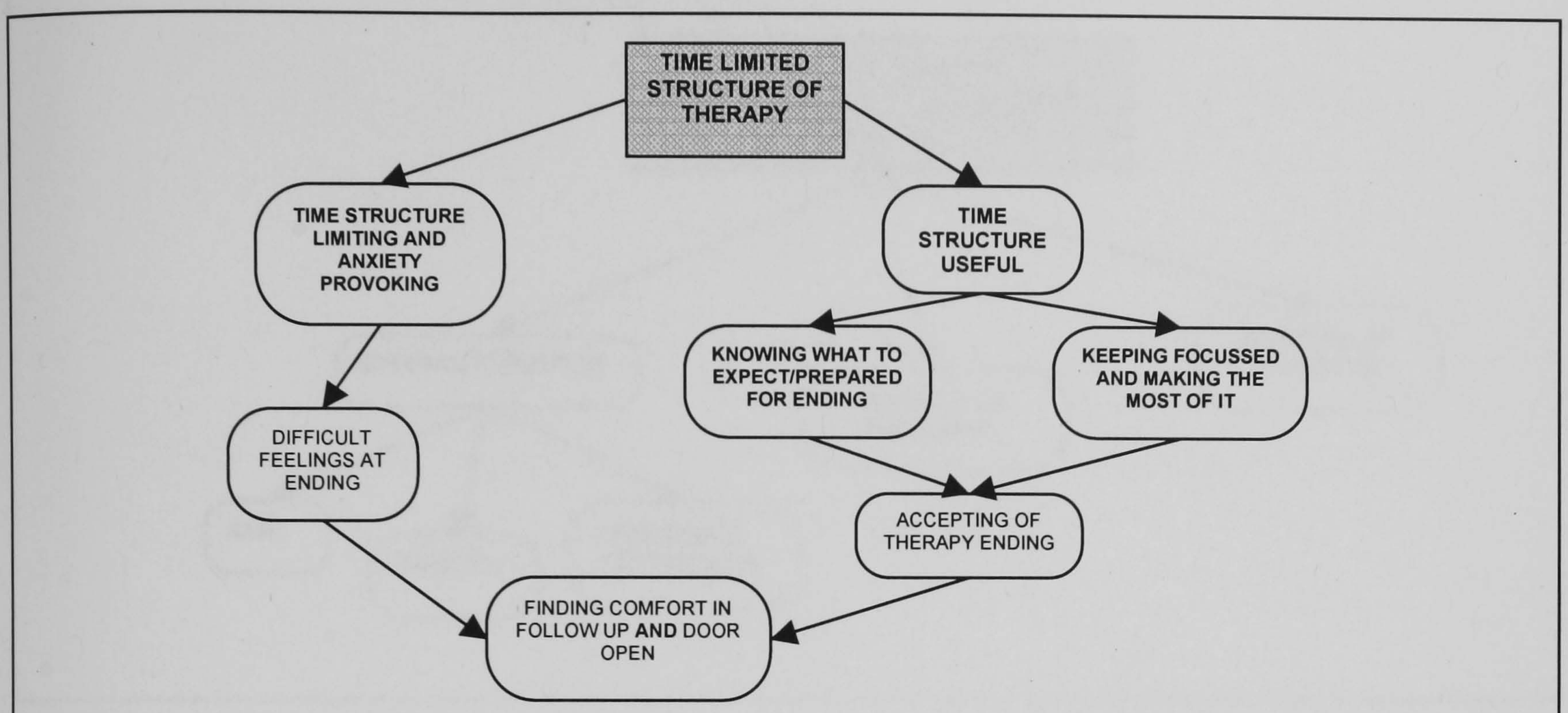
EXAMPLE OF LINE BY LINE INITIAL OPEN CODING

P: And so that's what we then did, we then wrote a contract and then we started this, this system together. And for me the really lovely bit about it, which gave me confidence, was that it was so defined.	***Negotiating Contract*** ***Working together*** ***Structure giving confidence***
R: Right.	
P: It was very prescriptive in so far as, 'you will have these numbers of sessions.'	***Knowing what to expect***
R: Um hum.	
P: 'You will know from the beginning that there's an end.'	***Knowing what to expect***
R: Yeah.	
P: 'That it is a measurable time, and that we've got certain tasks to do within it.' Now from the way I like to work with things, that was great.	***Keeping focussed*** ***Liking Structure***
R: Um hum.	
P: Because it was problem solving, it was time limited, we knew what we were doing. Umm, and that was really really helpful in that.	***Knowing what to expect*** ***Finding structure helpful***
R: Okay.	
P: What I didn't expect was it to be so blasted painful (laughs).	***Not expecting pain***
R: Right.	
P: It was … It got through to areas I didn't even realise were issues.	***Unaware of issues***
R: Really.	
P: Yeah.	
R: Cos you mentioned that there was some, umm, issues that you had put to bed.	
P: Yes.	
R: I wonder how…how did you, or why did you feel that you'd put them to bed?	
P: Umm (.) I think I had buttoned them away because that was the only way I knew how to, umm, to do that at the times in my life that they needed to be buttoned away.	***Repressing issues*** ***Needing to repress issues***

