Clients' Experiences of Engagement in Psychotherapy in a Mental Health Setting: A Risky Venture

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Thesis submitted in partial fulfilment for the award of

Professional Doctorate

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April 2012

Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctorate in Psychotherapy is entirely my own work, and that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

Signed:_____

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Date: 23 August 2012

Acknowledgements

I would like to extend my humble gratitude to the five participants in the study who gave so generously of their time and who shared their experiences with openness and honesty. Deepest appreciation to my friends, particularly Evelyn and Marette, who seemed to be divinely inspired to provide me with exactly what I needed at any given moment. Thanks to my work colleagues whose ongoing and unwavering encouragement and support helped me maintain a semblance of work, life and study balance over the last four years. To the many fellow doctoral travellers I met along the way, thank you for your generosity in sharing your wisdom, experiences and encouragement. Pamela and Mark – I could not have asked for better supervisors. Your tremendous humanity coupled with your humour, thoroughness and critical debates kept me on task and expanded my horizons exponentially. Lastly, and most importantly, my entire life journey to this point in time would not have been possible without the love and support of my family – I love you all dearly. To my dearest Mum and Dad, my heroes and the most knowledgeable and wise people I know, you always inspire and encourage me.

Thank you all.

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Abstract

Title: Clients' Experiences of Engagement in Psychotherapy in a Mental Health Setting: A Risky Venture.

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Client engagement in psychotherapy can be defined as intense involvement with the therapy tasks and materials, and presence with the therapist and the self. Client engagement is deemed important in determining the success of the psychotherapeutic process and outcome (Hubble, Duncan and Miller 1999). Client engagement has been investigated most often in the context of its intersection with other client related factors in psychotherapy such as attendance, accessibility, agreement on and completion of the tasks of therapy, or the mutual process of the therapeutic alliance (Tetley et al. 2011; Dew and Bickman 2005). Little is known about clients' experiences of engagement in psychotherapy and the key issues for clients therein. In this Interpretative Phenomenological Analysis (IPA) study, individual interviews were conducted with five clients who attended psychotherapy in a mental health setting with therapists of varied experience and therapeutic orientations. The transcribed interviews were analysed using the analytic method described by Smith, Flowers and Larkin (2009). The study highlights the complex, evolving and dynamic nature of engagement. It particularly illuminates the profound sense of risk of self-annihilation, through death of the physical self or destruction of the psyche that participants grappled with as they navigated a number of key interconnected dilemmas inherent in engaging in psychotherapy. The study contributes to the field by informing practice concerns such as therapeutic impasse, informed consent and drop-out. It also informs client response to mental health treatment in general in relation to issues such as treatment compliance and decision making. Additionally, the study has implications for training, policy and future research.

Chapter 1. Introduction: From Personal Interest to Research Question

1.1 Introduction

Over time I have developed a growing curiosity about how people engage in various areas of their life, hence, my interest in undertaking a study that explores engagement in psychotherapy. I view engagement as being present and being absorbed or involved in an experience. I noticed the movement of my own engagement with myself and the world that shifts over time, from within a day, to extended periods in my life and how my engagement is influenced by a host of factors. As a psychologist and psychotherapist working in the field of mental health I have noticed that my engagement waxes and wanes and while at times I can see why this may be the case, in other instances I am unable to explain this. I began to wonder how such experiences might impact on the therapeutic relationship, where it is considered important that therapist and client turn up psychologically and emotionally. I was intrigued to understand more about how this might be experienced by clients in the realm of psychotherapy, which by its very nature necessitates engagement with the self, the therapist and the therapeutic processes. Frankel and Levitt (2009, p.171) describe moments of disengagement as "moments when clients withdraw, distance or lessen their intensity of involvement with therapy-relevant material or relationships" and to some extent I was interested in the opposite phenomenon; moments or periods of engagement.

Client engagement in psychotherapy can be defined as intense involvement with the therapy tasks and materials, and presence with the therapist and the self. It is deemed important in determining the success of the psychotherapeutic process and outcome (Hubble, Duncan and Miller 1999). Client engagement has been investigated most often in the context of its intersection with other client related factors in psychotherapy, such as attendance, accessibility, agreement on and completion of the tasks of therapy, or the mutual process of the therapeutic alliance (Tetley et al. 2011;

Dew and Bickman 2005). Little is known about clients' experiences of the engagement process and the key issues for clients therein.

1.2 The Study

This Interpretative Phenomenological Analysis (IPA) study sought to explore clients' experiences of engagement in psychotherapy, in the particular setting of mental health. In this IPA study, individual interviews were conducted with five clients about their experiences of engagement. IPA is a systematic approach to gathering and analysing data that illuminates participants' experiences of a particular phenomenon and how they make sense of these experiences (Smith, Flowers and Larkin 2009). The researcher is deeply involved in shaping the study process and makes choices and decisions throughout; for example, about what is relevant and of interest. Thus, the study is inevitably influenced by the researcher's own interpretations and values. In IPA, the researcher's influence is encompassed in and accounted for by the systematic approach that guides researcher positioning at each stage of the study and the responsibilities placed on the researcher to consider each turn in direction from a critical and reflexive position (Smith et al. 2009). I have chosen to highlight some of the critical issues, insights and decisions that arose during this study by providing a reflexive commentary, based on excerpts derived from my reflexive journal. These are italicised in the text under the heading of "Reflexive Notes".

1.3 Thesis Layout

Chapter 1 provides a brief overview of the study background. It also provides an introduction to the thesis layout and a brief description of the content of each chapter.

Chapter 2 provides an overview of key aspects of relevant literature in the area, including the enormous body of psychotherapy literature that intersects with engagement and incorporates relevant literature in mental health pertaining to engagement. This chapter also provides a number of definitions and frameworks for

understanding engagement, as a means of broadly identifying the phenomenon of interest. The chapter elaborates my rationale for conducting the study in view of current gaps in knowledge and elaborates the research question along with the aim and objectives of the research.

Chapter 3 describes the aim and objectives of this research study and outlines the methodology and methods used. It discusses aspects of phenomenology, hermeneutics and idiography that provide the theoretical foundations of IPA. It explains the rationale for the use of the method of in-depth interviewing in capturing the unique accounts of participants. The chapter also presents the details of how the study was conducted from its inception to write-up, incorporating ethical considerations and how these were managed.

Chapter 4 outlines the findings of the study. These are represented as three subordinate themes and an overarching superordinate organising theme. The organising theme describes the continuous process of navigating risk throughout therapy. Each subordinate theme highlights particular dimensions of the risks that participants encountered and the associated dilemmas that subsequently required management. Although these themes highlight general patterns across participants' accounts, multiple quotations from participants are incorporated to highlight similarities and divergences between participants' accounts and to illuminate particular aspects and dimensions of each theme.

Chapter 5 embeds the findings of the study in the extant literature. It incorporates a selection of relevant literature that resonates with and diverges from the findings. It highlights how the study contributes to the knowledge base in psychotherapy and mental health. It also proposes alternative theoretical frameworks for making sense of the themes, thereby elaborating understanding of emergent issues.

Chapter 6 is concerned with the implications of the study across a range of domains and the quality of the research. It explores implications related to psychotherapy practice, training, policy and future research, and highlights issues related to mental health treatment in general. The study is considered in terms of its strengths and limitations and uses the quality framework proposed by Yardley (2000), which Smith (2010) affirms as fitting for IPA.

Reflexive Notes

At the time of writing my research proposal, it seemed like a good idea to explore engagement in psychotherapy, which was an area that I was interested in. I reviewed qualitative methodologies to select one that fitted with the aim of the study. Having chosen IPA, which privileges the insider's perspective, I was confident that I could draw on my expertise as a therapist to interview participants in order to gather relevant data. However, as a novice qualitative researcher, I felt uncertain about my (in)capacity to deliver on other aspects of the study, such as moving between the different levels of interpretation required and incorporating a reflexive stance throughout the process. I realised this would require a shift in mindset, commitment to struggle with unanticipated issues and perseverance to overcome perceived obstacles in order to progress the study.

Chapter 2. Literature Review: Setting the Scene

2. 1 Introduction

The purpose of this literature review is to contextualise and situate the issue of client engagement in psychotherapy, to elucidate the rationale for the study and to provide a reference point from which to begin to make sense of the data. It provides an overview of psychotherapy and a summary of the vast research in psychotherapy on therapeutic outcomes, processes and client related characteristics. It critically discusses key issues in the literature related to engagement in psychotherapy including definitions and frameworks for understanding it, intersecting factors and pertinent issues in mental health such as stigma and help seeking behaviour.

Although not always denoting similar meanings the terms engagement, involvement, participation, contribution and collaboration are used interchangeably in the literature to refer to aspects of the client's role in psychotherapy. In this study I have primarily used the term engagement as it incorporates aspects of doing and being or presence. I did not restrict myself to this term as on occasions a particular term was specifically used in the literature reviewed or seemed to enhance the coherence of my account by avoiding excessive repetition of the same term.

A systematic search of the literature was conducted using PsycINFO, CINAHL and MEDLINE for the terms psychotherapy OR therapy OR counselling OR counseling AND effectiveness AND efficacy. This body of literature is summarised below. A second search was conducted using the same databases for the terms psychotherapy OR therapy OR counselling OR counseling AND engagement OR collaboration OR involvement OR contribution OR participation. This literature is discussed later in this chapter. Some additional topics and literature was sourced from references in the literature reviewed; for example, material on stigma and help-seeking was sourced as

it arose as an issue in one of the main studies on engagement in psychotherapy in mental health.

2.2 What is Psychotherapy?

Zeig (1997) estimated that 450 different psychotherapies had been developed while Wampold (2001) gave a more conservative estimate of an excess of 250. This perhaps provides some basis for understanding the complexity of offering a definition of psychotherapy that could be universally agreed across the numerous models and why attempts to define psychotherapy are challenging. The various models of psychotherapy differ in the extent to which they subscribe to philosophical and practice issues such as the aetiology of psychological distress, therapist and client responsibility and activity and the most useful way to promote change. However, despite these complexities definitions of psychotherapy have proliferated. Some authors have presented broad general definitions that attempt to encapsulate the diversities and divergences across these models. Consequently it can be argued that such definitions lack essence and richness.

> Psychotherapy is a primarily interpersonal treatment that is based on psychological principles and involves a trained psychotherapist and a client who has a mental disorder, problem or complaint; it is intended by the therapists to be remedial for the clients disorder, problem or complaint and it is adapted or individualised for the particular client and his or her disorder, problem or complaint. (Wampold 2001, p.3)

This definition highlights the intervening role and intentions of the therapy and the therapist that are activated in relation to clients who are viewed as having deficits to be treated by the therapist via the therapeutic process. Other definitions of psychotherapy are arguably richer as they reflect the particular therapeutic orientation of the respective authors. However, being rather less concerned with the general applicability and more concerned with a high level of specificity, such definitions tend to be more contentious and perhaps less relevant to other psychotherapy models.

> We define psychotherapy as a process of helping clients use their inherent capacities for change. The process is akin to that of education. In education, students' built-in capacities for learning are used, mobilized, and supported so that students develop new perspectives, new skills, or their own creative capacity for invention. (Bohart and Tallman 1999, p.105)

This view emphasises the role of the client and his or her inherent capacity for change in the direction of health, which is activated and supported by the therapist through the medium of the therapeutic process. This definition, in contrast to the former, situates the client more centrally as an agent of change and implies the essential and active involvement of the client in the process of change, while it also highlights the role of the therapist in helping to find and activate the inherent capacities of the client. Although the two definitions presented are different and by no means exhaustive they provide a map of the general terrain of psychotherapy to which this study pertains. The latter definition appeals to me as it is consistent with my view of clients as active participants in psychotherapy and of a mutually collaborative working relationship between client and therapist. It also provides a partial rationale for my interest in client engagement and the importance of understanding this from an emic perspective as the definition points to the prominence and centrality of the client's activity.

2.3 Overview of Psychotherapy Research

An enormous volume of psychotherapy research exists that covers a range of interconnected areas. For the purposes of this review I will punctuate this literature to provide an overview of research in the related areas of psychotherapy outcomes, process and client characteristics. The following sections will give a brief overview of key issues and findings in these related areas.

2.3.1 Outcome Research

The psychotherapy outcome research discussed below provides an overview of qualitative and quantitative meta-analyses. There is much disagreement and debate in

the area about how these results are interpreted. Additionally, similar methodological critiques arise in qualitative and quantitative meta-analyses; for instance, the use of different theoretical approaches, failure to describe the theoretical framework, the influences of differing data gathering methods, the use of divergent outcomes and determining the rigor of the research process.

Psychotherapy outcomes have been researched largely by examining efficacy of psychotherapy, primarily through the use of outcome measures in randomised controlled trials (RCTs), and effectiveness, primarily through the use of outcome measures in routine clinical practice settings. Although not universally accepted, the body of literature in the area demonstrates that generally psychotherapies are both effective and efficacious in the treatment of a range of psychological problems (Valkonen, Hanninen and Lindfors 2011; Elliott and Freire 2010; Knekt et al. 2008; Wampold 2008, 2001; Carr 2007; Roth and Fonagy 2005; Weisz 2004; Bergin and Garfield 1994; Lambert 1992; Hubble et al. 1999). Furthermore, several meta-analyses of quantitative outcome studies have concluded that the average client treated with psychotherapy is better off than those who are untreated, regardless of their presenting problem (Elliott and Freire 2010; Lambert and Barley 2002; Smith, Glass and Miller 1980; Smith and Glass 1977).

There is a view that the main psychotherapy models are equivalent in terms of beneficial outcomes for similar presenting problems (Elliott and Freire 2010; Wampold 2008, 2001; Miller, Duncan and Hubble 2007a, 2007b; Rosenweiz 2002; Asay and Lambert 1999; Lambert 1992). Lambert and Ogles (2004) reviewed over 50 meta-analyses of outcome research and concluded that statistical differences sometimes found to indicate superiority of one model over another were not large enough to warrant consideration. The meaning of this issue of equivalency across psychotherapy models is highly controversial and has been interpreted differently (Wampold 2001). One interpretation is that equivalency across models can be attributed to a failure of research to address the range of phenomena that can be implicated in psychotherapy

(Shedler 2010; McLeod 2001) suggesting that future research address methodological issues that allow for more rigorous comparison across models or for broader and more idiosyncratic conceptualisation of outcomes. Another interpretation is that broadly equivalent outcomes are a reflection of significant commonalities in the processes that occur in all psychotherapies. For example, regardless of the therapy model, some authors view change in psychotherapy as a process that occurs by activating and mobilising the healing processes of clients (Wampold 2001; Bohart and Tallman 1999), as primarily related to the processes that occur as a consequence of the therapeutic relationship (Rogers 1951), or as an opportunity for corrective experiences (Castonguay 1993; Alexander and French 1946). The equivalency view is associated with a significant body of process research seeking to identify common factors across psychotherapy models, their interrelatedness and their effect on outcomes (Rosenzweig 2002; Wampold 2001).

In an attempt to balance the dominance of the quantitative leanings of outcome research, qualitative outcome studies have been incorporated into the psychotherapy research literature (McLeod 2001). A recent qualitative meta-analysis of nine outcome studies of person-centred and experiential psychotherapies highlight positive outcomes and interestingly the authors comment that few of the studies reported negative outcomes (Timulak and Creaner 2010). Outcomes were demonstrated in three main areas; appreciating experiences of self, appreciating experience of self in relationship with others and changed view of self and/or others. These main areas were further broken down into areas; for example, appreciating experience of self in relationship with others contained two other areas involving feeling supported and enjoying personal encounters. McLeod (2001) proposes that qualitative approaches can enrich outcome research as they allow for complex reflection by clients about what has changed in their lives as a result of therapy. He argues that quantitative research is limited because the researcher predetermines the areas of importance relative to expected change, which is subsequently measured.

In summary, outcome research suggests that psychotherapy is a useful intervention for many psychological problems regardless of the exact nature of the presenting issue or the therapeutic model.

2.3.2 Process Research

Process research is concerned with common factors and the interrelatedness of these factors. It focuses on identifying and investigating factors that are hypothesised to be implicated in psychotherapy outcomes such as the quality of the therapeutic relationship and therapeutic process. It has been defined as:

> The actions, experiences and relatedness of patient and therapist in therapy sessions, when they are physically together, and the actions and experiences of participants specifically referring to one another, that occur outside of therapy sessions when they are not physically together. (Orlinsky, Ronnestad and Willutzki 2004, p.311)

Lambert (1992), based on a review of psychotherapy outcome research, describes four factors common to all psychotherapies along with their estimated contribution to outcomes. The review is subject to similar critiques outlined earlier and Lambert (1992) acknowledges that there is a lack of consensus about the particular areas or their relative importance in outcomes. The four factors are: extra-therapeutic factors, common factors, the therapy model and expectancy factors. Lambert (1992) suggests that extra-therapeutic influences were estimated to account for 40% of the change process. This refers to factors such as the severity and duration of the problem and the client's ability to engage in relationships, their level of psychological mindedness and motivation, their readiness to change, their expectations of the therapist and therapy, and the level and nature of their engagement in the therapeutic process. Common factors were estimated to account for 30% of therapeutic change. This refers to variables such as the nature and quality of the working alliance, client and therapist characteristics such as empathy, warmth and acceptance. The therapy model is viewed as accounting for 15% of the change process. This refers to the theoretical framework

adopted to explain the development and maintenance of client difficulties and provide a guide for intervention. Expectancy effects are also estimated to account for 15% percent of therapeutic change. These include the placebo effect observed in psychotherapy such as the client's knowledge that he or she is being treated and the client's belief in the treatment. Lambert and Barley (2002) report that these estimates were based on reviews of over 100 psychotherapy outcome research studies that span decades and that research designs allowing for the greatest number of variables determining outcomes were particularly well represented in the review.