APPENDIX 9

EXAMPLES OF THE DEVELOPMENT OF AXIAL CODES FROM INITIAL OPEN CODES

AXIAL CODE: TIME LIMITED STRUCTURE OF THERAPY



EXAMPLES OF QUOTES ENCOMPASSED IN INITIAL OPEN CODES

LIMITING AND ANXIETY PROVOKING

"It was scary because I had a continuing sense of dread" Sarah

DIFFICULT FEELINGS AT ENDING

I tried to persuade T not to end, I'd be arguing about it and erm and I started to feel really bad." Sarah

TIME STRUCTURE USEFUL

"And so that's what we then did, we then wrote a contract and then we started this, this system together. And for me the really lovely bit about it, which gave me confidence, was that it was so defined. It was very prescriptive in so far as, 'you will have these numbers of sessions.'" Elaine

KEEPING FOCUSSED AND MAKING THE MOST OF IT

"I think it was, erm, based on the fact that there was t', there was work to be done and there was a, a definite time slot, so, erm, we both had to work from getting, the most out of each, each meeting." Sheila

KNOWING WHAT TO EXPECT

"Well, only because it gives you a, a sort of an understanding and a, a dimension to, how long is this going to go on" Margaret

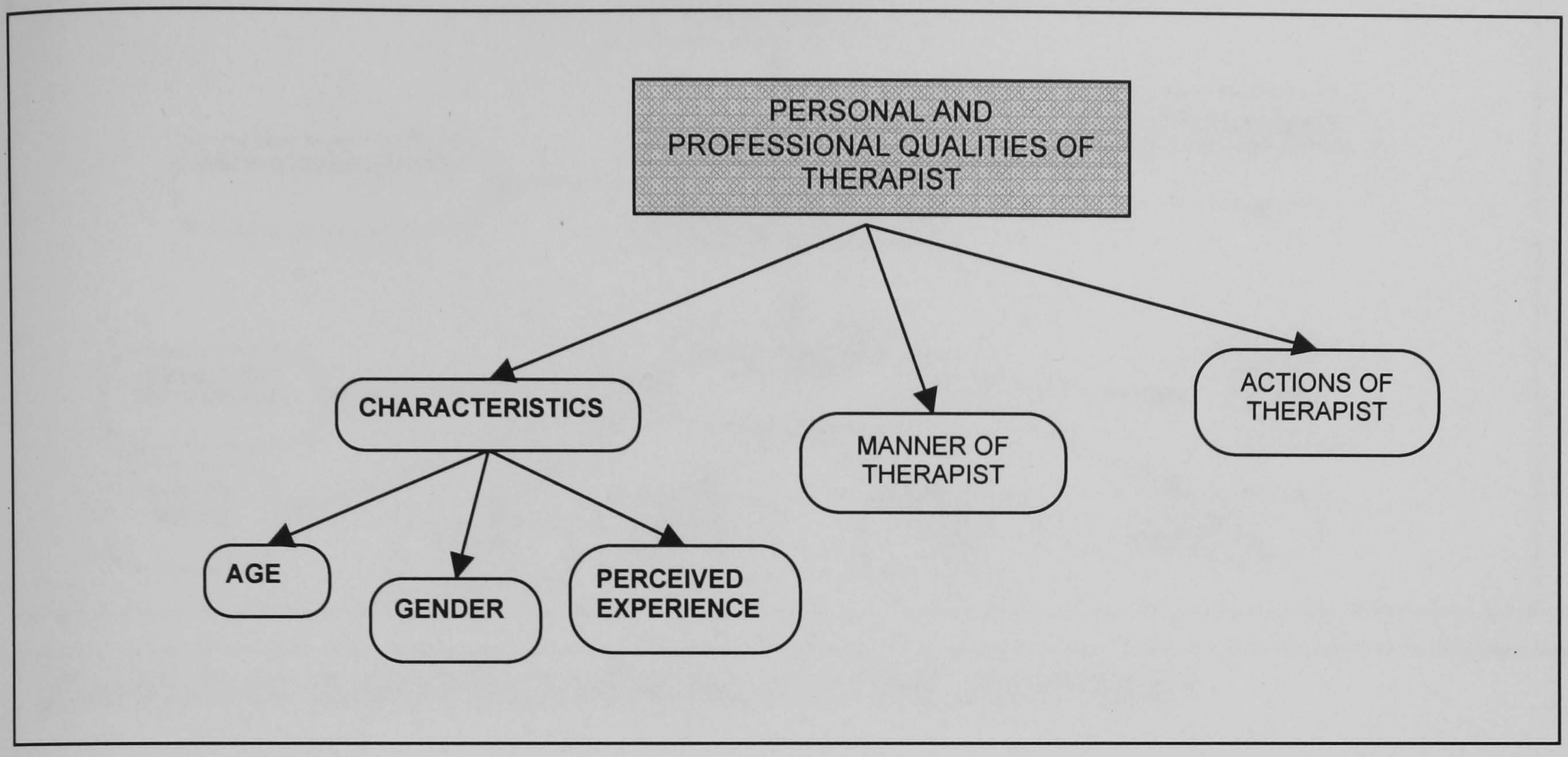
ACCEPTING OF THERAPY ENDING

"I mean in the end it wasn't that I didn't want to come for, in the end I sort of looked on it possibly "well that's a morning that I have got now to myself that I can do something else with", so it wasn't that I was longing for that, but it came to an actual conclusion, and I felt that the work had been done in inverted commas work and I was able to move on and erm in a way live out what had been erm set out so to speak." Sheila

FINDING COMFORT IN FOLLOW UP AND DOOR OPEN

"Umm, but there was that 'if there's a problem you can contact me, you can get back and I will come and see... ' And there was the part where you didn't just finish, you had a session where you came back in six months. You did that process, so there was that little bit of safety net. Which was, which was fabulous." Elaine