2.3.3 Client Related Characteristics

When the components comprising each of the common factors described above are examined it becomes clear that factors related to the client stand out as being most significant in terms of outcomes (Bohart and Tallman 1999; Hubble et al. 1999; Lambert 1992). Cooper (2008) proposes that theoretically they could account for up to 70% of outcomes. A number of client related characteristics have been identified in the literature as important in terms of outcome and these can be categorised into the three broad areas of; demographic variables, contextual issues and client related factors that are more directly related to therapy (Bickman 2005). Demographic variables include age, gender, ethnicity, socioeconomic status and severity of the problem (Orlinsky, Ronnestad and Willutzki 2004). Broader contextual factors include the nature and availability of practical, social and family supports; for example, work opportunities, housing and access to recreational activities (Clarkin and Levy 2004; Horvath and Bedi 2002). Client related characteristics are of particular interest in this study as client engagement is considered an important factor in influencing outcomes and processes (Wampold 2001; Bohart and Tallman 1999; Hubble et al. 1999) and certain client related factors, which will be discussed later in this chapter, have been identified as mediating engagement (Tetley et al. 2011).

2.3.4 Summary

The literature presented to date has established a broad outline of the terrain of psychotherapy and has demonstrated that psychotherapy is generally effective in treating a range of psychological and mental health issues. Factors common across models of therapy have been proposed as influencing outcomes and therapy processes and research has sought to identify these. Client engagement has been identified as one of these factors. Orlinsky, Grave and Parks (1994, p.361) based on a review of more than 2000 process outcome studies concluded that "the quality of the patient's participation in therapy stands out as the most important determinant of outcome."

2.4 Definitions of Engagement in Psychotherapy

There is no agreed or specific definition of the term client engagement. Thus, there has been a lack of consistency in the meaning of the term across studies (Bachelor et al. 2007). Some authors have suggested that definitions have been determined more by efforts to measure the construct as opposed to defining the nature of the concept (Bachelor et al. 2007). Tryon (1990, 1989, 1988) operationally defines engagement as returning for a second session after an initial assessment interview. Other authors define engagement as staying in therapy until an ending is mutually negotiated between therapist and client (Westmacott et al. 2010; MacDonald, Cartwright and Brown 2007). However, these definitions are narrow as they rely primarily on client attendance and assume this reflects engagement without explication of this assumption.

Drawing on Frankel and Levitt's (2009, p.171) definition of disengaged moments, engagement could be conceived of as times when clients move toward, approach or increase "their intensity of involvement with therapy-relevant material or relationships." Tetley et al. (2011, p.927) define engagement as "the extent to which the client actively participates in the treatment on offer." Hill (2005, p.433) similarly suggests that engagement reflects "the extent to which the client becomes immersed

in the tasks required of the particular therapy." These latter definitions are useful in terms of the broad area of interest of this study as they extend the concept of engagement to include the quality of the client's relationship with the therapist and with the tasks of therapy.

2.5 Frameworks for Understanding Engagement in Psychotherapy

There is a dearth of literature proposing theoretical understandings of engagement in psychotherapy. Some authors have proposed frameworks for understanding aspects of therapy that incorporate engagement, although engagement may not have been the specific focus of the theory.

Tetley et al. (2011), in a systematic review of 40 studies that explored measures of therapeutic engagement, indicate that client engagement and disengagement have been poorly defined in the literature. In addition, they highlight that engagement is often conflated with concepts such as motivation, readiness for change, the therapeutic relationship and progress. They argue that although these factors may mediate engagement they are not the same as it. Thus, they propose that a distinction be drawn between a definition of engagement, the behavioural manifestations of engagement and concepts that mediate engagement. They suggest that the construct of engagement comprises six core aspects, which are the behavioural manifestations of therapeutic engagement. These aspects are clients; attending scheduled appointments; completing the course of therapy; sharing their emotional experiences; disclosing aspects of their inner world; doing homework or thinking about issues between sessions; and developing a working relationship with the therapist. Although this framework introduces clarity in relation to terminology and highlights behavioural representations of engagement, it does not deepen an understanding of the phenomenon of engagement.

Thompson et al. (2007) view engagement as an essential component of psychotherapy, suggesting that the process of engagement requires client and therapist to build an alliance, which is based on two aspects: therapeutic tasks and the relationship (Hougaard 1994; Pinsof, Horvath and Greenberg 1994). Task based alliance refers to the agreement between client and therapist about the purpose, goals and tasks of therapy that are required for positive change to occur. Relationship focused alliance involves building trust and rapport and connects the client and therapist. This process of building the bond is understood as a way of relieving client's attachment anxiety (Thompson et al. 2007), which refers to the client's concern for closeness and protection, coupled with worries about the availability of the therapist and value of the self to the therapist (Janzen, Fitzpatrick and Drapeau 2008). This is hypothesised to facilitate a relationship to develop that allows positive change to occur through empowerment of the client (Thompson et al. 2007). The task based and relationship focused aspects of alliance are considered to be complimentary and dependent upon each other for development (Pinsof, Horvath and Greenberg 1994).

Rice and Greenberg (1990) suggest that therapy can be viewed as a sequence of affective and cognitive information processing tasks. In their research, which focused on change events in therapy, they propose that clients use different modes of engagement, depending on the specific change event occurring in the therapy. These modes involve different styles of information processing. When clients are discussing their problematic reactions to certain situations they process information in such a way as to re-experience the situation. This is called experiential searching and requires turning their attention inwards to access their immediate internal experience and trying to symbolise this in awareness. When clients are engaged in change processes involving conflict, splits or unfinished business, their energy is invested in expressing their immediate in-session reactions. This dimension is called active expression and facilitates the client to enact aspects of his or her experience in order to recognise it and claim ownership of it. This promotes contact between conflicted aspects of the self, allowing for differentiation and integration of these aspects. The third dimension

is called interpersonal experiential learning and involves change events relating to deep despair and fear. The therapist, by empathic reflection of the intensity of the client's feelings, facilitates the client in the first instance to engage with the full intensity of their own feelings and then to disengage from the intensity of the emotional experience. The therapist's reaction to the client is predicated on shared human experiences. Thus, the client's experience resonates with the therapist and this counters the isolation and fragmentation inherent in such intense experiences. Rice and Greenberg (1990) suggest that this helps the client to take the risk of engaging with deeply feared experiences.

Hill (2005), writing about the therapy process, proposes that therapist techniques, client involvement and the therapeutic relationship are interconnected variables that evolve through various stages during therapy. She describes client engagement in terms of the client becoming immersed with tasks required of the therapy. She proposes that this is demonstrated when clients initiate topics, explore issues, participate in activities that change behaviour, are open with the therapist about his or her reactions to the therapy or therapist and work to gain insight.

Hill (2005) proposes a four stage model to account for how these interconnected variables develop over the course of therapy. Stage one occurs at the initiation of therapy and is characterised by therapist techniques that are supportive and educational. Client involvement is characterised by building trust, leading to the beginnings of a therapeutic relationship. It is demonstrated by attendance and is mediated by the client's expectations, openness and motivation and the therapist's credibility. Stage two occurs when client and therapist have connected and the therapist's techniques are characterised by exploration. Client engagement is concerned with exploring his/her inner world leading to a deeper working relationship. This is demonstrated by clients disclosing thoughts, feelings and emotions. It is mediated by past relationships, observations of initial change, a sense of hope and by the therapist's communication of confidence to the client. In stage three therapist

techniques are characterised by strategies that are specific to the type of therapy being used. Client involvement is concerned with undertaking the tasks of therapy in and between sessions and working on obstacles in the therapeutic relationship further facilitating a deepening in the therapeutic relationship. This is demonstrated by testing the therapist's trustworthiness, increased openness and emotional expressiveness, new insights or new behaviour. It is mediated by client decisions about what to hold back, the therapist's change strategies and the willingness and ability of the client and therapist to work on obstacles in their relationship. Stage four is characterised by therapist techniques focusing on termination. Client involvement is concerned with processing the therapeutic relationship and the work completed and planning for the future after therapy. It is characterised by planning ahead and discussing termination and is mediated by the client's previous history of loss, the progress achieved in therapy and the readiness of the client to terminate therapy. Although this model proposes a dynamic and progressive interpretation of engagement, it suggests that engagement progresses sequentially through these stages. Indeed, Hill (2005) contends that if any stage is not successfully negotiated the next stage will not develop and therapy will not progress.

2.5.1 Summary

In summary, these frameworks for understanding engagement in psychotherapy provide a base for beginning to conceptualise engagement as an intra and interpersonal process that is mediated by a range of client, therapist and therapy factors. Thus, it is a complex and evolving phenomenon that can hold different meanings over time but nonetheless reflects the intensity of client involvement with self, therapist and therapy at a moment in time.

2.6 Factors that Intersect with Engagement

Tetley et al. (2011) suggest that a number of client related factors intersect with engagement. They suggest that these factors are typically either a predictor or a

consequence of engagement and are frequently conflated with it in the literature. A number of these factors are discussed below.

2.6.1 The Therapeutic Relationship

The therapeutic relationship is considered an essential component of psychotherapy outcomes and the strength of the alliance is one of the most significantly implicated factors in the success of the therapy process and positive outcomes (Horvath et al. 2011; Norcross 2011; Delsignore and Schnyder 2007; Hill 2005; Orlinsky Grave and Parks 1994; O'Malley Suh and Strupp 1983; Gomes-Schwartz 1978). Zetel (1956) describes the therapeutic relationship as the client's ability to use the healthy aspect of his ego to unite with the therapist in order to move in the direction of achieving therapeutic tasks. Luborsky (1976) proposed two aspects in the development of this alliance. The first is the client's belief that the therapist will be able to help and second is the willingness of the client to invest in and share the therapeutic process with the therapist. Bordin's (1979) conceptualisation of the therapeutic alliance is of an active collaborative relationship between the client and therapist that involves reaching agreement about goals and tasks of therapy in the context of a bond between them both. Each of these conceptualisations has in common an emphasis on what the client actively brings to the therapeutic process, thereby moving the client explicitly into the equation (Horvath and Bedi 2002). The therapeutic alliance and the client's engagement in the process of therapy have been described as inextricably bound (Delsignore and Schnyder 2007; Hill 2005).

2.6.2 Expectations and Preferences

Client expectations and preferences are deemed to influence psychotherapy outcomes (Constantino et al. 2007; Greenberg, Constantino and Bruce 2006; Weinberger and Eiq 1999). The client's willingness to engage in the therapeutic process is linked to his or her expectations and preferences about his or her role as a client, the therapist's role,

the therapy procedures, length of therapy and therapy outcome (Arnkoff, Glass and Shapiro 2002).

Delsignore and Schnyder (2007), in a review of the literature on expectancies, report that therapeutic change is strongly associated with clients who have high expectancies of positive outcomes. Tinsley, Bowman and Westcot Barich (1993) surveyed 72 psychologists about their clients' expectations. Unrealistic client expectations were generally viewed as detrimental to positive outcomes, with notable exceptions. Unrealistically low client expectations about the degree of personal involvement and motivation required for psychotherapy were viewed by psychologists as detrimental to positive outcomes. On the other hand, unrealistically high expectations of the therapist being directive were also viewed as detrimental. However, a combination generally judged to be helpful comprised unrealistically high expectations about the level of personal involvement required coupled with unrealistically low expectations that the therapist would be directive. The authors concluded that generally:

> Clients need to have realistic expectations about (a) the counselor's ability to be helpful, (b) the counseling environment, and (c) the role of the client in the counseling process. (Tinsley, Bowman and Westcot Barich 1993, p.50)

However, it is not clear from the research on expectancies what constitutes or who determines realistic expectations, whether these are consistent across different therapies, clients and presenting problems, or how clients might come to have more realistic expectations, particularly as there is no consensus about this among the professionals who provide therapy.

Arknoff, Glass and Shapiro (2002) in a review of expectancy literature indicate that most studies report a convergence of client and therapist expectations and preferences over the duration of therapy. This finding is perhaps not surprising considering that client and therapist become more familiar with each other and with

the requirements of therapy as it unfolds and perhaps those who do not accommodate towards each other's expectations and preferences do not continue in therapy together. Dew and Bickman (2005), in a review of expectancy and outcome research, report that realistic client expectations are related to client engagement, as measured by attendance and therapeutic change. Hughes (1995), examining the relationship between attendance and expectations, suggests that discrepant expectations about psychotherapy are not strong predictors of termination. Of note, this study was conducted early in the therapy process and did not track the relationship between expectancies and attendance over the duration of the therapy. Studies can be critiqued for assuming a direct relationship between attendance and engagement and viewing them as similar concepts. Dew and Bickman (2005) argue that research in the area of expectations and preferences has been confused by lack of distinctions between pretreatment and in treatment expectations and lack of specificity in relation to the point in therapy at which expectations or preferences were assessed. Delsignore and Schnyder (2007) critiqued the use of termination and dropout rates as outcome measures in some studies and highlight the absence of standardised scales to measure expectations and preferences. Furthermore, such critiques privilege objectivist, nomothetic and etic perspectives and preclude clients' perspectives on these matters.

2.6.3 Motivation

The importance of motivation for treatment is based on its assumed relationship with processes such as engagement and compliance (Drieschner, Lammers and van der Staak 2004). Lack of motivation is typically related to clients dropping out prematurely from therapy and failing to comply with treatment (Drieschner, Lammers and van der Staak 2004). This is frequently viewed as disengagement. Horowitz et al. (1984) indicate that the relationship between client contributions, alliance and outcome varies depending on the level of the client motivation. The importance of motivation throughout the therapy process is reflected in the significant amount of literature focused on building and maintaining treatment motivation (Drieschner, Lammers and

van der Staak 2004). These authors point out that the construct is not reliably defined and different definitions in research probably account for some of the variance in research findings. However, it is interesting that motivation is considered to be a variable that is dynamic and influential throughout the therapy process, thus perhaps alluding to the complexity of researching therapeutic processes that are influenced by time and other factors.

2.6.4 Hope

Hope is an emotional state related to empowerment and positive expectation about the future and it is deemed an important client characteristic (Snyder, Michael and Cheavens 1999). Frank and Frank (1991) assert that psychotherapy works partly by remoralising clients who typically come for psychotherapy having become demoralised for a variety of reasons; for example, persistence of their symptoms, failure to live up to expectations or inability to cope. Howard et al. (1986) suggest that 60 to 65% of change in psychotherapy occurs within six to seven sessions and Weiner-Davis, deShazer and Gingrich (1987) indicate that 40 to 60% of clients report improvement prior to commencing therapy. Hill (2005) suggests that for some clients making the decision to enter therapy can instil hope thereby alleviating demoralisation and moving clients from a passive to an active position with regard to their own well-being. These research findings suggest that factors beyond receiving therapy are implicated in improvement and hope is postulated as one such explanation for these findings. Synder (2002) proposes that common across interventions that seek to promote change are attempts to increase a person's sense of agency and their means of achieving their goals. Although expectations and hope have been linked, expectations can exist in the absence of hope and vice versa and research is inconclusive about how these factors are interconnected (Dew and Bickman 2005).

2.6.5 Collaboration

Collaboration refers to a client's co-operation in the mutual goals and tasks of therapy and in a meta-analysis on collaboration and outcomes, collaboration was significantly related to clients staying in therapy and showing increases in adaptive functioning and reductions in symptoms (Orlinsky, Ronnestad and Willutzki 2004). The review suggests that collaboration is necessary throughout therapy and that it is helpful for clients to recognise their role in collaboration.

Bachelor et al. (2007), in a two part study, sought to formulate a definition of collaboration based on clients' views and to identify the characteristics of collaboration, as rated by clients and therapists, in relation to the three areas of client psychological functioning, quality of interpersonal relationships and motivation. Questionnaires were used to assess collaboration, relationships and motivation and clients were asked to describe a therapy session or part of a session where they had a good experience of collaboration. The authors reported that they were unable to form a definition of collaboration that represented the various aspects and complexity of clients' views but their analysis identified three types of client collaboration. Active collaborative clients had a significant role to play in progressing therapy and characterised their contributions as a willingness to take the initiative in disclosing material in an open manner without prompting. They viewed therapists who adopted facilitative attitudes, fostered a relational stance and used interventions that fostered understanding as playing an important part in promoting collaboration. Mutual collaborative clients saw themselves and the therapist as having equal roles to play in progressing therapy. They contributed to collaboration by making authentic disclosures and highlighting their active engagement in the work of therapy both inside and outside the session. The therapist's facilitative attitude was also viewed as playing an important part in collaboration, specifically attentive listening and empathy. Clients who featured in the third group, the dependent collaborative group, were characterised by reliance on the therapist as the primary contributor to the work of

therapy and change. Although seeing themselves as participating in therapy, they viewed collaboration as located within the therapist. They emphasised that contributions to collaboration stemmed primarily from the effective interventions of the therapist and they noted the importance of therapist facilitative attitudes and listed more of these than the other two groups.

Overall, the authors conclude that clients perceive and experience collaboration differently. They propose that client collaboration can be viewed along a continuum from highly active clients at one end, to minimally participant clients at the other. However, this suggests a somewhat linear perspective on collaboration. Ascribing clients with designations such as highly active suggests that collaboration is a static characteristic of an individual client and does not necessarily allow for the possibility of change over time or in different contexts and such thinking may disenfranchise clients by foreclosing expectations and therapist responses.

Interestingly, Bachelor et al. (2007, p.187) note that although clients could describe a variety of therapist related actions and attitudes they "reported relatively few personal contributions to the collaborative process." Perhaps this was influenced by not being asked directly and explicitly about their contribution to collaboration and Bachelor et al. (2007) encourage further research that privileges clients' perspectives. My study set out to explicitly address clients' perspectives, specifically their experiences and understanding of their engagement in psychotherapy thereby attempting to address this methodological gap.