AXIAL CODE: *PERSONAL AND PROFESSIONAL QUALITIES OF THERAPIST*



EXAMPLES OF QUOTES ENCOMPASSED IN INITIAL OPEN CODES

MANNER OF THERAPIST

"T's attitude was very calm and quiet and that was very good. That was a comfort as well." Margaret

ACTION OF THERAPIST

*"I was like wow, amazing, I cant believe, this persons doing, so much in a nice personal way of doing things *self and writing, typing letters out *self and you know, rather than just, giving it to some secretary" Susan*

" every so often T would say 'but how do you feel about that?' or, umm, 'how does that make you feel?' T made me think about what I was saying. T made me go into myself. T didn't actually tell me anything I don't think. T did it all by questioning and making me think about it and making look into me" Dorothy

CHARACTERISTICS:

AGE

"I don't know, if, it was, it just happened to be somebody a little bit older than me, but I don't know, if I would have, felt differently if the person had been quite young. Erm, I suppose maybe I felt that, that the person and, had, had, a lot of experience, and, not just maybe saying of therapy but experience of life, and that, that maturity," Sheila

GENDER

"I liked it that it was a woman, and again it was a woman who was a younger woman, but, umm, yeah, I...I enjoyed, I like that. If it had been a man and they had got that competence, it wouldn't, it didn't matter. But what I did, what I did find, I did find that warmth that was there. And I think there's a different dynamic that can happen (.) with another woman, that you perhaps would react differently with another man.. So I think there's that, I dunno....

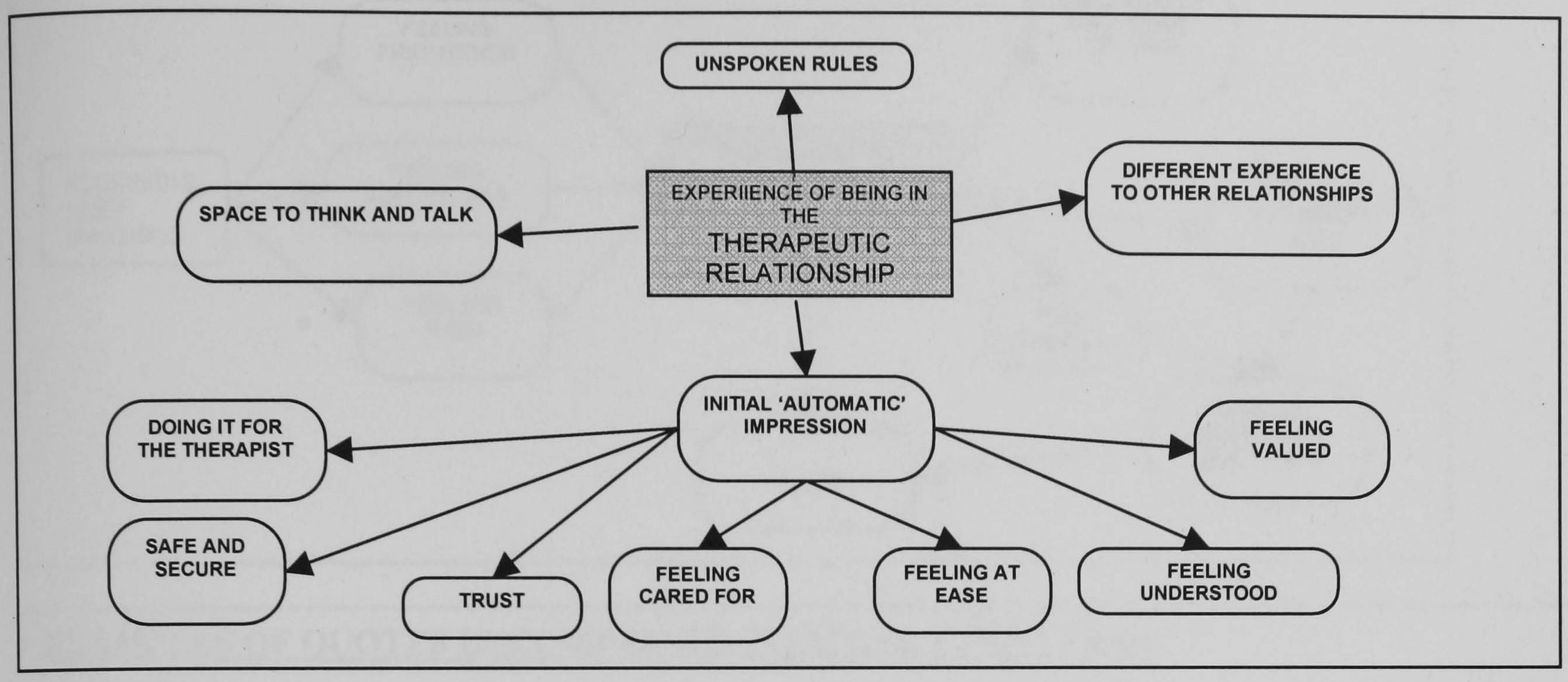
R: In…in what way, can you explain it a little bit more or?

"I think there's a lot of social roles, that, that can come in between the relationship, that, that can, that can sometimes block that empathy, that, that 'do you actually understand' bit." Elaine

PERCEIVED EXPERIENCE

"[therapist had] gone, through the training and was good at her job" Dorothy

AXIAL CODE: *EXPERIENCE OF BEING IN THE THERAPEUTIC RELATIONSHIP*



EXAMPLES OF QUOTES ENCOMPASSED IN INITIAL OPEN CODES

UNSPOKEN RULES

"... I didn't feel that there were any boundaries that you could actually see, between the friendship and, somebody doing a professional job. But it was there...there was no feeling that either of us would overstep the boundaries" Dorothy

DIFFERENT EXPERIENCE TO OTHER RELATIONSHIPS

" I wasn't used to talking. Like I didn't talk very much to anyone about anything. Er, from my family, historically, we didn't talk emotion, about emotions or personal things" Sarah

SPACE TO THINK AND TALK

"...it was the talking it out and, I did thinking through" Margaret

INITIAL 'AUTOMATIC' IMPRESSION

"...you will make a decision about somebody within, you know, sort of a couple of minutes of being there. And that is incredibly almost automatic response. I think if you then have a negative view, it's much harder" Elaine

DOING IT FOR THE THERAPIST

at that time I could actually a couple of times during an interview with her, when I thought, think I said that because that's what she wanted me to say" Dorothy

SAFE AND SECURE

"being able to be comfortable and feel safe and secure with the other person- fantastic to have that" Susan

FEELING VALUED

"feeling that somebody has that time for you, you know that you matter" Sheila

FEELING UNDERSTOOD

"I felt, oh gosh, you know, someone actually understands why I am so, angry" Margaret