2.6.6 Relationship Style

Moras and Strupp (1982) investigated the relationship between therapists' pretherapy assessment of clients' interpersonal relationships, the therapeutic relationship and outcomes. They suggest that the client's ability to form good interpersonal relationships, when assessed prior to therapy, indicates their ability to form a strong therapeutic alliance with the therapist. However, their study was limited by using only

male participants, relying on clinical judgements to determine interpersonal relationship ability and rating clients' therapeutic alliances without considering the effects of the therapist. Furthermore, Clarkin and Levy (2004) point out that this research did not show that poor interpersonal skills were correlated with poor alliance. In a controlled clinical trial Piper et al. (1991) examined the relationship between the proportion of therapist interpretations, outcomes and the therapeutic alliance in psychodynamic psychotherapy. They indicate a strong association between a low number of interpretations offered by the therapist, a history of good relational ability in clients, strong therapeutic alliance and favourable outcomes. This study was limited by the use of predetermined outcome and alliance measures. Orlinsky, Grave and Parks (1994), in a review of more than 2000 process outcome studies, suggest that; 80% of studies linked client openness rather than defensiveness with positive outcomes; 70% linked client investment in their role in therapy with positive outcomes; 69% of studies linked co-operative rather than resistant client roles with positive outcomes; 64% associated a collaborative rather than controlling or defensive client attitude with positive outcomes. They conclude that "the quality of the patient's participation in therapy stands out as the most important determinant of outcome" (Orlinsky, Grave and Parks 1994, p.361).

2.6.7 The Therapist

In a series of studies on engagement using qualitative and quantitative methods in alcohol and drug counselling services researchers found that clients are more likely to engage if they feel at ease, if they experience the therapist as liking them, interested in them and as being warm and friendly towards them (MacDonald Cartwright and Brow, 2007; Cartwright Hyams and Spratley 1996; Hyams Cartwright and Spratly 1996). Conversely, clients were more likely not to engage if they experienced the therapist as critical, demeaning and withholding information or playing a role rather than being genuine in the relationship. These findings echo Rogers' (1951) emphasis on the importance of therapist empathy, warmth and congruence. However, in this series of

studies the definition of engagement is limited as it is defined in terms of attendance after initial interview and at two further individual counselling sessions, or five group sessions within three months of the assessment interview. Furthermore, it is not clear if there were other factors that may have impacted on attendance, such as accessibility of the services or financial burden. Acknowledging some limitations of their studies, MacDonald, Cartwright and Brown (2007) suggest a role for systematic qualitative research in this area, guided by specific research questions. This study sought to build on this methodological recommendation in its phenomenological approach.

2.6.8 Summary

In summary, it can be seen that a range of factors have been identified that intersect engagement. These factors may explain to some extent how and why some clients engage in therapy and why others do not. However, at times these factors have been conflated with engagement itself. The literature highlights the complexity of research in the area by drawing attention to a range of intrapersonal and interpersonal factors that influence engagement and how such factors, while enlightening on the one hand, also have been used in limiting and obfuscating ways.

2.7 A Paradigmatic Turn

As the most important ingredients in the therapeutic process are considered to be the client's collaboration with the therapist and the client's active involvement in therapy tasks (Norcross 2011; Bachelor et al. 2007; Tryon and Winograd 2002) there has been growing interest in what and how the client contributes to therapy (O'Brien and Houston 2007; Bachelor et al. 2007; Greaves 2006; Tryon and Kane 1995). Pragmatically, Arnkoff, Glass and Shapiro (2002, p.335) highlight the essential point that regardless of the therapy model with inherent assumptions about how change occurs, fundamentally "the client must actively engage with the process." Therefore, they propose that research should address factors that either promote or hinder the

client's involvement in psychotherapy. Similarly, Bohart and Tallman (1999) advocate that the most important thing a therapist can do is to find ways of helping clients become more invested and involved in the therapy process.

In a meta-analysis conducted by Karver et al. (2006) the strongest predictors of positive treatment outcomes were therapist interpersonal and influential skills and the willingness and actual participation of clients in treatment. They argue that despite a growing body of research aiming to understand the role of the therapeutic alliance in engagement there are several areas requiring further research; for example, few studies have been conducted that draw on clients' perspectives. Furthermore, drawing on Kazdin and Nock (2003), they argue that if research is to be relevant to practice it needs to take place in naturalistic real world practice settings, which further supports the need for emic focused research in this area. Greaves (2006) critiques studies that focus on client responses to treatment rather than on research that privileges clients' capacities to participate in meaningful ways in psychotherapy. Greaves (2006, p.209) encourages research that elucidates "the nature of client involvement as an agentic, generative, learning-driven, and creative human being."

> It is stressed that studies of user perspectives may allow for the development of broader and more vigorous understanding of clients as the primary agents of their own change processes. (Dreier 1998, p.296)

Interestingly, in the context of the current study, although the therapeutic alliance has often emerged as a predictor of therapeutic success (Norcross 2011; Lambert and Barley 2002; Martin, Garske and Davis 2000) this association seems to be particularly strong when clients rather than therapists define successful outcomes and assess the quality of the relationship (Horvath et al. 2011; Horvath and Bedi 2002; Castonquay et al. 1996). A number of authors highlight that client and therapist perceptions about a range of factors and processes in psychotherapy frequently do not match (Timulak, 2010; Bachelor et al. 2007; Macran et al. 1999; Eugster and Wampold 1996). Horvath

and Bedi (2002) indicate that early in therapy clients' ratings of the relationship are better predictors of outcome than therapist ratings. Timulak (2010) carried out a review of significant events in psychotherapy, referring to moments in the therapy process that clients identified as being important in terms of either helping or hindering the therapeutic process. The review concludes that client and therapist perspectives match approximately 30 to 40% of the time, with clients more invested in relational aspects of the therapy and therapists more invested in events related to the tasks of therapy, such as insight. Together these findings lend weight to the importance of examining client related factors, including their part in the therapeutic relationship and doing so in a way that acknowledges and attends to clients' own perspectives. This has influenced what my study seeks to do by privileging the accounts of participants.

2.7.1 Summary

There is increasing understanding and acknowledgement of the importance of research in psychotherapy that includes the views or experiences of the people who use psychotherapy. Thus, there is increasing understanding in psychotherapy research that clients have valid and useful comments and contributions to make to research and that this adds another dimension to knowledge in the area (Macran et al. 1999). These were some of the important issues for me in considering my approach to this study, which seeks to build on this trend by exploring client experiences of engagement.

2.8 Engagement and Mental Health

Bachelor et al.'s (2007) research aimed at furthering understanding of collaboration was discussed earlier. However, there is an additional aspect of their work that is of interest to and provides further rationale for the current study. They suggest that 71% of clients from a mental health setting, who were diagnosed with more severe and chronic disorders than others in the study, were in the client dependent collaborative category, which seems to carry the most negative prospects for engagement. They

conclude that diagnostic category or specific types of disorder may negatively affect the quality of the working alliance with such clients. However, other explanations are possible. For example, through their involvement in mental health services this group may have been socialised into a particular way of viewing themselves, their diagnosis and what is expected of them when they attend for treatment, such as viewing themselves as less able or others as experts. Thus, issues pertaining to stigma and to the dominant discourse or perspective in mental health are relevant to this study as it is set in a mental health context.

In mental health settings the prominence of the biological model of psychiatry has been critiqued for its overreliance on diagnosis and biological interventions. It has also tended to position the practitioner as an expert on the client and the client as a passive recipient of treatment and in so doing created a hierarchical power differential between the practitioner and client (Bracken and Thomas 2001; Macran et al. 1999). This has resulted in some individuals feeling objectified and consequently dehumanised and devalued (Szasz 1970) and has enabled stigmatisation to flourish (Corrigan and Watson 2002). Alternatives to the biological model of psychiatry are approaches that privilege the client as expert on himself and his life and the practitioner as expert facilitator of the intervention process (Hubble et al. 1999; Anderson and Goolishian 1992) and such approaches may socialise clients into different expectations of treatment and of themselves, which may facilitate and promote engagement.

2.8.1 Stigma

Corrigan and Watson (2002), writing about mental illness and stigma, suggest that stigma comprises three components: stereotypes, which are negative beliefs about those who have mental health issues; prejudice, which is when an individual or the general population concurs with that belief and may have an emotional reaction towards the particular group, and; discrimination, which is a behavioural response towards the group. A distinction is made between public or social stigma and self-

stigma (Vogel and Wade 2009; Vogel, Wade and Hackler 2007; Corrigan 2004; Corrigan and Watson 2002; Watson and Corrigan 2001). It is proposed that self-stigma about mental illness develops as public stigma is experienced and internalised by an individual and the individual adopts a view of him or herself as unacceptable because of the mental health issues they experience (Vogel and Wade 2009; Vogel, Wade and Haake 2006; Corrigan and Watson 2002; Watson and Corrigan 2001).

Although the term stigma has been contested as potentially stigmatising itself by focusing attention away from those who promote discrimination onto those who are being discriminated against (Peterson, Barnes and Duncan 2008) the impact of the phenomenon gives rise to concern (Vogel and Wade 2009; Peterson, Barnes and Duncan 2008; Corrigan and Watson 2002). Stigma is associated with both reluctance to seek treatment and concealment of mental health concerns (Vogel and Wade 2009; Vogel, Wade and Hackler 2007; Corrigan 2004). It is linked with negative help-seeking attitudes and behaviours that impact the recovery process for the client (Ritsher and Phelan 2004) and at times this can result in the fatal outcome of suicide (National Office for Suicide Prevention [NOSP] 2005). At the very least it prolongs their agony and sense of being alone and on the edge of life and living (Gordon, Cutcliffe and Stevenson 2011). Rogers and Pilgrim (2005) highlight that there is significant interest in examining help-seeking behaviours due to the health costs of delayed treatment and loss of productivity associated with mental and physical concerns. They suggest a general reluctance to seek help by individuals with mental health concerns due to the perceived stigma of mental illness, the perceived ineffectiveness of medical interventions and a greater tendency to deny psychological symptoms. In relation to suicide and mental health, Cleary (2005) deems negative help-seeking patterns to be more prevalent among men. In a review of the literature on men and help-seeking behaviour, Galdas, Cheater and Marshall (2005) concur that men are more reluctant to seek help in relation to general health problems from professional sources and are less likely than women to view symptoms as psychological in nature.

2.9 Summary

This literature review highlights a number of points that are pertinent for the current study. First, despite differences between the main models of psychotherapy, research demonstrates that the main psychotherapies achieve broadly equivalent benefits in terms of outcomes (Orlinsky, Ronnestad and Willutzki 2004; Wampold, 2001). Second, research exploring positive outcomes and client related characteristics stand out as having a particularly influencing role. Finally, research also suggests that these variables are more accurately associated with outcome when the client defines and assesses them.

Although the literature on engagement points to the interplay of many personal, relational, therapy related and external factors, it is not clear what the mechanisms of interaction are between such factors. In this regard, Wampold (2001) highlights the correlation between the strength of the positivist paradigm with the underdevelopment of alternative research perspectives that may be better placed to study such complex areas of interest in psychotherapy. My study builds on this by employing IPA to illuminate client engagement. It is anticipated that clients' views and experiences can bring different and important perspectives to those of researchers and practitioners. Macran et al. (1999, p.325) advocate for service user involvement in psychotherapy research as the "client's contribution to, and therefore their perspective on, their therapy is equally important to any other perspective." They argue for a collaborative approach to research that allows clients to set the agenda for what is important and meaningful for them in therapy. Although the research agenda in this study was chosen by the researcher, the study goes some way towards meeting the objective of inclusion of clients' voices and IPA allows for the voice of both participants and researcher to be attended to.

Finally, the literature reviewed demonstrates that there are different ways of defining engagement and various models have been proposed for understanding aspects of

engagement. However, the literature is difficult to integrate in the absence of an overall framework for understanding engagement in psychotherapy. The literature demonstrates that client engagement in psychotherapy has been investigated most often in the context of its intersection with other client-related factors such as client attendance, motivation, expectations or the mutual process of the therapeutic alliance (Dew and Bickman 2005). Such research generally has utilised therapists' or others' ratings of clients on various factors thought to be predictive of or associated with client engagement (Bachelor et al. 2007) and has typically been undertaken in the context of trying to determine a definition of the construct and develop measurement scales. More recently, there has been a move towards including clients' perspectives of these factors and attempting to gather their views of what contributes to these factors. This change in direction is an attempt to develop a more holistic and comprehensive understanding of the phenomenon of engagement (Fitzpatrick et al. 2009; Bachelor et al. 2007) and is fitting with the direction of health services research of increased inclusiveness and participation of clients in research (Department of Health 2006).

This literature review establishes that there is a gap in knowledge relating to the nature and meaning of client engagement in psychotherapy and establishes a rationale for the benefits of conducting qualitative research focusing on clients' phenomenological accounts. This allows for clients' lived experiences of engagement to be elaborated and facilitates consideration of how clients make sense of their engagement in psychotherapy, thereby gleaning important information for clients and therapists, and perhaps others, working therapeutically.

For the purposes of this study engagement in psychotherapy was defined as an intense involvement with the tasks of therapy and presence with the self and therapist. The specific research question that was addressed in this research was how do clients experience engagement in psychotherapy in a mental health setting? The overall aim

of the study was to illuminate clients' lived experience of engagement in psychotherapy in a mental health setting and elaborate how they make sense of this.

Reflexive Notes

When I began the literature review I realised there was a vast amount of literature related to engagement, comprising intrapersonal and interpersonal dimensions such as personal motivation and the therapeutic alliance. It was a challenge to incorporate such a volume of diverse literature and to attempt to delineate those aspects of it that related directly to the research topic and those that were more indirectly related perhaps mirroring some of the confusion in the literature or the complexity of engagement. An unanticipated burden that I experienced in conducting an IPA study was selecting relevant literature that would provide an adequate background to and clear rationale for the study. Making such choices is inherent in IPA and ensuring they are well informed is an essential responsibility carried by the researcher.

Chapter 3. Methodology and Methods: Executing IPA

3.1 Introduction

This chapter provides a review of the aims and goals of this research study and elaborates the rationale for choosing IPA as the methodology most fitting with achieving these. It explicates the key philosophical assumptions underpinning the methodology and how this influenced my position as researcher. It describes how the methodology was translated into the specific methods used in this study. The chapter also describes in detail the procedures that were used to access, gather and analyse the data and outlines the ethical considerations that emerged as pertinent to this study and how these were addressed.

3.2 Aim and Objectives

This study sought to address the research question: how do clients experience engagement in psychotherapy in a mental health setting? The overall aim of the study was to illuminate clients lived experience of engagement in psychotherapy and elaborate how they make sense of this phenomenon.

The discrete objectives of the study were to illuminate:

- Participants lived experience of their engagement in psychotherapy
- How participants understand their engagement in psychotherapy
- Participants' perspectives on what influences the level and nature of their engagement in psychotherapy
- If and how participants' experiences in psychotherapy might resemble or differ from their engagement in the mental health system more generally.

3.3 Choosing a Methodology

There is much debate in the research literature as to how different approaches to research can be described and/or differentiated (Crotty 1996; Willig 2001). Research is variously described in terms of its aims and philosophical underpinnings leading to distinctions such as qualitative or quantitative, or along a continuum from realism to relativism, leading to methodological and philosophical confusion (Ponterotto 2005; Crotty 1996). Crotty (1996) suggests that this confusion stems from obfuscation of the related topics of ontologies, epistemologies, theoretical perspectives, methodologies and methods. He suggests a framework whereby the researcher elaborates the method and methodologies and justifies these elements by explicating the underlying theoretical perspectives and epistemology. It can be argued that the traditional divide of qualitative and quantitative research eludes more to differences at the level of method and methodologies, and does not necessarily distinguish the underlying theoretical perspective or epistemology (Robson 2002; Willig 2001; Crotty 1996). Crotty (1996, p.10) further argues that ontology is closely related to epistemology, thus "each theoretical perspective embodies a certain way of understanding what is (ontology) as well as a certain way of understanding what it means to know (epistemology)." From this perspective it is important to elaborate theoretical perspectives, methodological approach and methods that inform and are best suited to IPA.

As described in the last chapter, the bulk of the literature relating to engagement in psychotherapy relies upon seeking the "expert" views of therapists. This is based on psychotherapy sessions that are typically observed for evidence of behaviour hypothesised to be manifestations of engagement, or from the use of client or therapist measurement scales constructed to assess a number of proxy variables the presence of which is hypothesised to signify engagement; for example, the Working Alliance Inventory (Horvath and Greenberg 1986) and the Psychological Mindedness Assessment Procedure (McCallum and Piper 1990). Although these sources provide a

knowledge base about engagement from those perspectives, there is a gap in what is known about how clients subjectively experience and make sense of engagement. This study was primarily interested in generating in-depth client accounts about the phenomenon of engagement as it was experienced in psychotherapy in a mental health setting. Therefore, it required an approach that privileged detailed and uniquely individual emic accounts. This required a shift in focus to the client in psychotherapy as a valid source of information. This was achieved by acknowledging clients' expertise and relevance to the study by virtue of them having experienced the phenomenon of interest. Each participant brought their own unique perspective of this phenomenon and their individual accounts were the key source of data for initial analysis in the study, which then progressed to an across account level of analysis to enrich and elaborate individual accounts.

The study also required an approach that considered experience and meaning making as valid and useful data for exploration. There were two aspects in my phenomenological endeavour; one involved participants generating rich accounts of their experience of the phenomenon of engagement in psychotherapy and the second entailed my in-depth detailed analysis of these accounts, also referred to as the double hermeneutic. This required a complex iterative process whereby the participants and the researcher were actively involved at different levels and to differing extents in the production and interpretation of the data. Such explicit involvement of the researcher in the process was one of the attractive features of IPA for me.

This study was particularly interested in the phenomenon of engagement in psychotherapy as it occurs in the context of a mental health setting, thus it required an approach that is sensitive to context. Context not only includes the location of the research but also the timing of the research, the population involved and the wider cultural views that surround the topic. Participants were involved in mental health services and had received one or more psychiatric diagnoses. Hence, the study needed to consider what, if any, impact this has on their experience of engaging in

psychotherapy. Holding an assumption that context influences experience and understanding also alerted me to attend to the ways that the participants and I were influenced by and influenced the research process. For example, it was important to reflect upon the possible implications of conducting the research in the mental health service where I worked and where the participants attended and met with a range of professionals such as psychiatrists, psychotherapists, nurses and other members of their multidisciplinary mental health teams.

Such key issues influenced my choice of methodology. The focus on individual accounts suggests a qualitative rather than quantitative methodology (Robson 2002; Willig 2001). Within the broad spectrum of qualitative methodologies, phenomenology stands out as an inquiry approach that is fitting with the aims and objectives of this research, as phenomenological inquiry is particularly concerned with lived experiences and meaning making, which are viewed as inextricably connected with existence and one's being in the world (Van Manen 2011; Willig 2001). Although phenomenology represents a vast area of inquiry in both philosophy and human sciences, this study is located in the latter area and therefore is more concerned with the practical applications rather than philosophical underpinnings of the inquiry (Van Manen 2011).

> Phenomenology is an influential and complex philosophic tradition that has given rise to various related philosophical movements...but phenomenology may also be considered a human science method: a profoundly reflective inquiry into human meaning. (Van Manen 2011 [Online])

Phenomenological inquiry is not a singular method but encompasses several approaches, having in common an assumption that "any attempt to describe an external, 'objective' reality is futile without pertaining to the inner, subjective world of private experience, as the two are intimately related" (Cope 2003, p.4). Berglund (2007) suggests that one way of beginning to draw some distinctions between phenomenological approaches is to consider them along a continuum from descriptive to interpretative.

Three key phenomenological approaches were considered including Giorgi's (2009) Descriptive Phenomenological Method, Van Manen's (1990) Hermeneutic Phenomenological Inquiry and Smith's (1996) IPA. Although each of these approaches has some similarities there are also points of divergence and differing degrees of emphasis. Giorgi's (2009) approach can be viewed as an attempt to describe the structure of experience and it involves privileging description of the phenomenon over the role of the interpretative activity of the researcher (Berglund 2007; Karlsson 1993). Van Manen's (1990) approach can be viewed as primarily concerned with trying to recreate the essence of the experience in a way that resonates with the reader and thus could be viewed as more concerned with subjective experience rather than concern with the phenomenon itself (Berglund 2007; Crotty 1996). IPA was chosen as it combines attention to participants' phenomenological experiences, their interpretative processes in describing these experiences and the researcher's interpretations and agency in the research process (Smith et al. 2009). Thus, IPA can be viewed as a middle ground between what Berglund (2007) refers to as what it is (description) and what is it like (interpretation).

3.4 IPA

IPA is one of many phenomenological approaches to research that privileges subjective experience and meaning (Smith et al. 2009; Smith and Osborn 2008; Smith 2004; Smith 1996). Although there is debate about whether IPA is a method or a methodology (Giorgi and Giorgi 2008), I view it as being both and have used it this way in this study. I have drawn on the philosophical underpinnings to guide my approach to developing and conducting the study and I have used the methods and procedures associated with IPA such as semi-structured interviews and the data analytic method described by Smith et al. (2009) to move through each stage of the study.

IPA was developed by Jonathan Smith (1996), a psychologist and researcher, to help redress what he viewed as the imbalance between qualitative and quantitative

research in psychology at that time. In his view psychology research was inferior to other fields in social sciences as it continued to be heavily dominated by quantitative research, which he argued limited its knowledge base. IPA was proposed as an alternative approach to knowledge in the field of psychology by providing a systematic qualitative approach to researching subjective experience and personal accounts. Since its development it has been used in a number of fields outside psychology including psychotherapy.

IPA is informed by key aspects of phenomenology, hermeneutics and idiography, as elaborated below. Thus, it is centrally concerned with lived experiences, how these are interpreted and immediate claims about the group being studied (Smith et al. 2009). It seeks in-depth examination of a phenomenon via the subjective accounts of individuals who are considered experts in that area, as they are familiar with the phenomenon by virtue of having experienced it (Smith et al. 2009; Smith and Osborn 2008; Willig 2001; Smith 1996). In IPA these accounts are assumed to: 1) be influenced by context, 2) be only ever partial and 3) represent a snapshot at a particular point in time. Thus, according to Taylor and Loewenthal (2001, p.65), "whatever is said is likely to be different at a different time, in a different place with a different person." Hence, there is no expectation that a similar study would reveal the same findings.

The context that influences participants' accounts includes not only the local research environment and the wider socio political background but also the intersubjective relationship between the participants and the researcher. Thus, IPA assumes that both researcher and participant influence the research process (Smith et al. 2009; Eatough and Smith 2008; Smith and Osborn 2008; Smith 2004; Smith 1996). IPA also assumes that the researcher's influence is significant not only in determining the area of interest and the approach taken to it, but also in analysing, interpreting and reporting the data. Therefore, the outcome of any IPA study is viewed as socially and historically situated and in the interest of quality the researcher is expected to take account of and account for his or her interpretative process.

3.4.1 IPA and Phenomenology

IPA draws on the philosophy of phenomenology, which is primarily concerned with people's lived experiences. IPA proposes a connection with Husserlian phenomenology in its primary concern with detailed and systematic examination of human experience and an attitude of openness and curiosity about what is yet to be illuminated. Thus, in order to go beyond what is taken for granted the researcher is required to have an awareness of what she already knows professionally and personally and her presuppositions about the area of interest and the study population. The influences of Heideggerian phenomenology can be seen in IPA's assumption that experiences are understood as occurring as part of one's being in the world. Thus, they are situated in time and context and they always have aspects of relatedness and so cannot be viewed in isolation. Another implication of this assumption is that participants and researchers share an ability to communicate and make sense of each other by virtue of being in the world.

In IPA Merleau-Ponty is credited for the inherent assumption that our ways of communicating with the world and our ways of knowing in the world develop from our own embodied perspective (Smith, Flowers and Larkin 2009). Thus, an event can only ever be experienced from the perspective of the person living the experience and attempts to get close to that experience are dependent on interpretative accounts of it (Rizq and Target, 2008).

Satre's influence is seen in IPA's assumption that participants' accounts are partial and that the world is shaped as much by what is present as by what is absent. This introduces the notion that the researcher's interpretations go beyond the explicit accounts of participants. What is present or absent changes the direction of perception and influences what emerges as foreground or background. Thus, IPA particularly emphasises the role of personal and social relationships in how experiences are conceived (Smith et al. 2009). Hence, the researcher is inextricably implicated in the

production of the account by virtue of her presence and relationship with a participant and close analysis of this encounter is encouraged.

3.4.2 IPA and Hermeneutics

Hermeneutics is concerned with the art and science of interpretation and IPA draws upon this philosophy by assuming that description in the absence of interpretation is not possible. Interpretation is a complex process involving not only the interpretations that the participants attach to their experiences, but also the interpretation of the researcher in trying to access the personal world and lived experiences of the participants (Conrad 1987) and the intersection and interaction of both (Smith and Osbourne 2003). Lyons and Coyle (2007) describe participants as engaging in first order sense making, while the researcher engages in second order sense making. This is referred to as a double hermeneutic (Shaw 2010; Smith et al. 2009).

The centrality of the researcher's involvement in the research is highlighted. The researcher's very act of interpreting the intentions and meanings portrayed by the participants in their respective accounts allows the researcher to go beyond the explicit claims of the participants and to expand the parameters of interpretation to include the researcher's own perspective on the account, thereby adding another dimension to interpretation. Thus, drawing on ideas from Ricoeur, a critical attitude of interpretation can be incorporated into IPA (Smith et al. 2009). This can be seen as an aspect of the double hermeneutic where the researcher focuses both on trying to understand the participants' perspective from the participants' point of view as far as is possible, while acknowledging that the researcher has her own perspective. This involves adopting a curious and critical attitude towards participant accounts by allowing scope for the researcher to question these accounts and claims. For example, by focusing on the person's motives and intentions, or what has been left out of their accounts, or including a sense of something going on that is perhaps outside the awareness of the participant (Lyons and Coyle 2007). Smith et al. (2009) describe Ricoeur's distinction between a hermeneutics of empathy and one of interpretation

and they propose that IPA takes a middle ground. They suggest an attitude of questioning whereby interpretation is "based on a reading from within the terms of the text, which the participant has produced" (Smith et al. 2009, p.37).

IPA also draws on the concept of the hermeneutic circle that considers interpretation as an ongoing iterative process between the general and the detail. Thus, interpretation of parts of the text are only possible with reference to interpretation of the whole text and vice versa so that interpretation involves a back and forth movement between the parts and the whole, while stressing that texts can only be interpreted by reference to their cultural, historical and literary context. In IPA this is explicitly incorporated into the systematic analytic method whereby the researcher begins with a detailed analysis of each individual account before looking across the accounts for patterns, areas of overlap and diversity, only to return again to each individual account and begin the process anew.

IPA credits Heidegger and Gadamer with its belief that the researcher's perspective is mutually and cyclically influenced from the detailed analysis of the text, the patterns and connections emerging from the larger data set and dialogue with extant theory (Smith et al. 2009). From this perspective, the process of interpretation is seen to involve an iterative movement between a new stimulus and the researcher's preconceptions, thus interpretation involves "a dialogue between what we bring to the text and what the text brings to us" (Smith et al. 2009, p.26). They propose that although a researcher can identify some preconceptions in advance, sometimes it is only in the process of engaging with a new object that other preconceptions emerge.

3.4.3 IPA and Idiography

The third theoretical perspective that IPA draws upon is idiography (Smith, Harre and Van Langenhove 1995), which is concerned with unique and particular examples of a case. This can be seen as complementary to a nomothetic approach with its focus on general accounts that facilitate the generation of general laws related to large groups

or a general rather than specific population. Thus, in IPA idiosyncratic and micro perspectives are valued as a means of generating in-depth knowledge, which can have resonances with more macro and general levels but do not seek to confirm or disconfirm these.

> The idiographic study can form part of, and work towards a general law, but the way of doing this will be different from methods beginning with nomothetic assumptions. (Smith, Harre and Van Langenhove 1995, p.59)

This perspective is particularly evident in IPA's commitment to detailed and in-depth analysis and concern with "how particular experiential phenomena have been understood from the perspective of particular people, in a particular context" (Smith et al. 2009, p.29). Although IPA has a focus on the particular and distinct, it also seeks out what is common or shared among the group of participants (Rizq and Target 2008) and thus it can make claims about the group from the particular. Although highlighting the division between the particular and the general, Smith et al. (2009) also indicate that such a division is not as distinct as it may appear. Drawing on the work of Goethe and Warnock, they offer a view that exploring the particular allows for exploration of the general. In this study, the idiographic perspective is concerned with client accounts of their engagement in psychotherapy in a mental health setting, with a curiosity about how this information may resonate more broadly with treatment engagement and beyond.

3.5 Researcher Positioning

How the researcher positions themselves in relation to participants, the topic, the data, the study process and outcome is determined by his or her personal and professional context. Hence, it is important for me to explore how my own presuppositions have influenced my relationship with the study. I have already outlined some of my preconceived ideas about engagement and my interest in the topic in Chapter one; however, other presuppositions emerged as my attention shifted

to new foci throughout the study. Thus, it has been important for me to have an ongoing method of questioning my (un)awareness and managing emerging assumptions and their implications.

Reflexivity refers to how one uses their own emergent knowing to inform how they respond and move forward in a given situation (Steier 1991). Reflexivity in research can be enhanced through the use of peer consultation, supervision and reflexive journaling, all of which I used throughout the study to assist me in identifying presupposition and blind spots. This has allowed me to consider the opportunities and limitations of the presuppositions that came to my awareness throughout the study so that they were neither purged nor privileged and that their practical, methodological and ethical implications could be addressed. I commenced a reflexive journal early in the development of the research proposal and maintained this throughout and I found it useful as an aid in seeking to expand my way of thinking and being in the study process. I have incorporated reflexive notes at the end of the chapters based on my reflexive journal by way of illuminating aspects of my internal account of the study, which sometimes paralleled and sometimes jarred with the external account of how the study was progressing. I also noted, although did not always welcome, the critical perspectives of others throughout the research process in the form of supervision and peer consultation and incorporated many of these reflexive endeavours into the text of the study. Thus, I attempted to position myself as a critical participant-observer of the study phenomenon, the study process and myself throughout.

3.6 Method

This IPA study utilised individual semi-structured interviews with five participants, which is a method recommended by Smith et al. (2009). This method of data collection allowed for in-depth accounts to be generated, consistent with the data required for an IPA study. The data were analysed using the systematic analytic method described by Smith et al. (2009), outlined below. The participants who volunteered for the study

were typical of the population of clients who attended the psychotherapy service where the study took place, in that they had a range of psychiatric diagnoses and presenting problems and had been involved with the service for a number of years.

3.6.1 Recruitment

In IPA purposive sampling is considered an appropriate method, which means identifying and inviting participation of those who can best inform the area of interest because of their expertise by experience. In order to acknowledge and facilitate clients' self-agency, I displayed posters (Appendix 1) and left more detailed participant information leaflets (Appendix 2) in the waiting areas in the premises where potential participants attended for psychotherapy. This approach provided an opportunity for potential participants to make direct contact with me about the research, rather than being selected by a therapist. However, recruitment was slow via that method and in order to expand opportunities for recruitment I later circulated an information letter to psychotherapists informing them about the research (Appendix 3). The letter outlined the purpose of the research, what it involved for participants and asked them to bring the leaflets to the attention of the clients with whom they worked. The letter also asked therapists to be mindful about informed consent and therefore to neither encourage or discourage potential participants to become involved. It was also useful that therapists were informed about the study in the event that issues raised in the study interview were subsequently brought to therapy, as was the case with three participants.

Potential participants were advised that they could ask the mental health clinicians they were involved with to pass on their contact details to me or they could contact me directly themselves. The former strategy was to enhance ease of access by having someone else initiate contact and by eliminating the cost of a phone call. The information about the research was displayed for three months allowing ample time for potential participants to see or hear about it, as the frequency of attending the service was typically between once per week and once a month. In IPA it is

recommended that a small number of interviews are carried out as there is an emphasis on depth rather than quantity of data and five interviews fits with this recommendation (Smith et al. 2009). When all five participants had completed their respective interviews I replaced the recruitment posters with posters thanking participants for their involvement and indicating that recruitment had ceased (Appendix 4). A similar letter was circulated to clinicians (Appendix 5).

All participants contacted me directly and during the initial phone call we discussed the aim and rationale for the study, in addition to what their participation would involve. During the phone call participants indicated that they had read the participant information leaflets. I arranged to meet each participant for an interview one week after the initial contact, to allow sufficient time for them to digest the information and withdraw if they had reconsidered participation. At the start of the interview the participant information leaflet was reviewed again and an opportunity for further questions and queries was given. Participants gave written consent (Appendix 6) to participate in the study, to have their interviews recorded and to be contacted again by the researcher for further clarification or information. Participants were considered able to consent by virtue of being able to explain their understanding of the research and what was required of them.

3.6.2 Inclusion and Exclusion Criteria

In IPA a homogenous sample is sought who have in common their experience of the phenomenon of interest. Thus, the sample was considered homogenous based on their experience of engagement in psychotherapy in a mental health context. Participants were sought who had attended psychotherapy within the three months prior to participation in the study. This was to ensure that their experiences of engagement in psychotherapy were accessible by virtue of being familiar and recent. Participants were also required to have to have attended at least six sessions of psychotherapy to ensure that they had sufficient opportunity to experience the process.

Current and recent clients with whom I had worked in psychotherapy were excluded. This was to reduce the potential for undue influence or coercion that participants may have felt having been in a therapeutic relationship with me with different functions, boundaries and expectations.

3.6.3 Participants

Demographic information was gathered from participants (Appendix 10). I initially considered that a concise way of presenting the demographic data and introducing the participants was to create a table and insert pertinent details. However, having done this I realised that the table read more like a profile of each participant and that the information made them easily recognisable to themselves, to each other or to people who knew them, particularly staff working with them. This challenged my agreements with participants about confidentiality and anonymity as the thesis will be available publicly. I resolved this by generating a descriptive summary of the demographic data and an account of the flavour of my encounter with each of them during the research interviews.

3.6.3.1 Descriptive Summary

Gender: Participants included four men and one woman.

Age: They ranged in age from 35 years to 68 years. Three participants were in their forties.

Marital status: Two participants were married, one was separated and two were single.

Work status: Three were employed, one was retired and one was receiving disability allowance.

Length of time in current therapy: They were all attending psychotherapy at the time of the study and had attended between 10 and 25 sessions with their current therapist.

Number of previous therapies: Participants reported having attended at least three therapists prior to their current therapist.

Types of therapy received: They described receiving a range of therapies (the number in brackets indicates the number of participants concerned): cognitive behaviour therapy (5), psychodynamic or psychoanalytic psychotherapy (4), systemic family therapy (2), group analytical psychotherapy (2), counselling (2), Gestalt therapy (2) and integrative psychotherapy (2).

Length of involvement with mental health services: They had been involved with mental health services for between 5 and 25 years.

Usage of private mental health services: Four had attended a number of public or private mental health services prior to their involvement with the current public service.

Diagnosis: They described a range of diagnoses that they had acquired over the course of their involvement with the mental health services: depression (5), anxiety (5), psychosis (2), personality disorder (2), substance misuse (2), bipolar affective disorder (1) and panic disorder (1).

Suicidality (ideation and suicide attempt): Four participants reported that they had experienced suicidal thoughts on several occasions and two indicated that they had attempted suicide.

3.6.3.2 A Flavour of my Interview Experience

When I met each participant I was relieved that they had no difficulty understanding the notion of engagement in psychotherapy and they all felt able to speak to the area. Jim, Dan and Dave felt well-engaged in their current therapies while Mike was ambivalent and Ann felt disengaged. Although they each impacted me differently, the level of pain and anguish in their lives stayed with me. Jim's evocative and eloquent use of language contributed to both of us being on the verge of tears or laughing outrageously at various points in the interview. Dan's persistence and selfless good nature was evident despite the cruelty of his world at times. Ann's sense of loss and disappointment at not feeling engaged in therapy was tremendous and I found myself wanting to help her sort that out, no doubt a typical researcher-therapist dilemma. Mike's philosophical stance failed to hide his tormented struggles to make sense of deep contradictions in his thinking and experiences that generated a sense of going around in circles. Dave's descriptions of his treatment in hospital where he was denigrated and blamed chilled me to the bone and I felt shocked, enraged and helpless. These traces of the participants and their unique experiences linger and challenge me.