FEELING AT EASE

" it felt totally natural" Dorothy

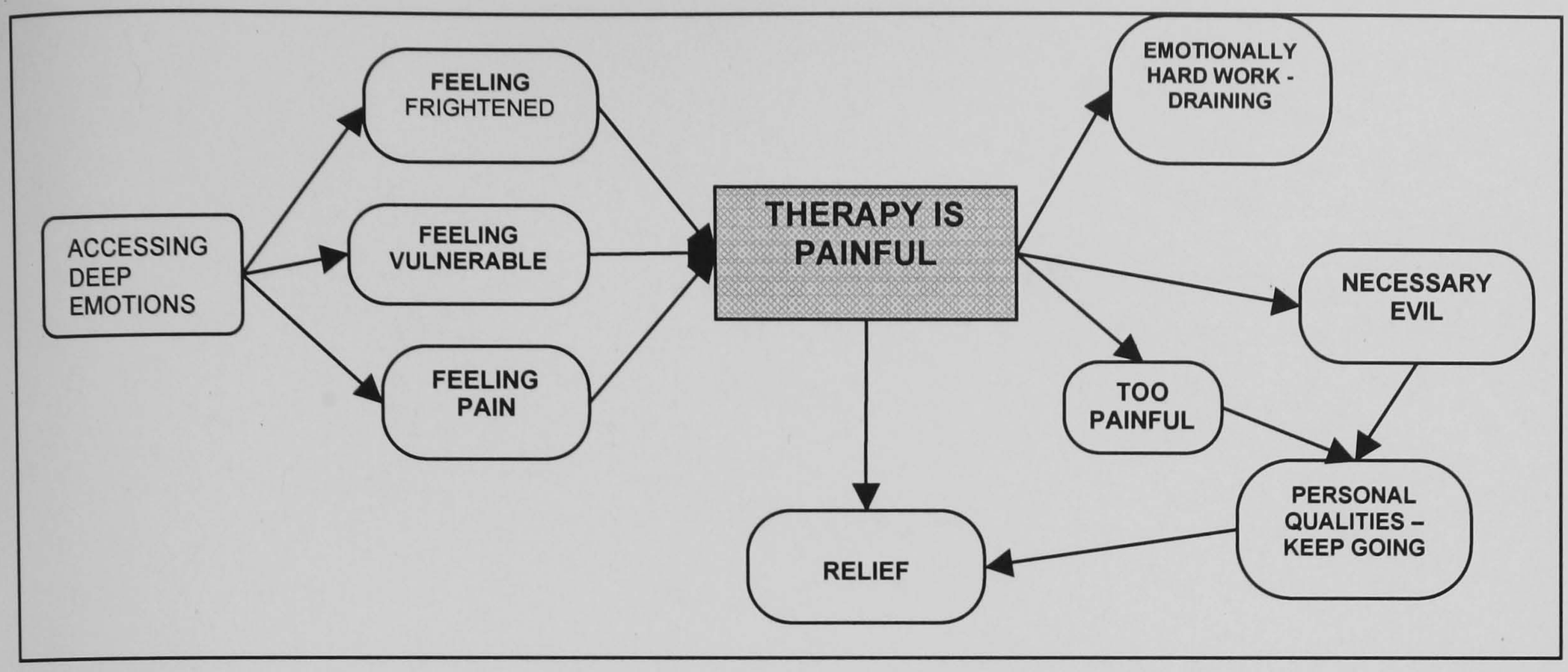
FEELING CARED FOR

"I felt like T cared enough to challenge my thoughts" Sarah

TRUST

"Like erm, someone I totally trusted and felt was on my side...." Sarah

AXIAL CODE: THERAPY IS PAINFUL



EXAMPLES OF QUOTES ENCOMPASSED IN INITIAL OPEN CODES

ACCESSING DEEP EMOTIONS

"Erm, and going through things that you haven't been through before, with anybody" Susan

FEELING VULNERABLE

"particularly something as sensitive as this, you are vulnerable, erm, you are power, not powerless, but I would never, er I wouldn't suggest that, I was made to feel powerless in any way, cos I wasn't, but there's that automatic, you're in someone else's hands, to a lot of to a great extent" Margaret

FEELING FRIGHTENED

"..your opening a Pandora's box, A little bit like that, you know, sort of, not quite sure what's going to come out...that's absolutely petrifying actually, to be honest, you know I, I wont say it, it wasn't, cos it was." Susan

FEELING PAIN

" it was painful, there were some things that came up that were perhaps difficult.... Memories, things like.." Sheila

HARD WORK AND DRAINING

"I think because, when it's so painful, it is so overpowering and so incredibly tiring. You literally, you're exhausted" Elaine

NECESSARY EVIL

"And sometimes I'd go home and think about [the painful issues], and didn't like, I didn't like that at all, nobody's gonna like that. But I could see it as a necessary evil, I could, I could see what [therapy] was doing" Dorothy

TOO PAINFUL

"and there was one occasion when I thought 'I don't want to come back.' Didn't want, I didn't want anymore pain" Dorothy