3.6.4 Data Gathering

One-to-one semi-structured interviews were used to gather participant data in the form of in-depth rich subjective accounts of engagement in psychotherapy. Using interviews facilitated the idiographic nature of their accounts to be explored and allowed me to inquire further as interesting or novel data arose in the interviews. Smith (1995, p.10) asserts that semi-structured interviews and qualitative analysis are especially suitable where "one is particularly interested in complexity or process or where an issue is controversial or personal." Although the issue of engagement is not controversial, it is a complex intrapersonal and relational process.

The semi-structured interview format allowed me to be flexible to explore aspects of each account while also ensuring that I stayed on topic and asked about pertinent areas and areas I was interested in. This was important as I noted my therapeutic inclination to follow up on particular areas that seemed particularly relevant and interesting rather than allowing areas to emerge. The interview schedule and making time to prepare for interviews mitigated this. I devised an interview schedule that incorporated nine main guiding questions related to engagement in psychotherapy (Appendix 7), one of which I used as a general opening question. My closing question was an invitation to return to anything that had been discussed that the participant wanted to expand on or to introduce something that had not been talked about that they felt was relevant. The semi-structured interview schedule also included a number of prompts that I used to facilitate participants to expand their accounts in relation to the main questions or if participants were struggling with the initial broad open questions. These prompts were used cautiously so as not to foreclose articulation and explorations of participants' experiences by introducing specific language or ideas, particularly early in the interview. A formal piloting of an interview was not conducted as the schedule was viewed as a guide and in IPA at times it is "preferable to abandon the structure and to follow the concerns of the participant" (Smith et al. 2009, p.64). Thus, the claims and concerns of the participants and the active co-participation and in-depth probing of the researcher are privileged over the interview schedule (Flowers and Larkin 2009). The interviews lasted on average one and a half hours. Participants were given a choice of location for the interviews. Four interviews were conducted in the psychotherapy service and one in a comfortable and safe location convenient to the participant's workplace.

3.6.5 Data Management

Storage, access, retrieval and erasure of data are important in safeguarding anonymity and confidentiality and respecting the uniqueness and personal nature of participants' accounts. The one-to-one interviews were recorded on a digital device and then saved

onto a computer that was password protected and an encrypted USB device was used for back-up. The interviews were erased from the recording device once stored on computer. Each interview was transcribed verbatim and identifying details were removed such as locations and participant and therapist names. Transcripts, which were identifiable by number only, and consent forms were stored in a locked filing cabinet. A log of names and identification numbers was stored separately from the transcriptions on the password protected computer. Transcripts will be kept for four years after submission of the thesis to DCU and ethical approval was granted for this.

3.6.6 Data Analysis

In qualitative research there is recursivity and fluidity between data gathering and data analysis as emergent themes inform the enquiry process. However, in order to ensure a systematic approach, a phased analytic process can be incorporated into IPA (Smith, Jarman and Osborn 2003). The focus of the analysis was an in-depth intensive engagement with each account, which was analysed in detail before subsequent accounts were each analysed in turn. Hence, themes from each account were identified before patterns across accounts were sought, which privileges the unique in addition to the more connected concerns of participants (Smith and Osborn 2008; Smith, Harre and Van Langenhove 1995).

Data analysis included the following steps:

Stage one: The initial encounter with the text

I transcribed the interviews and reread them several times to become familiar with the data. Initially, I made notes in the right column of the transcript that reflected and documented my initial thoughts, observations and reactions to each account. I noted aspects of the accounts that struck me as unusual; for example, particular phrases or images.

Stage two: Identification of themes

I read the text in a more systematic way to identify and label themes associated with sections of the text. These themes were recorded in the left column of the transcript. Willig (2008, p.58) states that "theme titles are conceptual and should capture something about the essential quality of what is represented in the text." Emerging themes were highlighted using phrases that tried to capture the intrinsic and key qualities of the participants' responses and any theoretical connections between themes (Dallos and Vetere 2005; Willig 2008). This analytic process was used to enhance my continued connectedness to participant experiences, as each level of analysis was grounded in the text (Dahl and Boss 2005). Appendix 8 contains extracts from three interviews with stages 1-2 of the analysis completed.

Stage 3: Clustering of themes

Emergent themes from stage two were listed and connections and hierarchical relationship between them were made. Connecting themes were clustered using labels that identified their essence. Subordinate themes were developed for each account that pulled a number of clusters together. This process was iterative and involved a back and forth movement between the text and my interpretations, being sensitive to drawing distinctions between the participant's perspective and my own interpretations.

Stage four: Production of summary table

To obtain a clear and systematic overview the clusters and associated subordinate themes were formulated into a table, which also connected them with relevant participant quotes or keywords and the location in the text. Some themes were excluded at this point as I thought they were not well represented in the text or were marginal to the phenomenon (Willig 2008). As decisions about what to include and

exclude are inevitably influenced by the researcher's own world views and interests, Willig (2008, p.59) suggests that the summary table should "reflect the meanings that structure the participant's account rather than the researcher's expectations of what constitutes an acceptable number of clusters and themes." An enormous volume of data was generated and inevitably, as Taylor and Loewenthal (2001, p.71) highlight in relation to a discourse analysis study they conducted, "choices had to be made about which fragment of transcript, from whom, which theme, which argument."

Stage five: Integration of cases

Each transcript was managed in the same way and only when one was completely analysed was the next text examined. After each individual text was analysed I looked for convergences and divergences across all texts and a final table of one superordinate theme, three subordinate themes and clusters was constructed (Appendix 9). Themes and clusters were prioritised based not only on their prevalence within the data but also on the richness of the data and themes and their relationship with other aspects of participants' accounts.

In summary, there were three levels of data analysis for each text. At a practical level data was recorded, transcribed, reread repeatedly and initial coding, phrases and themes were identified. At an analytical level the codes, phrases and themes were clustered into connecting themes and a superordinate theme was identified. At a reflexive level my interpretations and responses to the text were recorded.

3.6.7 Reporting the Data

Reporting the findings of an IPA study is predicated on the assumption that this process represents both the participants' accounts and the researcher's interpretation of these accounts. Hence, direct quotes from the raw data, including page and line numbers from the respective transcripts, were used to illuminate rather than confirm a particular theme. Chapter four outlines the findings of the study based on the data

analysis as described above. The findings are presented initially looking at three subordinate themes that emerged across participants' accounts and one superordinate theme, which I viewed as an overarching "organising device" (Smith et al. 2009) that both reflected the dynamic interconnectedness of the three subordinate themes and also the synergy of the themes. Thus, the superordinate theme is similar to the whole being greater than the sum of its parts.

However, despite the systematic approach, managing the sheer volume of data was a challenge, as was balancing the idiographic nature of participants' accounts with my interpretative activity. I tried to address this in how the findings were presented. The general themes were introduced first before moving to presenting the various particular dimensions of the theme, with relevant participant quotations used that illuminate the prominence or distinctiveness of the theme, and then shifting back again to more elaborated and abstract interpretations. Although each theme was present in each participant's account, participant accounts differed in the dimension or prominence of the theme that was illuminated. Thus, moving between the particular and the patterns across accounts allowed for a complex and rich unfolding of the theme.

3.7 Ethical Considerations

Ethical permission was sought and gained from the organisation from which participants were recruited. The ethics application form is not included as an appendix as it would identify the organisation and potentially compromise the confidentiality and anonymity agreed with participants. Research is underpinned by a number of ethical principles that guide the researcher in planning and conducting the study with the utmost regard for the safety of all concerned. These principles include beneficence, non-maleficence, justice, autonomy and integrity. Attending to how they might be compromised at each stage of the study allows the researcher to attend to practices and build in management strategies for participant, researcher and

contextual safety. Ramcahran and Cutcliffe (2001) argue that qualitative research has an emergent design and therefore not all ethical issues can be known in advance of conducting a study. They suggest that although the broad approach can be outlined prior to the study, the detail of how the study is conducted only occurs in the doing of the research. They propose an "ethics as process" model highlighting the dynamic and fluid nature of qualitative research and ethicality as an ever evolving rather than static process. Every action or decision can be seen as having an ethical dimension that the researcher needs to consider. This model has been particularly useful as new issues came to my attention at different stages in the study and new perspectives and learning have been incorporated into the ethical realm. Key ethical considerations and how these were addressed are outlined below.

3.7.1 Anonymity, Confidentiality and Vulnerable Populations

Anonymity and confidentiality of participants cannot be totally guaranteed by the researcher particularly in small scale research within one organisation where recruitment was facilitated by colleagues. However, certain measures were taken in this study to safeguard this as far as possible and the limitations to confidentiality were explicitly outlined for participants. Participants obviously could choose who they told about their participation in the study and it was interesting that a number of them assumed that I would be routinely informing their therapist about their participation. However, I clarified that this was not the case, apart from the explicit limits to confidentiality, even if the therapist had suggested the research to them in the first instance. Anonymity and confidentiality were also safeguarded by: separating transcripts from participant demographic information; attending to how participant demographics were presented; removing identifying details from transcripts; using quotes carefully; safely and securely storing and limiting access to data; and undertaking to destroy all data following successful completion of the doctorate programme.

As potential participants were involved in mental health services they could be viewed as a vulnerable population (Moore and Miller 1999). As a consequence of their mental health issues some may have had prior experiences of breaches of confidentiality and reduced autonomy due to the conflict between client wishes and clinicians' "duty of care" to protect the client. This is one of the reasons that I considered it important to have the option of recruiting directly and not through referral, which is the usual gate-keeping system. Indeed, previous such experiences of compromised autonomy and breaches of confidence in the mental health system may have deterred some people from even considering participation in the research.

3.7.2 Informed Consent

Informed consent in this study involved making sufficient and accessible information available to participants about the purpose of study, potential benefits and risks, what participation would involve and how the outcomes would be used and allowing sufficient time for participants to consider the information and come to an independent decision about participation. When developing the posters, leaflets and information sheets I was aware that some potential participants may not be able to read for a variety of reasons; for example, eyesight problems, literacy issues or English may not be their first language. The option that therapists could tell potential participants about the study helped in some way towards addressing these issues. However, this awareness also prompted me to be sensitive in my initial phone contact and not to assume that written information would be a sufficient means of imparting information. One participant declared difficulty reading the participant information sheet due to poor eyesight and we collaboratively generated a solution that involved him asking his wife to read it to him.

I was also conscious that it can be difficult to take in and absorb new information and that this may be more difficult for people taking medication or whose concentration is limited due to distress arising from their life situation or mental health issues. This prompted me to ensure that potential participants had sufficient time, at least one

week, between receiving the information sheet and meeting me to discuss their participation. I invited them to take time to review the material and discuss issues or questions they might have with other people or to formulate questions or clarifications they might have when they met me.

In terms of autonomy and self-determination, it was important that participants were not coerced into participating in the research. Therefore, self-selection rather than other selection was preferable and clients with whom I worked were excluded. This also reduced clinician risk of subtle coercion or social desirability from therapists to assist a colleague. Thus, it was interesting to note that all the participants made the initial contact with me themselves and it was important for me to clarify early in the process that their participation was voluntary and that I would not be talking to their therapists about their participation.

3.7.3 Insider Researcher

Being an internal researcher can provide both opportunities and challenges for the researcher; for example, it can shape and limit what participants disclose in interview and how this is interpreted. Although there is always a risk that participants will provide the kind of information that they think the researcher is looking for and/or edit information that they consider irrelevant or are uncomfortable discussing, I think this can be a greater issue for the internal researcher. Participants may have unspoken concerns about negative implications of their disclosures or may have unrealistic expectations that this will serve to positively influence their involvement with the organisation depending on their interpretation of my motives in conducting the study. In this study I was talking to participants directly about their involvement with my therapist colleagues and their engagement with services where I worked. This was a complex area, which undoubtedly influenced both what was said and not said; therefore, I attempted to probe areas of interest gently. Another related issue I had to be alert to was the previous experiences participants had of psychotherapists, mental health clinicians or mental health services and how these might emerge in the

interviews. Therefore, I adopted a curious and questioning attitude with participants, which I considered was more useful in accessing these potential sources of rich data than adopting either an empathic or suspicious one.

I was motivated to conduct this research as I had an agenda for what it might achieve within my work context and this inevitably informed my interview schedule, shaped what I asked and did not ask in interviews and influenced data analysis. For example, I was hopeful that the study would influence referral practices so that more people might engage in psychotherapy and the mental health services generally. I also hoped that clinicians might consider their taken for granted practices that I think influence referral and engagement negatively such as prescribing therapy or a specific type of therapy or trying other interventions first. Thus, I realised that critical supervision of completed interviews and data analysis was important and I had rigorous structures in place for this. These included peer group review, academic research supervision and reflexive journaling.

Finally, the most challenging aspect of being an "insider researcher" to date has been to notice how my socialisation into the context of mental health services has influenced how I embarked upon this research. Initially I planned to recruit through psychotherapists and other clinicians. However, I realised that this mirrored the existing referral system, which is underpinned by a belief that clinicians are better able than clients to decide what activities they are best suited to undertake. At another point in the process of my research I asked some of my psychotherapy colleagues to brainstorm with me the kinds of questions I could ask participants that would indicate my area of interest. When I reflected on this I realised that I was undermining participants' abilities and expertise in the area by presuming that participants would not be able to answer the questions or choose not to answer what I was expecting my colleagues to answer. I was challenged by the irony of this when my research claims to seek out and value participants' perspectives.

3.8 Appraising IPA and IPA Studies

3.8.1 Critiques of IPA

IPA has been critiqued for not attending sufficiently to the influences of the researcher's responses on the direction of participants' subsequent comments (Woofitt and Widdicombe 2006). However, their critique comes from a discourse analysis perspective, which privileges deconstructing the influences of social context, language and culture on areas of interest, whereas this is not the aim of IPA. IPA privileges experiences and interpretations thus, similar to Spinelli's (2007) account of existential psychotherapy, it is concerned with accessing the lived experience of participants as it presents itself in the immediacy of the encounter with the other.

IPA has also been critiqued on a number of fronts by Giorgi (2010). He argues that IPA is not grounded in the philosophy of phenomenology. However, Smith (2010) argues that IPA clearly draws on the philosophical influences and interconnectedness of phenomenology, hermeneutics and idiography. As suggested earlier, there is a difference in emphasis between phenomenology's philosophical and scientific approaches to inquiry (Van Manen 2011) and perhaps this debate reflects some of these differences.

Giorgi (2010) also critiques IPA for being unscientific as he claims as it is not prescriptive in its methods as is demanded by scientific criteria and therefore in the absence of the researcher detailing how the methods were employed other researchers would be unable to check the results or replicate the study. Smith (2010) contends that IPA is not prescriptive in the sense that although there are guidelines to be followed these will vary depending on the research area and the researcher's skills. He advocates that researchers need a threshold of proficiency in the skills required to do the work and that this will influence the quality of the work rather than following a prescribed set of procedures.

Smith (2010) further argues that most qualitative researchers would not view replication as a criterion best suited to evaluating their research. Given the methods employed such as interviewing, it would not be realistic for one interviewer to come up with the same interview schedule or approach as another interviewer and the same also applies to the analytic process. Smith et al. (2009) contend that in good IPA studies both the quality and validity of the work should be accounted for.

3.8.2 Validity in IPA Studies

The validity or trustworthiness of the study is appropriately demonstrated through independent audit (Smith 2010; Smith et al. 2009). This can be demonstrated by a transparent audit trail that provides a coherent and credible account of the development of the study from inception through to the final research report and that demonstrates the rigour of this process. In relation to checking the findings, Smith (2010) contends that this is necessary in IPA and can be achieved in a number of ways; for instance through supervision, description of the method and the reader checking for a coherent, sustained and evidenced analytic report. The latter typically demands that "each theme presented has been supported with sufficient extracts from participants to illustrate both convergence and divergence in how the theme is manifest" (Smith 2010, p.190). Typical processes and components involved in an audit trial include the researcher's notes about the research question, the research proposal, transcripts of the interviews that include notes of analysis, draft reports and reflexive journal. The validity of this study based on these guidelines will be discussed in Chapter six.

3.8.3 Quality in IPA Studies

Eisner (2003) argues that all forms of enquiry, like all forms of representation, have their own advantages, limitations and biases, thus the key strengths and limitations of IPA do not detract from the outcome. However, there is a need to evaluate the study using an appropriate framework and it has been suggested that the variety of

qualitative research methodologies require different methods of appraisal (Spencer and Ritchie 2012; Yardley 2000; Seale 1999). Although there is no consensus for judging the quality of qualitative research or IPA, Yardley (2000) has proposed a framework for appraising qualitative research that has been deemed appropriate to the evaluation of IPA (Smith 2010; Smith et al. 2009). The framework comprises four broad principles: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance.

Mindful of the range of qualitative methodologies available and the impossibility and indeed undesirability of having a one size fits all approach to quality, Yardley (2000) proposes that each of these four essential characteristics can take many different forms. Sensitivity to context, for example, requires the researcher not only to pay attention to existing research and literature but also to how he or she interprets that information so complex and diverse perspectives can be used by the researcher to further his or her own analysis. Given that different methodologies have different aims and objectives Yardley (2000) maintains that it is essential that the researcher knows the philosophical underpinnings of the approach. Awareness of the socio cultural setting of the study is also considered important "since language, social interaction and culture are understood by most qualitative researchers to be central to the meaning and function of all phenomena" (Yardley 2000, p.220).

Commitment can be demonstrated by in-depth immersion with the topic and previous knowledge about the topic and a constant commitment to developing skills and competencies in the methods related to the chosen methodology. Rigour can be demonstrated by the researcher producing a complete account of the data analysed and in phenomenological methodologies this requires not only in-depth focus on individual accounts but a final account that highlights similarities and divergences. Coherency can be demonstrated by the researcher's presentation of the research material in a way that is persuasive to the reader, while transparency can be demonstrated by explicating and disclosing all aspects of the research process,

particularly the details of researcher's reflexive processes. Impact and importance can be demonstrated by the utility of the research in relation to its aims and objectives; for example, in this study it would include how the outcome is seen as relevant and useful by clinicians, psychotherapists and service users in mental health settings. These quality issues will be discussed further in Chapter six, specifically in relation to how they applied to this study.

3.9 Summary

This IPA study is situated within an overall phenomenological approach as it is primarily concerned with the lived experiences of participants and "how individuals make sense of the world in terms of the meanings and classifications they employ" (Reeves et al. 2008, p.949). IPA has been described as one of many broadly phenomenological approaches that privileges experience. This approach also assumes that the awareness, analysis and interpretations of the researcher are integral to the interpretative process. This influences how the researcher positions him or herself in relation to the study organisation, process and outcome and how ethical and methodological dilemmas are resolved. This required me to engage critically and reflexively with each aspect of the study and with my own evolving thinking throughout.

IPA, developed by Smith (1996), draws on phenomenology, hermeneutics and idiography. From a phenomenological perspective, the Husserlian concern with detailed and careful examination of human experience is evident (Lyons and Coyle 2007). Several aspects of hermeneutics; for example, from Heidegger, Satre, Gadamer and Ricoeur (Smith et al. 2009; Lyons and Coyle 2007) are also central to how the IPA researcher positions him or herself. Thus, it assumes that knowledge is not possible without interpretation and highlights how interpretation involves both the participant and the researcher and the interplay between description and understanding. It also espouses an idiographic approach that privileges the local over the general account.

IPA is characterised by in-depth analysis of the data. Hence, methods such as one-to-one interviews are used that are fitting with an emphasis on the centrality of dialogue in illuminating the lived experiences of interviewees. Purposive sampling is also used, fitting with the need to recruit participants who are experts on the phenomenon being studied by virtue of their insider knowledge.

Five participants who had experienced psychotherapy and were involved with the mental health services were recruited for this study. Ethical considerations concerned the nature of the research population, who might be considered vulnerable, in addition to attending to practices required to ensure that they were not disadvantaged or exploited in any way. The following chapter provides a detailed outline of key themes emerging from analysis of their accounts of engagement in psychotherapy.

Reflexive Notes

There were a number of anticipated and emergent philosophical, methodological and ethical issues that required consideration. I was both excited by and concerned about the iterative nature of IPA whereby one anticipates potential issues and challenges and at the same time holds open the possibility for the unanticipated and the novel to emerge. Hence moving forward is both an adventure into the unfamiliar whilst also having a tentative map for researcher positioning and a systematic method for conducting the study.

Chapter 4. Findings: Engagement as a Risky Venture

4.1 Introduction

This chapter describes the key findings from this study, which explored engagement in psychotherapy in a mental health setting. It provides a rich and detailed description of the three main interconnected themes and the overarching organising superordinate theme that constitutes the notion of engagement in psychotherapy as "a risky venture". Although the themes are related and mutually influencing they have been punctuated by me in this way to underscore their distinctive aspects.

The first theme entitled "inner pain and desperation for change" related to participants' intolerable and persistent inner turmoil and despair, which challenged the survival of their psyche and physical self, and this risk of annihilation forced them to seek change. The second theme "a leap of faith" illuminates participants' struggle with what they knew and did not know about psychotherapy and how they managed the associated risks as they took a leap of faith into the unknown. The third theme "revealing and concealing" elaborates participants' dilemmas about the risks involved in what and how to reveal or conceal about themselves and their lives, as they judged at a moment in time how willing or able they or the therapist were to confront difficult and unsavoury aspects of themselves or their lives.

Thus, engagement in psychotherapy was "a risky venture". Participants entered psychotherapy with a belief and hope that it would bring relief and long-lasting change. However, they were simultaneously terrified, as they faced the possibility of failure, which could quench their desire to carry on with life or overwhelm their psyche. Hence, their decisions and actions were weighed up carefully to mitigate the risks of such failure and to manage their fears about such an outcome. They had to face the irony that doing nothing or engaging in psychotherapy both carried risks of exposure and annihilation.

Table 1: Master Table of Themes

Superordinate Theme	Subordinate Themes	Clusters
A risky venture	Inner pain and desperation for change	The black pit
		Getting off the merry-go-round
		A matter of life and death
	A leap of faith	The known and unknown
		The trusted stranger
		The dreaded stumble
	Concealing and revealing	Hiding from self and other
		Skirting around the edges

4.2 Inner Pain and Desperation for Change

This theme attempts to capture the immense inner pain and turmoil experienced by participants, which both brought them to the edge of survival and forced them to seek relief from their despair. Hence, it served as both an impetus for change and a source of inner torture. This theme is explicated around three clusters; “the black pit’’, “getting off the merry-go-round” and “a matter of life or death”.

4.2.1 The Black Pit

Having lost or buried essential aspects of themselves that they found unacceptable and finding themselves unable to enjoy critical life experiences that left their world dull and devoid of meaning or pleasure, participants experienced inner pain that was all-consuming, intolerable and persistent. Continuing life in this vein was not an option as they questioned if life was worth living. Confronting their own survival they realised that their situation must alter, and a growing sense of desperation drove them to seek relief and change, which brought them into contact with mental health services and psychotherapy.

Life was an endurance test for Dan and he went through the motions of living while feeling empty and lifeless inside, thereby failing to experience a sense of being alive and having pleasure. Life was a matter of mere survival and nothing more. There was no balance between pain and pleasure and nothing to help cushion him in the bad times.

> I couldn't laugh and like you know if something funny came up, or something like that, I couldn't laugh. I was dead. I was absolutely dead inside. Down a black pit but worse than that. (Dan p.15, l.19)

Jim experienced pain and turmoil that left him feeling isolated and alone. Confused and helpless he felt exposed and totally dependent on others for survival, safety and protection. At his worst, he had no idea how to improve his situation and felt compelled to look outside himself for help to survive the intensity of his experiences, while simultaneously resenting his dependence on others and feeling like a burden.

> You reach a really bad stage and you're curled up in a ball and you're crying your eyes out and you don't know where to go or where to turn. (Jim p.27, l.10)

Dave's family were important to him and he wanted to have a good life with his wife and children but this did not seem possible to him. Life was hopeless and nothing, regardless of its importance, could compete with his desire to terminate his inner distress. This was so intolerable that it had to end, even if that meant that death was the only way to achieve relief.

> I didn't want to live. I wanted to live for my children and wife but I didn't want the pain I was going through. (Dave p.22, l.668)

Ann had attended an addiction counsellor and their strong relationship helped Ann to disclose when she was finding it difficult to carrying on living. This helped her accept the help that was on offer and trust the counsellor's advice, however unwanted it was at the time.

> The addiction counsellor knew everything about me and when I would be very unwell she would be the one going, 'I have to tell the doctor about you.' Once I was admitted and it was the best thing she ever done. (Ann p.21, l.29)

Mike's misery had been life-long and had brought him to consider suicide. He wanted his circumstances to change and to be able to live life differently. He had tried and failed to shed the sense of responsibility he carried for causing his own misery. However, he saw therapy as a way of achieving this and accepted that he just wanted an ordinary life.

> I suppose for me counselling was about trying to look at the mistakes I have been making all along to make myself so miserable, that is it, and how I can just change and become like some other guy who is not necessarily super happy but not miserable. (Mike p.11, l.28)

For participants, acknowledging the intensity of inner turmoil and the fact that they felt that this could not continue seemed to be an important impetus in their decision to engage with mental health services and to seek psychotherapy.

4.2.2 Getting Off the Merry-go-round

Although extremely uncomfortable and frightening, the persistent and intolerable nature of participants' inner distress became an important aspect of their survival. They wondered if any semblance of change would be better than no change and relief came in many guises. At times participants took actions that might make a difference as this combated their sense of futility and fostered a sense of agency and worth. At other times, overwhelmed by their suffering, they did nothing, which exacerbated their situations and deepened their sense of hopelessness.

Jim reminded himself that he was doing therapy for himself and this was his decision. His future life was in the balance so he pushed through his fears and concerns.

> It's a battle at the start cause your compulsion is to run away and you have to grab yourself and say this is your own personal happiness that's at stake here and you frogmarch yourself into the situation. (Jim p.21, l.10)

Dave reminded himself that he had gone through life thinking everything was going well until his world suddenly appeared to disintegrate some years earlier. He could not afford to continue being blind to how he was living his life. He wanted to change his circumstances and have life-long benefits. He had tried different medications and experienced some short-term relief from his symptoms, only to find the positive effects wore off with near lethal consequences, and he realised that he needed a different option - one that involved talking about himself and his life to a therapist.

> I knew that talking was really the only option, the long-term option for me because I wasn't thinking short-term. I was thinking what is going to be the best for me in the long-term,

> someone with an illness who is trying to recover (Dave p12. L.360)

Self-agency was important for Jim because his despair constantly forced him to seek help from others and reinforced his disdainful view of himself as lacking in self-reliance, autonomy and independence. Ironically he persevered in several therapies, even in the absence of progress, as this challenged his negative and undermining view of himself.

> I'm jumping from one to the other. I'm not getting anywhere. And looking back now they are what I needed to keep me sane and feeling at the very least I am doing something to help myself. (Jim p.25, l.8)

His ability to differentiate between what and who was helpful and harmful, and his capacity to trust his judgement, encouraged him as he tried out different avenues that inevitably entailed facing uncertainties.

> There are certain things that I don't know if everyone has them but I've definitely had them in the past where as messed up as I've been and as confused and in pain as I've been there's been something that's gone "ah that's not right" so you're still aware on some primal level of someone who is there to help you and someone who isn't. (Jim p.35, l.10).

For Ann, bringing about change was also about gaining self-agency. Having come from an abusive and controlling intimate relationship, she needed to regain a sense of being able to influence her own destiny. Seeing herself taking charge and making decisions combated her previous relational experiences in a positive way and she began to challenge her negative view of herself.

> It is kind of like you are taking control of your own life. You are playing a part in your own life. (Ann p.22, l.18)

Mike turned to pornography for temporary relief and initially savoured the release, soothing and gratification that this provided. However, feeling guilty about this behaviour, he began to torment himself about whether or not he could live with pornography as it clashed with his world view of how he should be and what he believed would be helpful to him. He found himself in conflict with himself and was haunted by self questioning about how he might be exacerbating his turmoil in the long-term, thus adding to his current torment, when what he most wanted was for this negative cycle to end.

> So a while back I would have said I have to stop looking because of the balance sheet. What you get versus what you feel about yourself afterwards. And then thinking that this is not just something that you can walk in and look and walk back out. It filters its way into your thinking and to think in those terms is just wrong because you want to get back to the guy you want to be. (Mike p.27, l.27)

Mike tended to have a pessimistic outlook on life and perhaps unsurprisingly desperation forced him to do things that inspired a sense of hope. It was important for him to continue to try new things that could help improve his experience of life as he realised that he had to change himself.

> Oh yes, guinea pig. I have to find hope that is it. I mean you learn over time that I guess you have to change yourself. A lot of things really are just icing on the cake and you are the cake and you are only changing little things about yourself, it just keeps you going I guess. (Mike p.10, l.1)

Dan's intense need for his situation to improve opened him to hear other people's ideas about what might be helpful. He was prepared to try anything to break the cycle of despair.

> If you asked me to fly to the moon and I could do it doctor, I'd do it to get off this merry-go-round. (Dan p.23, l2)

Although on one level he was prepared to experiment with anything that might help, he was also discerning regarding his options. Like the other participants, he was cautious not to do anything that he thought was likely to compromise his situation and bring about adverse consequences. Hence, he questioned the usefulness of temporary relief measures as he was pursuing more permanent positive changes.

> Look if I go around and I get a bottle of whiskey and have a glass of whiskey and I feel ok for three or four hours, then I will have another glass of whiskey and I will be an alcoholic in no time because I will be looking at the whiskey as a cure. That is not going to cure me. That is going to kill me. (Dan p.24, l.18)

Thus, participants developed or rekindled their capacity to differentiate between activities and people who might help or hinder them in their search for change and to trust their judgement and act on this inner knowing.

4.2.3 A Matter of Life or Death

Participants strove for positive change and permanent relief and were acutely aware of avenues that might make their situation worse. Their inner pain and turmoil was already unbearable and anything that might add to this would be devastating and would threaten their actual survival. Change therefore became a matter of urgency involving life and death concerns.

Dave, having recently come up against a significant adverse life situation that threw his world into chaos, was clear that there was no room for anything less than permanent change in the direction of life and living. Having attempted to take his own life on several occasions, he was no longer prepared to accept things as they were. He realised that he had been preoccupied with success and achievement and maintained a future orientation, therefore life had been passing him by and he had been missing out on important events in the here and now. He wanted to be present and participate in life and saw psychotherapy as a last resort in moving toward this goal and away from his overwhelming distress and preoccupation with death.

> In order to move that step forward to getting better the therapies had to be the way forward and talking with someone and trying to make sense of what happened...it was a last resort...in order to have a happier life and a much more fulfilling life for me, the conclusion was that therapy was the only option. (Dave p.9, l.6)

Death was an option that participants had considered as it brought with it possibilities for permanent change in their circumstances and a hope of finding enduring peace.

Ann continued to carry the scars of her abusive relationship and had been let down several times by therapists who were not in a position to see her consistently for various reasons. Thus, she not only struggled to accept her own worth and wondered if life was worth living, she also questioned if the effort required to engage in psychotherapy was too burdensome for her given her previous disappointments in therapy and in life.

> If I thought when going to bed tonight that I wouldn't wake up in the morning, I would go to sleep very peaceful because I'd say "let everyone else sort stuff out" and I'm just tired of it. (Ann p.27, l.8)

Jim struggled since an early age to build a strong and secure sense of himself, one that he had not got growing up but one that could help him navigate life circumstances without being overwhelmed and finding himself unable to cope. Although not feeling he was to blame for his predicament he felt responsible for changing it.

> ...there are people out there who didn't really get what they needed to give them a solid foundation in themselves and they will spend the rest of their lives trying to look for that or rebuild it. That's no tragedy really if you look at it like it's my job to give myself a lot of the things that I didn't get when I was younger and it's worth it. (Jim p.9, l.8)

He took on the serious venture of changing his life. He tackled it systematically and with commitment as he knew his survival was at stake.

> I go at it too hard like it's a business plan for a business that my life depends on or something. (Jim p.10, l.3)

He desperately wanted to avoid the overwhelming feelings of devastation and terror that pulled him into a position where he felt helpless and hopeless. However, he was aware that he was so driven to change himself that whatever he tried could become a problem because he pushed himself to extremes and was in danger of overwhelming his psyche and ending up back where he had started from.

> That it's possible to learn these things but not have to kill yourself learning them. (Jim p.10, l.7)

Dan experienced depression as a devastating disease that controlled and attacked his mind and had the capacity to strip away his defences and leave him vulnerable to the destructive forces of his mind. Once it took hold, he experienced a downward spiral that became so unbearable that death seemed like the only option for relief.

> The lower down you go the more pulverised you are and it's very difficult. I can't believe I am where I am now because on many an occasion I didn't want to be anywhere only out of this world. (Dan p.14, l.22)

Similarly, Mike experienced unpredictable changes in his mood that at times seemed to bear no connection to his life circumstances, leaving him wondering if there was anything he could do to lessen their effect on him. These mood changes were significant and changed his whole view of himself to the extent that he lost sight of positive aspects of himself and his life and became consumed with negativity. He considered suicide as a way out and simultaneously felt the need to hide these dark thoughts and experiences from others in his social circle

> I suppose you talk about yourself in such a detrimental way that you think people would look at you, like if you did it with your friends they would really be overly concerned about you,

> you know. If you even mentioned the fact that you were so low you were going to leave the world. (Mike p.12, l.16)

4.2.4 Summary

Driven by utter desperation, participants chose to alter their situations by doing things that were likely to bring about relief and their desired changes in themselves and their lives. Participants believed that psychotherapy could be helpful in this regard and they trusted their basic inner sense of what might be helpful or harmful and acted on that basis. Thus, their level of desperation, coupled with a sense of inner knowing about what was likely to make their situations worse seemed to help them to take a gamble on psychotherapy and energised them to face the uncertainties associated with this venture. Perhaps having confronted their own survival there was relatively little to lose and much to gain.

4.3 A Leap of Faith

With so much at stake participants faced the challenges of engaging in psychotherapy when they did not know what the process would involve or what the outcome would be. Furthermore psychotherapy involved another person - a therapist - who was also an unknown entity. Despite these uncertainties, they knew that in psychotherapy they were expected to talk about themselves and their inner pain and turmoil, which although it made sense to them was also a frightening prospect that entailed risks. Navigating these challenges and uncertainties facilitated participants to make choices about the nature and level of their engagement in psychotherapy.

4.3.1 The Known and the Unknown

Participants knew that there were many different types of psychotherapies and they grappled with trying to decide which one was best for them. This was a frustrating experience, as practitioners did not always tell them what therapy model they were using and what this entailed for participants who were all too aware of the need to make good choices, given that their future lives depended on it.

Ann had been hurt and disappointed in relationships and did not like surprises. Thus, it was important to her to know what she was getting into. However, it was not just practical knowledge that was important, but the fact that the therapist took the time to involve her in an explicit and shared account of what he or she expected. This perhaps validated Ann's expectation of playing a central and collaborative role in the therapy, which strengthened her own sense of agency and helped her to feel safe enough to proceed.

> Well if I could see where it was leading to, that there was going to be, not an end, but if I was talking about something that [therapist] was talking about, it could be made into something constructive you know things like that. And yes definitely I need to be sat down and told "look this is how this works". (Ann p.12, l.3)

Participants found it difficult to commit to therapy and positioned themselves on the edge when they did not know what was involved. They wondered what they were supposed to do and what the therapist expected of them. Knowing what information to look for and where to get it was difficult.

Ann felt that as the therapist had not indicated how therapy might progress this left leaving her wondering about what would be important and helpful for her to discuss. This contributed to her feeling confused and disengaged.