PERSONAL QUALITIES-KEEP GOING

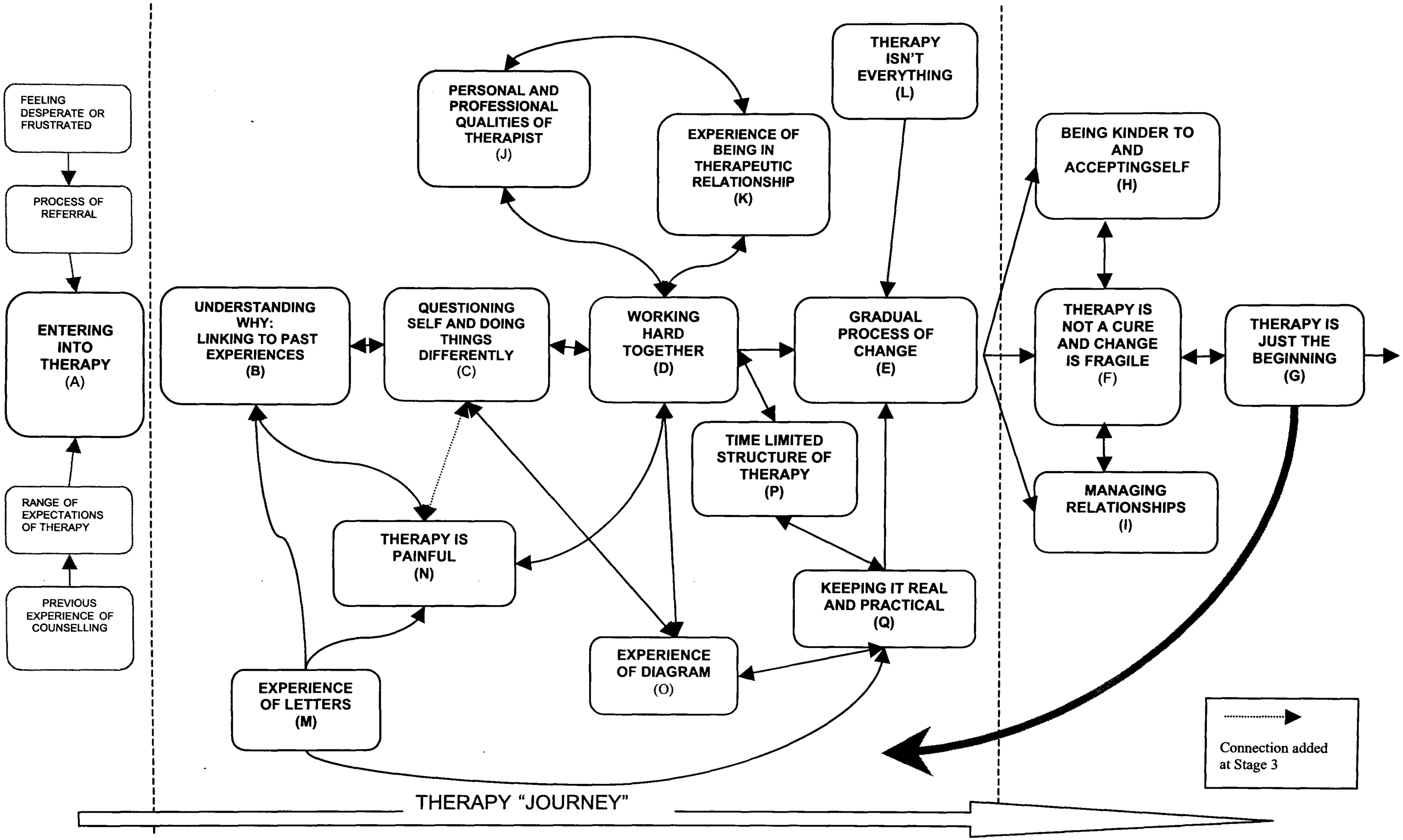
"...once I've set myself a goal, I have learnt that if you keep on and keep determined and don't go, there is something at the end, you just keep going. And so I'm...I'm very much a finisher" Elaine

RELIEF

"...I felt relieved, about giving it away. Er, like giving it to another person and keep it..." Sarah