> But sometimes I just felt disconnected from what the therapy was and I was confused. You know the lady explained to me there is this form and there is that form and there is this form and that form. Well I never knew what form I was getting. (Ann p.9, l.15)

Participants tried to make informed choices about therapy with little information and in the absence of having adequate information, they frequently went along with what was offered and hoped for the best.

When Dave was hospitalised he struggled with being told to do different kinds of therapies. He was scheduled for family therapy, cognitive behaviour therapy and group therapy without any rationale for this combination of approaches with his medication regime. Having had his world collapse around him he was struggling to make sense of what happened to him and to regain a sense of coherence and control. This absence of explanations about his treatment package contributed to his sense of confusion and disorientation. Hence, he found himself caught between wanting to be a good patient and therefore doing as he was advised and wanting to be autonomous and decide for himself what would be best.

> Well they said it would help reduce stress levels and it would be good to talk to somebody but they didn't really explain what I needed to do as part of that therapy so there was no real…I wasn't given a good background, (Dave p.3, l.63)

Mike had searched for years trying to find what would fit and work well for him. He had come to realise that looking for someone who could put all the information together about different potential avenues for change was unrealistic, so he informed himself as best he could. He realised that practitioners' knowledge tended to be limited and they seemed to infer that their way was superior and would result in progress and bring about desired change.

> It's the same thing when it comes to mental aspects, if you go to anybody and they will say that they can fix you, hypnotherapists, acupuncturists, even massage therapists say they can help out, nutritionists, any of these people will say they will help. (Mike p.5, l.8)

Even when participants knew something about the type of therapy that was being offered and were prepared to give it a try, they did not know what would be considered a reasonable timeframe to allow for some significant or adequate changes to occur or what to expect in the therapeutic exploration. They grappled with

persevering with the unknown versus cutting their losses and moving on to try another avenue.

Jim had been in different types of psychotherapies and wanted cognitive behaviour therapy, which was not always available to him. Therefore, he entered other types of therapy while not really sure that anything substantial would emerge, or if something did emerge if he would benefit from this revelation.

> I had to have blind faith that if I dug around in the past for long enough I might be able to come up with something that would help me understand why I am so miserable as I am today. (Jim p.6, l.21)

Additionally, participants discovered that even when they thought they knew what type of therapy they needed and wanted it was not always as they expected. This makes sense given that the therapist also influences how therapy is delivered, nevertheless it was another unknown aspect of psychotherapy for them.

Dave had spent a lot of time researching different types of psychotherapies as he was afraid that going to the wrong type of therapy would set him back and this was not a risk he could afford to take. He settled on one that he believed would bring about the kinds of changes he was looking for in a safe manner. It seemed unlikely that it would overwhelm him, as he believed it would concentrate on current issues and bypass difficult past experiences, however this was not the case. He realised that some events in his life were not so neatly separated from other aspects of his life. Although he hoped that this would serve to protect him in therapy, he came to realise that the process was more complex and demanding.

> Not realising that once I engaged in the sessions that I am going to have to go back to my childhood...but going through the process it is interesting to see that they are all interlinked. (Dave p.32, l.981)

Participants had expectations about what therapy would be like and these expectations were based on their previous experiences of therapy and treatment and also on what they had read or heard about therapy. However, despite attempting to find out as much information as they could about the therapy they were getting, they began to realise that once therapy started it could go in various directions that were neither predictable nor imaginable. Perhaps there was a protective factor in this, as if they had known at the start what they came to know later in therapy, the risks might have seemed too high and the expectations too much to overcome and they might not have engaged at the outset.

4.3.2 The Trusted Stranger

The beginning of therapy was a difficult time for participants and highlighted fears and created further uncertainties. Not only were they dealing with questions and fears about the type of therapy and the kind of outcomes that were realistic but they also had to enter into the complexities of a new relationship with the therapist who was as yet unknown to them.

Initially the therapist was a stranger, which was seen as a mixed blessing. Participants struggled with how to open themselves to someone they did not know or trust, while also realising that this was necessary in order for change to occur in therapy. They feared that the therapist would respond to them unhelpfully, judge them or misunderstand them, furthering their inner pain, increasing their desperation and bringing them closer to devastation. All they had to hold on to initially was hope that this would not be the case. They depended on basic survival mechanisms to generate a sense of safety until they became more familiar with the therapist and the therapist had opportunities to demonstrate that he or she was an ally.

Jim knew that he needed things to change and had put his faith in therapy. However, he was forced to wait for the therapeutic relationship to develop and for the therapist

to act in a way that showed understanding of him so that trust and safety could be built.

> You can't do it immediately. You can feel safe with someone immediately but you can't really properly trust them until they've shown you, they've proved that you can trust them a few times. (Jim p.29, l.14)

Ann attended many therapists and knew that it took time to get to a point where she felt connected and comfortable enough to talk about the things that were really upsetting her and were deeply important to her. Her previous negative experiences in intimate relationships and with some therapists added to her caution.

> It takes me a long time to get adjusted to someone. Now I can be very friendly and outgoing, I normally am with people, but as you get to a connecting point, it takes a while (Ann p.19, l.15).

A connection with the therapist precipitated a sense of progress and helped participants to continue in therapy, perhaps validating their gamble to date. When Ann felt connected to the therapist, she had sense of making progress and self-agency, which counteracted her painful experiences of worthlessness.

> It was a good involvement. It made me feel I was progressing. It made me feel I was taking steps in my life. It made me feel I was getting back part of myself that had gone, that I was making changes that were beneficial to me and not doing things that were destructive. (Ann p.12, l.16)

Participants found ways of managing instances when their therapist misunderstood their circumstances or their needs. They were generally forgiving towards their therapist, especially early in the therapy, favourably interpreting these misattuned moments as a lack of information rather than lack of attention or interest on the part of the therapist and thus allowing the therapy to continue.

Ann had just started with a new therapist when her former partner died. The therapist, not yet aware of Ann's violent and traumatic relationship with him, suggested she do something to mark his death and help her process her emotions. Ann was shocked and angered by the therapist's suggestion and felt caught in a bind. She did not know the therapist well enough to disclose her discomfort, yet she desperately needed to remain in therapy to give her a chance for a better life, so she said nothing and risked being viewed as resistant or uncooperative.

> And I know one time, one of these people dared to say to me, maybe if you brought in a few things belonging to your husband and spoke about them. And I didn't understand that and I said I'll think about it. And the next time I went she said did you bring anything, a picture or something like that. And I said no. And I didn't say "I don't want to. I can't see the benefit of it." (Ann p.7, l.2)

Participants desperately looked for and needed responses from the therapist that countered previous unhelpful and even damaging experiences, while also fearing that these might be repeated.

Jim feared that the therapist would undermine his self-agency and reinforce his dependence on others, furthering his negative view of himself as impotent and adding to his inner distress.

> My biggest problem has been that I don't believe in myself... 'You're not in control of your life. You know you are the last person I'm going to believe'. I'd believe anyone else who claims to have authority and I think because of that I have put too much belief in counsellors and doctors and professionals. (Jim p.22, l.6)

Participants also had to trust that the therapist would be able to cope emotionally once they had been exposed to the participants and their inner worlds. It was important for them to believe the therapist was skilled enough not be burdened by them.

Ann found it disquieting when her therapist indicated she had been thinking about her between sessions. She did not want to feel responsible for causing the therapist harm.

> She said 'I was thinking about you when that happened'. And I had the feeling then that I didn't think that was professional. I would feel maybe sometimes she went home with this baggage. And I don't know how you would leave it all behind you. If I was a psychotherapist I would be mental by the time I finished. (Ann p.21, l.7)

Participants also had to trust that the therapist would act in their best interests and when things were not going well would provide skilled support and encouragement rather than withdrawing their approval and involvement.

Dave, feeling desperately overwhelmed, trusted that those providing help to him would be professional and competent. However, this was not his experience with all healthcare professionals. In the past when he attempted suicide he felt blamed, punished and utterly let down by their response. This left him wondering if these professionals were able or willing to help him and alleviate his distress.

> When you are already so vulnerable and so alone that the people are looking at you differently and they are thinking this person has tried to kill themselves. Was it that they didn't want to acknowledge that I had tried and was desperate? Or was it they didn't have the skills to be able to talk to me? Because it must be very hard to go up to someone and say 'why did you do that' and 'how are you feeling?' And I don't think they had it in them to actually say those things to me because they didn't want to open a can of worms. Because if they could contain me and not open the can of worms then they could manage the situation until I went home. (Dave p.21, l.618)

Despite their concerns and reservations, participants reminded themselves of what was at stake should life not change and this helped them contain their fears and uncertainties about the therapist, whilst allowing them to engage. It helped

participants when they could see that therapist was competent to deal with those aspects of themselves they feared most.

Jim had been tormented by his emotional world and was terrified of it. In therapy he could not avoid it, yet he knew that he became overwhelmed and disoriented by it. With his personal happiness and his future at stake, he trusted that the therapist would be skilled and able to help him and would not be shocked or frightened by the intensity of his experiences.

> You need to feel that you're in the hands, or at very least in the presence, of someone who knows what they're doing, that can help you if it gets too much. One of the fears with me frequently was I'm not going to go near that at an emotional level cause what happens if it starts like a volcano and just can't stop. (Jim p.28, l.19)

Although they initially forced themselves to attend therapy, it became less of a battle as they began to experience the therapist as someone who had their best interests at heart. Therapists demonstrated this by what they said and how they said it. This allowed participants to feel that the therapist was on their side and seemed to diminish their level of concern and fears about the therapist. These gestures or acknowledgements of goodwill from the therapist helped participants navigate the risks they were taking.

Dave felt blamed and unsupported by his medical team and felt he had been pushed into a number of therapies before he was ready. He went along with everything but it backfired on him. In his current therapy he realised how important it was for him to feel his therapist was an ally.

> If I could only trust the therapist to be acting in my best interest, that is my hope. (Dave p.50, l.1526)

Dan wanted someone to talk to who would listen and understand the burden he carried from holding everything inside. When his therapist responded sympathetically and demonstrated this kind of understanding he felt cared for and this was crucial for him in trusting the motives of the therapist. This relational subjective change experience was more important to him than objective changes in his life situation.

> Yes [therapist] is trying to help me get well, whether it works or doesn't is irrelevant. [Therapist] is trying and I appreciate that. (Dan p.31, l.3)

In therapy Dan had to confront his fear that these life-long patterns with significant others in his life would be re-enacted with his therapist. Dan chose to take a risk that his therapist would understand and respond helpfully to him when he began to reveal himself and his torment.

> You're meeting a stranger as such and probably the hardest person to be honest with sometimes is a stranger because they don't understand you or maybe they don't understand what you're saying or why you're saying it. (Dan p.12, l.18)

Participants revealed the complexity of the therapeutic alliance and demonstrated the multiple layers of relational issues that needed to be negotiated in order for mutual trust and respect to develop.

4.3.3 The Dreaded Stumble

Despite the patterns of familiarity that developed in the relationship between the therapist and the participant, there remained the possibility for the therapist to introduce things that were unanticipated and indeed sometimes uninvited and unwanted. This kept participants somewhat on edge because it was a constant reminder that despite the safety and trust they felt, the process itself was a risky and scary venture because the next steps could never be fully anticipated and the therapist was alert to events or utterances in therapy that they viewed as significant, while

these same events often went unnoticed or were disregarded by clients. The therapists had strategies that could evoke aspects of the participants' lives and their being in the world that were challenging, painful or shameful and that had previously been concealed.

Jim had settled into therapy but was still wary to some extent of what the therapist might suggest. Although knowing the therapist's strategies were typically helpful he nonetheless did not find them easy. Thus, he experienced a constant rise and fall in his anxiety level and his sense of safety as he went through therapy despite becoming more familiar with the therapist and more accepting of himself.

> You don't know what the counsellor is gonna take out in terms of their bag of tricks to help you come to see things from a certain angle or to help you change or whatever. You got to be frightened of it and I am particularly frightened and do dread when I feel like something is going in that direction. (Jim p.21, l.5)

Mike had come to know that the focus of the therapy could shift rapidly; for example, in one moment the focus could be on his story and it could then shift to something he had inadvertently revealed about himself through his story. He would know by the therapist's response that he had said something of particular interest and that the therapist would explore more about this despite his own reluctance. He dreaded these moments, not knowing what he had revealed or whether the therapist knew more than he did about himself, therefore, he suddenly felt out of control and out of his depth.

> And then if you stumble on something, I mean the counsellors love it when you stumble on making a mistake. They will go for the Freudian slip. So it is as if they are waiting for you to deliver something from your subconscious into what you are saying. 'What did you say? Oh I meant to say such and such. But what you actually said was'...Oh here we go oh Jesus. (Mike p.23, l.7)

Initially Dan was anxious and suspicious about the questions that the therapist asked, wondering what they meant and what his answers would reveal about him. Not yet having experiential knowledge of the therapy he did not understand or trust the process. However, over time this began to make sense, which helped him to feel more relaxed and comfortable with the therapist and the therapist's strategies.

> After a few times you relax with the person and you realise the questions they've been asking you, the reasons they've been asking you these questions and you sort of let yourself relax more with that person and I feel I could tell [therapist] anything now. (Dan p.12, l.24)

However, while challenging, participants knew that staying connected to the therapist and the therapy process with all its uncertainties, as well as facing some difficult issues, could be potentially helpful and have a profound impact on their life.

4.3.4 Summary

At the start of therapy, participants did not know if therapy would be helpful or what kind of therapy might suit them or meet their needs. They grappled with trying to work out how therapy was supposed to work, how they would know if they were making progress, and if another type of therapy might be better for them. They tried to inform themselves about psychotherapy, which reduced their concerns to some extent.

They grappled with the unknown therapist and put their faith in the therapist's professionalism and competency to mitigate their fears of negative judgement or ridicule. It took time to develop a connection and this was built initially on safety and over time on trust and familiarity. It helped mitigate the initial risks when therapists began to prove their competencies and their benevolent intent. However, participants could never quite anticipate what direction therapy would take and the therapist's strategies were not predictable. Participants had to cope with the fear and anxiety that these strategies evoked as they found themselves increasingly drawn to reveal more of themselves, their vulnerabilities and failures. They clung on to the few certainties they

had and desperation for survival, coupled with hope, helped them to navigate the risks and uncertainties and to take a leap of faith and engage in the unknown terrain of psychotherapy.

4.4 Concealing and Revealing

As participants began to reveal more about themselves they became aware of what they had perceived to be negative aspects of themselves, which they had concealed from themselves and others. However, engaging more in psychotherapy inevitably meant exposing these hither-to-fore unconfrontable aspects of themselves and their lives and facing the discomfort and fear that this evoked as they realised that this meant not only facing the therapist but also facing oneself. These were the parts of themselves and their lives that they generally associated with failure and inadequacy and that had contributed significantly to their low opinions of themselves and their compromised sense of self. Intense feelings such as loss, shame, guilt and anger were aroused when they acknowledged these parts of themselves and they were terrified that such feelings would be overwhelming and would not dissipate. However, participants also knew that their yearning for change rested, at least in part, with facing their demons so that these could be resolved or managed in a way that allowed them to move forward with life and living.

4.4.1 Hiding from Self and Other

Fearing the discrimination and marginalisation that was associated with the social stigma of mental illness, participants concealed parts of themselves that highlighted their sense of difference in the world. They experienced first-hand the consequences of stigma, being denigrated, viewed as inadequate and irresponsible and feeling unvalued. They began to internalise these views, describing themselves pejoratively and hiding aspects of themselves.

Dan experienced the torment of mental illness yet despite this he tried to be sociable and helpful to those around him. It was important to him that people had a positive view of him that countered the stereotypical view of people with mental illness that he was exposed to in everyday casual conversation. He was dismayed and disgusted to hear people suggest that having a mental illness and taking medication could be seen as excuses for unacceptable behaviour, which created a view that such people were not responsible or competent.

> They maybe go to court or something and they say 'well I was on medication.' Medication, it never caused me to do anything I didn't want to do, it never affected me in that way. (Dan p.25, l.1)

Sometimes participants were forced to conceal themselves by others who were unable to hear their pain. Dan weighed up his need to talk about his inner pain against his fears about being misunderstood and rejected if he opened up to his therapist. In other significant relationships, where he had expected support and concern, he had been let down. He was not allowed to talk about his torment in his family and when he did so he was punished, rejected and abandoned therefore he learned to keep these aspects of himself hidden.

> But my wife would be in bad form because from all the time I have been ill she has never asked me 'How do you feel?' And like I mean she went off for three months to get away from the situation. So I was in the house for three months on my own. (Dan p.28, l.17)

Despite the challenges of the unknown therapist as discussed earlier, there were also benefits in this. Being able to talk to someone, who was not family or part of the participants' social circle, meant they could have different types of conversations and could expect different more positive responses that would allow different aspects of themselves and their lives to come to the fore.

Mike appreciated not knowing his therapist beyond their professional relationship. He could say whatever he wanted without fear that he would come face to face with this person as he went through his daily life. Thus, the stigma he felt by virtue of his long-standing life difficulties and thoughts of suicide could be both contained and exposed in therapy, breaking his day to day strategy of concealing the parts of himself that were disallowed.

> I just know that I am not that secretive a person but having said that, it is just that added factor of somebody not having a part of your life…It is that element, it is a safety, it is like a priest, you can go in and admit your sins and know that there is confidentiality there. (Mike p.17, l.17)

Regardless of how much he trusted his friends there were some things Mike did not think were acceptable to talk about because they were too dark, too exposing or too worrying. With his friends he managed this by presenting a happy, positive, funny demeanour. With his therapist he could be himself more and this was facilitated by not having to worry about the effect he had on the therapist such as burdening him or her, or fearing negative judgement.