APPENDIX 10

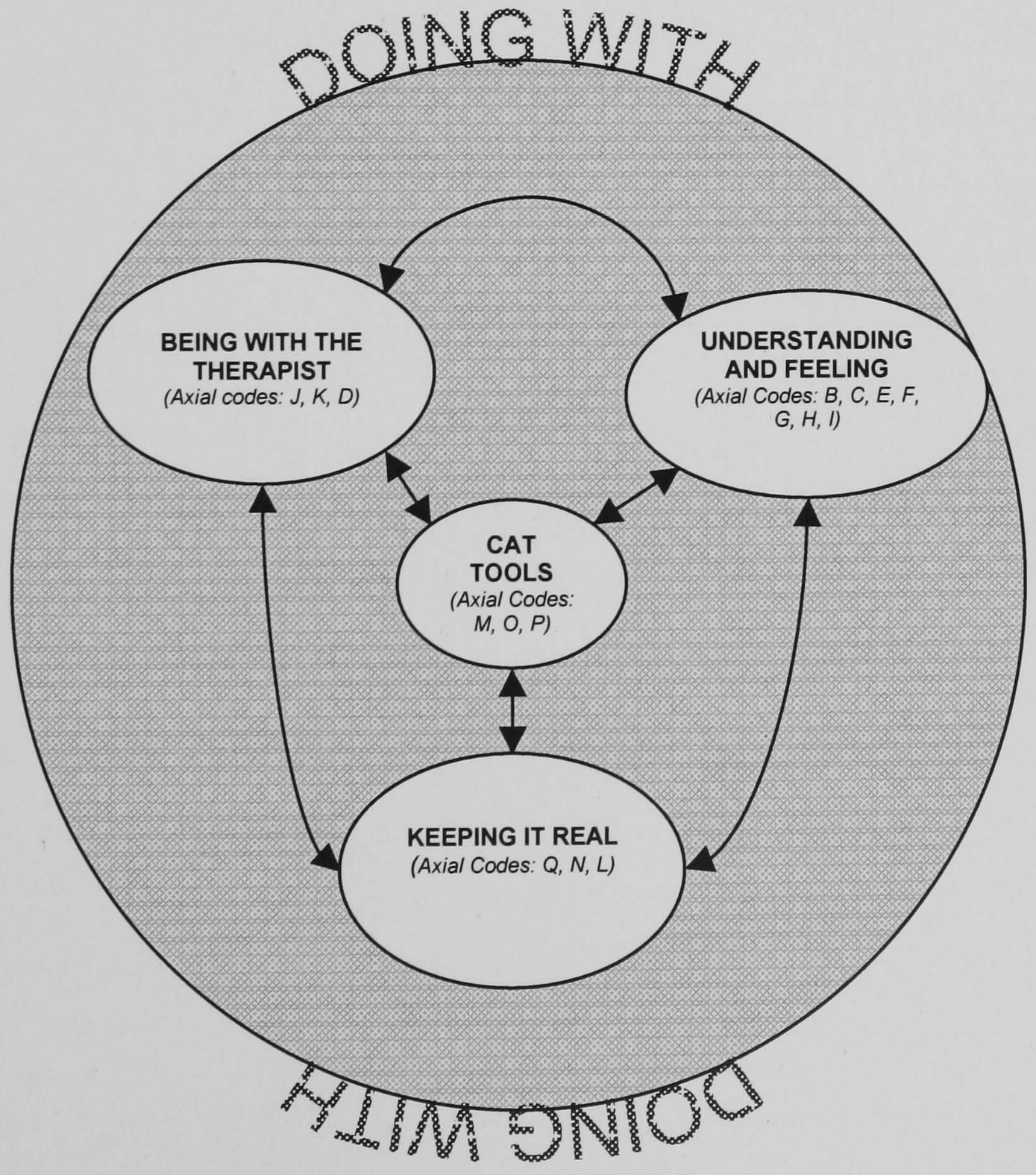
HYPOTHETICAL REPRESENTATION OF RELATIONSHIPS BETWEEN AXIAL CODES



APPENDIX 11

HOW THE AXIAL CODES FIT INTO THE DEVELOPED MODEL CONCEPTS.

CONCEPT	AXIAL CODES
BEING WITH THE THERAPIST	Working Hard Together (D) Personal and Professional Qualities of Therapist (J) Experience of Being in the Therapeutic Relationship (K)
CAT TOOLS	Experience of Letters (M) Experience of Diagram (O) Time Limited Structure of Therapy (P)
UNDERSTANDING AND FEELING	Understanding Why: Linking to Past Experiences(B) Questioning Self and Doing Things Differently (C) Gradual Process of Change(E) Therapy is Not a Cure and Change is Fragile (F) Being Kinder to and Accepting Self (H) Managing Relationships (I) Therapy is Just the Beginning (G)
KEEPING IT REAL	Therapy isn't Everything (L) Keeping it Real and Practical (Q) Therapy is Painful (N)



APPENDIX 12

Sheffield City Council

Sheffield Care Trust NHS
Mental Health and Wellbeing

Client's Experiences and Understanding of Change Processes in Cognitive Analytic Therapy

Doctorate of Clinical Psychology Research Study
University of Sheffield

University Supervisor: Andrew Thompson
NHS Supervisor: Sue Walsh

Information for Clinicians

As part of my professional training in clinical psychology I am conducting a qualitative study looking at client's experiences of receiving Cognitive Analytic Therapy (CAT). Despite the emphasis on the collaborative nature of CAT there is little, if any, previous studies directly exploring and understanding the client's perspective of this type of therapy. I am particularly interested in the meaning client's make of any changes they have experienced as a result of therapy and their understanding and perceptions of the reformulation process and specific CAT tools such as the letters and SDRs.

I am hoping to recruit about 8 participants from Sheffield Care Trust services.

I am hoping to interview participants between December 2004 and May 2005.

Enclosed is some information about the study for yourself together with a copy of the information sheets for interested clients and the research information sheet.

If you have any questions, comments, ideas or advice based on your clinical or research experience I would really like to hear from you. If you think you would like to be involved in the research by recruiting participants or want more details about the study then please contact me so we can discuss the nature of this further.

Contact details:

Kate Rayner
Trainee Clinical Psychologist,
Clinical Psychology Unit,
University of Sheffield,
302 Western Bank,
Sheffield
S10 2TP

Tel: (0114) 222 6570

E mail: pcp02cdr@shef.ac.uk

What sort of clients are you looking for?

I need people who have received 8, 16 or 24 session CAT with, ideally, a qualified CAT therapist, however, clients from therapists still in training may also be considered. Client's diagnosis is not an inclusion criterion for this project therefore anyone, irrespective of his or her presenting problems or reason for referral, may potentially participate. For safety I would ask you to use your clinical judgement and prior knowledge of clients to exclude those who have ongoing risk issues. This would include: self harm, violence to self or others, active suicidal intent, distressing hallucinations and active substance abuse. One focus of this research is to explore the meaning client's make about change processes they have experienced in CAT therapy. Therefore clients who subjectively report some positive change will initially be interviewed. However it may be necessary to 'test out' some of the interview findings or common themes with clients who have not exhibited any clinical change as a result of therapy.

What would I be asked to do?

If you are willing to be involved in this study there are a number of stages that may require your participation.

- ***Identify potential participants***

Identify participants from your current and prior caseload. Participants must have completed a course of CAT within the last 18months (i.e. their follow up session must have been within the last 18months).

- ***Introduce the research study to your clients***

Once you have identified potential participants, I would ask you to talk to your client about the study and give them the initial information sheet after their follow up session. The timing of this can be left to your clinical judgement as to when seems most appropriate without impacting on therapy processes or alliance. Alternatively, if the client has already been discharged from the service I would ask you to write to them to introduce the research project and send them the relevant information sheets.

If they are interested, they can fill in their contact details on the form attached to the initial information sheet and post it back to me in the envelope provided. Alternatively you could post this form back to me if they complete it in your presence. A copy of the research information sheet and consent form will be kept in the clinical file.

What would my client be asked to do?

Once they have expressed an interest in participating in the study I will contact them by telephone to answer any queries they may have, and, if they are willing to take part, arrange a convenient time for an interview. I anticipate the interviews to take place at the NHS base where they attended for therapy and last about an hour. In line with grounded theory procedure, participants will be asked to take part in a second interview. This is so any comments and feedback can be gained about emerging themes from the analysis of initial interviews. Participants will be paid £10 for any out of pocket expenses including travel costs.

What will you ask them in the interview?

The interview is intended to be participant led in order to allow them to communicate their subjective experiences freely. However the semi-structured interview schedule utilised will

aim to explore the following areas: 1) The client's general experience of therapy. 2)The use and perceptions of the reformulation process including the letters and SDRs. 3)Their understanding of how the change they may have experienced came about.

What if my client becomes distressed during or after the interview?

If I am concerned about a participant's current mental health I will discuss this with them at the end of the interview. If appropriate I will suggest they contact yourself or their GP or get their agreement for me to do this on their behalf. Confidentiality issues will be openly discussed at the beginning of the research interview as in routine clinical practice. The participants will be informed of the circumstances that may require the researcher to break confidentiality. Such circumstances might be, for example, if the participant disclosed intent to self-harm or put others at risk. If this occurred in the interview this would be openly discussed and the participant would be informed of the researchers duty of care and responsibility to act upon them accordingly. If the researcher is concerned about the participant then this will be discussed with the individual therapist.

What if my client complains about me?

If the participant expresses serious dissatisfaction with the help they received they would be made aware of the local NHS complaints procedures. If the participant described therapeutic practices that I was concerned about I would in the first case discuss these with my supervisors without identifying the therapist or client. Further action would only be taken if serious professional misconduct was suspected.

Will anyone be able to identify me or my client?

Only the researcher and a paid transcriber (who will be asked to sign a confidentially form) will listen to the end of therapy interviews. In the transcripts discussed with research supervisors, therapist and client names will be deleted and in the final report I will remove or change all identifying information.

What will you do with the data?

I will analyse the transcripts of the taped interviews using the qualitative method of Grounded Theory. Common themes will be identified, which will ultimately result in the development of a theoretical model of client's experience of CAT. As noted, in line with the recommended Grounded Theory practice participants will be revisited and asked further questions in line with the emergent themes. Furthermore a summary of the final themes will then be sent to the participants of the study, should they choose to be involved in this process, for their comments and suggestions. This is anticipated to be around April/May 2005. This will be discussed and explained further at the end of the initial interview and consent will be gained from participants who wish to take part in this additional part of the study. Participants are under no obligation to do this and their initial interview will still be valid.

The final research report will then be written up and submitted as my D. Clin. Psy. thesis in July 2005. I also hope the study will be written up for publication in psychology/counselling journals or other relevant CAT publications.

Thank you for taking the time to read this.

APPENDIX 13

THE UNIVERSITY OF SHEFFIELD
Clinical Psychology Unit
Department of Psychology

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

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TP UK

Telephone: 0114 2226570
Fax: 0114 2226610
Email: dclinpsy@sheffield.ac.uk

Unit Director: Prof Graham Turpin
Assistant Director : Prof Pauline Slade
Prof Gillian Hardy

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

18 July 2005

Kate Rayner
Third year trainee
Clinical Psychology Unit
University of Sheffield

Dear Kate

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

Literature Review: Clinical Psychology Review

Research Report: Option A.

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

Yours sincerely

Jason Davies
Research Tutor

APPENDIX 14

Guide for Authors

SUBMISSION REQUIREMENTS: All manuscripts should be submitted to Alan S. Bellack, Department of Psychiatry, The University of Maryland at Baltimore, 737 W. Lombard St., Suite 551, Baltimore, MD 21201, USA. Submit three (3) high-quality copies of the entire manuscript; the original is not required. Allow ample margins and type double-space throughout. Papers should not exceed 50 pages (including references). One of the paper's authors should enclose a letter to the Editor, requesting review and possible publication; the letter must also state that the manuscript has not been previously published and has not been submitted elsewhere. One author's address (as well as any upcoming address change), telephone and FAX numbers, and E-mail address (if available) should be included; this individual will receive all correspondence from the Editor and Publisher.

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