> [Therapist] is not my friend. [Therapist] is a nice person but is not my friend so I don't care. So I don't have to sugar coat anything. With friends, no matter how open you are, you are afraid of judgement and afraid of just putting more worry on them than you would want. You don't want to be that dark, because I never was. I was always the joker. (Mike p.13, l.11)

However, Mike also feared that the therapist's strategies meant that he had to look at aspects of himself that he had been avoiding. He was terrified that if he really faced these parts of himself and began putting them into words that this would make them more real and allow them to take over, diminishing his sense of being in charge of his own life and sentencing him to a life of misery.

> What could stop you engaging is that you don't want to hear some of the things you could really say about yourself, hear those words. You would prefer to almost not see yourself that way so you don't want to say these words because you feel that forever they will become your stamp. (Mike p.23, l.24)

Although Jim's family and friends were largely supportive towards him he noticed that they tended to want to make him feel better and take his side in situations. Although this was perceived as supportive, he needed someone who, while having his best interests at heart, would also be more objective and challenge him or suggest alternative points of view that would help him move forward. Even though it was difficult to put himself in a position that would involve challenges to himself or his views, he knew that this level of exposure and attention to the negative side of himself was necessary and helpful.

> It was difficult it was unpleasant and I didn't want to be there but yet I pushed myself to going every week because I was in such a miserable state at the time. This was my support. This was my only outlet to talk about it really. I could talk about it to my sister they were all just interested in me being ok and they couldn't make the decision for me. (Jim p.34, l.1)

Participants also experienced how stigmatisation could be mirrored in the treatment system. This happened when their view was ignored or they were excluded from important decision-making about themselves, leading to them feeling inhuman, exacerbating their sense of being objectified, and promoting and perpetuating self-stigma.

Dave felt disempowered when he entered the mental health system. He had been given and took on the role of a patient, which meant doing as he was told and getting better. He was excluded from decisions about himself and this initially fostered a sense of passivity and over-reliance on healthcare staff. This gave him subtle messages about his inability to handle responsibility.

> It is almost like you have been a patient now and that is that. Take you medication and your GP will write you a prescription and come back to us if you have a problem. It was very disheartening to go through that experience when you are trying to come to terms with an illness as well. (Dave p.19, l.556)

He experienced what it was like to be in a relationship with people where significant power differences abounded, where he felt vulnerable and was viewed as unimportant. Sometimes this took the form of being treated with the utmost contempt; for example, when his situation deteriorated he was blamed and punished, despite doing everything that was suggested by the professionals.

> It was almost like 'Take your medication. Don't cause me any hassle. Be a good patient and just do what you are told.' And because I had taken my medication but reacted to my medication, tried to kill myself, I was now a bad boy and [psychiatrist] is not going to have someone like that, [psychiatrist] won't tolerate it. (Dave p.19, l.586)

Such experiences caused participants to choose not to reveal themselves to practitioners who they perceived as judgemental or incapable of hearing their story and empathising with their pain. They judged carefully who could be approached, confided in and trusted with their lives.

Ann was familiar with the mental health system but did not feel her needs had been taken into account when she constantly had to see a new healthcare professional. She felt treated like an object passed from one professional to another without any regard for her. In these circumstances she was reluctant to reveal information about herself and deliberately concealed her concerns about herself.

> It drives me insane. So I just go in and say 'Oh I feel a lot better.' When actually I am thinking of going home and taking an overdose but I am not going to tell you that. Give me my prescription and I will be gone. (Ann p.14, l.24)

Risking rejection and denigration in exposing themselves to their therapist was perilous enough but participants also realised that they could not do that without exposing themselves to their own scrutiny and judgements. Having gotten by in life by staying within their safety zones and their secret selves, as they got more involved in psychotherapy they realised that change demanded they move outside their comfort zone and confront their hidden side.

Jim felt comfortable talking on an intellectual level about his situation and his experiences. However, he realised that this kept him in a safe place and while protective, this strategy was not going to deliver the kind of relief and change he was desperately seeking. He had to face his emotional experiences also and knew this would be a challenge for him.

> It is a two way process being able to open yourself up and reveal things about you. You can reveal facts about yourself and that's honest too. To reveal an emotion is more difficult and then to leave yourself open long enough for someone to get in there with you and help you revisit the most painful times in your life and your most painful emotions in your life is very difficult. It's extremely difficult. It's the most difficult part for me of counselling. (Jim p.16, l.15)

Connecting with the concealed aspects of one's self and life also opens space for regret and loss to emerge. Dave was very glad to be seeing progress in therapy. He felt he was beginning to make sense of what had happened in his life and was making connections between this and his way of being in the world. Although experiencing relief and change, this inevitably also involved pain as he noticed a sense of loss and regret at missed opportunities in his life.

> And I think that it is a relief to kind of understand what makes you tick. What makes you think that way. But it is also quite painful as well because then you have things like regret…and it's not just regrets, it is about the whole thing of if I hadn't been so extreme I could have enjoyed life better, could have

> participated in life rather than just been driven. (Dave p.44, l.1336)

Thus, participants found themselves confronted with the choice to disclose their unsavoury and dark side in the belief that this would be helpful, or to conceal parts of themselves from themselves and others. The participants in this study chose the former, which allowed them to continue therapeutic work and see the benefits of this.

4.4.2 Skirting Around the Edges

Participants were ambivalent about revealing themselves. Although they believed that talking honestly with the therapist would be helpful to them and they pushed themselves to do this, they were also frightened of what they would find out about themselves. They also believed that there was probably good reasons for splitting away the uncomfortable aspects of themselves in the first place, therefore these defences were slow to be abandoned.

Ann found it too difficult to connect with the therapist and indeed with herself because when she began to review her life and how she had managed situations in her life, she started to feel the depth and intensity of the self-blame and self-loathing that she had towards herself. This seemed too powerful and destructive to confront and she felt unable to do so.

> At the moment I just don't like me. There are a lot of things I don't like about me and it is very difficult for me to bring stuff to the situation where I don't like myself… I just feel I have destroyed myself. And I don't like myself and I am feeling angry at myself. And I can't bring that. I just can't kind of connect with it. (Ann p.23, l.9)

Participants feared that revisiting the sources and memories of their pain in psychotherapy would open up old wounds that might never heal. Dismantling their old defences might leave them in a worse situation. They imagined being left to fend for

themselves and being defenceless with nowhere to hide that would be safe and protective.

Jim was terrified that his emotional world, once tapped into, would become overwhelming. He feared delving into his past and how this connected with his present, concerned that he would get stuck in the raw pain of the past and that this would not pass.

> You think to yourself I don't want to do this because first of all you know it's really difficult and I might end up in tears or angry or revisiting these emotions and feeling them again and then what do I do I'm an open wound and I walk out the door that's what you're kind of afraid of. (Jim p.18, l.1)

To manage many of these risks participants were concerned with pacing the work of therapy based on their readiness to face difficult issues. They made constant judgements about this and adopted a range of strategies to slow down the therapy when they did not feel able or prepared to engage with issues that they perceived as overwhelming, undesirable or indeed dangerous to reveal at a point in time. Such strategies included distancing, distraction and avoidance and served as protective mechanisms that allowed them to remain in therapy, while carefully timing what they felt able to work with from each moment to the next.

> I was just buying for time. It is like you have got an essay to write but you find housework to do first. I was like that initially in psychotherapy and maybe sometimes when I am feeling a bit vulnerable I still do that in psychotherapy. I kinda skirt around the edges. (Dave p.37, l.1138)

Jim, although attending therapy for some time and feeling familiar with his therapist and the therapeutic tasks and strategies, had times when he was reluctant to attend. Although he forced himself to attend, he steered the therapy in a particular direction and firmly resisted his therapist's attempts to nudge him in a particular direction towards exploring his emotional reactions and responses. Although he had

experienced the powerful effects and changes that had come about for him from working on an emotional level, sometimes he felt too vulnerable to do this work and wanted to protect his vulnerability while also experiencing the support of the therapist. He lessened his emotional engagement and remained present on an intellectual level, thus delaying entering the emotional domain until he was ready. At those times his capacity to be involved was reduced but nonetheless he kept himself involved at some level albeit more at the periphery of therapy.

> Things that hinder me in my engagement I talked about my reluctance to kind of be open to certain non-intellectual types of explorations. (Jim p.20, l.9)

Ann adjusted her presence in therapy and did so depending on how she felt the relationship with the therapist was developing, how well she understood what therapy was about or how able she felt to deal with her personal distress. At times she felt fully absorbed in what was happening in the therapy and at other times, although she would attend, she was withdrawn psychologically and emotionally from the therapist and engaged in what seemed like idle conversation that moved from one topic to another. However, interestingly she was able to observe and reflect on this process.

> I would have been sitting in a chair watching me talking...I would feel my voice was here talking to this person but over there was the real me just sitting down just watching all of this. (Ann p.14, l.11)

Mike was ambivalent about psychotherapy. He had no framework for understanding how it worked and this left him sceptical, yet he was pragmatic and keen not to dismiss anything that might be helpful. He fantasised that the negative and unsavoury parts of himself meant that he was selfish and cruel, similar to the way he perceived another family member. Although he held out for a significant insight about himself from therapy, he consumed the therapist's acceptance and the constant reminder from the therapist that he was not the same as that relative. This made a significant difference

to him and allowed him to get on with life. However, he grappled with bringing new material into psychotherapy as he could not predict where it might take him. He was frightened of what he would find out about himself and that his worst fears about himself would be confirmed. He stalled at the point of introducing such material, by talking at length about other matters that were not important, until he had summoned up enough courage to explore the issue openly with the therapist.

> I mean if it is new territory then what might stop you from engaging is that you might waffle on for ages, which I am pretty damn good at, about stuff that is irrelevant. (Mike p.23, l.2)

Hence, the participants managed to remain in therapy by carefully and skilfully navigating if, how and when to reveal and conceal aspects of themselves. Pacing strategies allowed this to occur in a tolerable way.

4.4.3 Summary

Participants had hidden what they perceived to be unsavoury parts of themselves and their lives, leaving them only able to engage partially with themselves and the world and with therapy. Exposing themselves in therapy meant facing these hidden aspects of self and life over time, which inevitably evoked more pain and sometimes regret for lost opportunities. They had to take the risk that this pain would pass and would be different to the persistent and intolerable pain from which they were trying to escape. Sensing the therapist's presence and benevolence helped them to see the therapist as an ally, which combated their frequent felt sense of isolation and fear. They gambled that whatever progress they made in therapy would make enough of a difference in their lives that they would avoid returning to the point of desperation that they had previously experienced. They skilfully monitored and managed their engagement so that exposure to self and other was paced at a level that would allow them to go on in life and therapy in an acceptable way.

4.5 A Risky Venture: The Wager is Too Big for the Pot

Engaging in psychotherapy was a risky venture. Participants faced a number of dilemmas and risks that had to be navigated throughout therapy that in turn influenced the nature and level of their engagement. On one hand, being buried in intolerable and enduring emotional pain there was no light at the end of the tunnel, no hope that things could be better. The immense and disturbing nature of their pain coupled with hopelessness left them struggling with ambivalence about their desire to live or die. Their survival was at stake, sometimes in the form of their physical and biological survival and sometimes in the form of their sense of self or their psyche. Desperation was a double edged sword that intensified their despair while also driving them towards a desire for relief and change. They wanted to break the vicious cycle of despair and pain they experienced but they were also cautious about further failure as this could bring them back to where they had started from and would jeopardise their survival. Thus, their drive for change was continuously weighted against a fear of failure and the risk of devastation entailed in seeking an alternative way to be. Initially, it seemed like they were in a no-win situation either way risking their own destruction and annihilation.

Although at times the odds on change and progress seemed slim and the probability of failure seemed high, their desire to survive was stimulated and they took a leap of faith believing and hoping that progress was not only possible but also probable. A leap of faith involved facing and managing uncertainty. With such high stakes, it was important that they made the right choice of therapy and therapist. They tried to seek information to help make informed choices but realised that there was only so much they could know and foresee. The information they sought was factual but as they entered into therapy they realised that the nature and course of therapy could not have been predicted.

Along with the uncertainties, there was one significant undesirable certainty that they were all aware of; for therapy to work they had to be prepared to reveal painful and unsavoury aspects of themselves and their lives and this too entailed risks. There were no guarantees that the therapy and therapist they were attending would work in their favour or what the outcome would be. The therapist was like a trusted stranger and participants had to have faith and trust in the therapist to have their best interests to the fore. This was difficult early in therapy when participants and therapist were unknown and unfamiliar to each other. It was also an issue as therapy progressed, as participants did not always know if therapy was going in the right direction. Over the course of therapy and despite a growing familiarity with the therapist and trust in the therapist's competence, participants were still watchful for strategies the therapist could use that might destabilise and overwhelm them therefore they could never quite relax their guard. From time to time, they had niggling doubts as their issues became more personally exposing that the therapist could fail them. Thus, they needed to convince themselves that the therapist would not bring them where they themselves were not yet able to go.

The material participants had to contend with in therapy was intense and frightening and they doubted their own ability to face and manage issues that might emerge. They had to face their deep despair and their crippling fears. They confronted aspects of their experiences or aspects of themselves that they had hidden away because they were too unbearable and overwhelming. Throughout therapy they navigated decisions about how much of themselves and their experiences it was safe to reveal or what it was better to conceal. Initially in therapy, revealing was difficult as it left them vulnerable to rejection or ridicule by the therapist. However, as the therapist proved him or herself to be trustworthy participants became more distrustful of themselves and fearful of the risks of self-rejection, self-ridicule and shame. These fears were difficult to surmount as they knew that while they had to confront and manage these painful parts of themselves and/or their experiences in therapy, they also faced the

paradox that these aspects had become hidden as a form of self-protection, hence there was inherent danger in uncovering them.

At times participants did not feel able to or did not want to expose these more unsavoury parts of themselves. Sometimes this was influenced by situations and relationships that occurred outside therapy. They employed a number of strategies to distance themselves, avoid or delay making revelations. Tentatively approaching and/or avoiding issues in this way allowed them to pace themselves in terms of what they felt able to reveal and examine and allowed them to protect themselves and stay safely in therapy until they were ready to confront difficult issues.

> If you are putting stuff out there is it truly rectifiable or is it just talking and that is all it is. So if that is all it is and there is no resolution maybe I should hold back on certain things because the wager is too big for the pot that is the way it feels. I don't know. (Mike p.24, l.16)

Thus, engagement was a continuous process of decision making and managing risks about the potential gains or losses of being present in therapy. It was influenced by in-session material and external events in the lives of participants. Sometimes the risks were apparent to them and at other times they seemed to be operating on the edge of or outside their awareness. Similarly, processes used to manage the risks were sometimes explicit and at other times seemed implicit.

4.6 Summary

This chapter illuminates engagement as an overarching risk for participants as they tried to balance potential dangers and benefits of being present to themselves, the therapist and the tasks of therapy. The key dimensions of risk emerging from the study are interconnected, as participants' pain and desperation became an impetus for change driving them to take the leap into the unknown terrain of therapy and face their inner dark world. Successful navigation of the complex dilemmas involved

enhanced engagement and allowed therapy to continue. Alternatively, strategies were used to retract engagement to a safe level and this allowed therapy to continue until a greater level of engagement was possible again. Different dimensions of these dilemmas arose in different ways and at different times during psychotherapy, forcing choices about what would be prioritised or overshadowed at a given moment. These decisions were based on their judgement of what was best for them coupled with what they were able to do, acknowledge and confront at that moment in time and influenced the nature and level of their engagement. Hence, the quality of engagement was about the extent to which participants were able to navigate the risks and be more or less present with themselves, the therapist and the therapy process at a moment in time.

Reflexive Notes

Having been interested in engagement in general and in psychotherapy for some time prior to the study, I was surprised at the depth of despair that drove participants to psychotherapy. Having worked with people who have been suicidal I have been witness to ambivalences about living and dying and at times with the immediacy and urgency of survival. However, I was taken aback at the possibilities of self-annihilation, both of the psyche and physical self, that the participants grappled with that were inherent in and perhaps reflected into engaging in psychotherapy.

Chapter 5. Discussion: Making Sense of Multidimensional Risk

5.1. Introduction

This chapter seeks to make theoretical sense of the findings from this study, which sought to illuminate the relatively neglected area of clients' experiences of engagement in psychotherapy in a mental health setting (Bachelor et al. 2007; Graves 2006; Karver et al. 2006). It explores how the findings, which illuminated that engagement in psychotherapy in a mental health setting is the presence of the self influenced by an ongoing iterative navigation of risks, resonate with and add new dimensions to the extant literature. The chapter examines extant literature in relation to the two main topics of engagement and risk incorporating intersections with the subordinate themes of inner pain and desperation for change, a leap of faith, and revealing and concealing. Alternative theoretical frameworks for understanding the overarching theme of risk that emerged in relation to engagement are highlighted. The literature presented in this chapter highlights particular lenses that resonated with me as enhancing client, therapist and clinician understanding of engagement and risk in order to maximise the theoretical value of and practical utility of the study. Thus, some of the literature draws on areas beyond psychotherapy, specifically human resource management and decision making.

5.2 Engagement

This study was concerned with how engagement in psychotherapy was experienced and understood by clients. At the start of the study engagement was conceptualised as intense involvement with the tasks of therapy and presence with the self and therapist. The findings of the study has illuminated a richer account of engagement as a complex intra and interpersonal process that reflected the client's presence within the therapeutic relationship and with issues of significant and personal importance, and their involvement in the therapeutic tasks. It elaborated that engagement was a

continuous process of decision making and managing risks about the potential gains or losses of being present in therapy. In this section, the concept of client engagement is explored in relation to the therapeutic relationship, the active client, presence and engagement beyond psychotherapy drawing on literature from the field of human resource management.

5.2.1 Engagement and the Therapeutic Relationship

Client engagement in psychotherapy can be partly located within the realm of the therapeutic relationship, which has been considered to involve agreement between the client and therapist about the goals and tasks of therapy and the quality of the bond between them (Bordin 1979). However, in this study engagement also meant presence with the self and navigating the tensions between self and other. This view of engagement resonates with Safran and Muran's (2003) interpretation of Bordin's conceptualisation of the alliance as assuming a continuous conscious and unconscious mutual negotiation of the tasks and goals of therapy.

> At a deeper level it [*therapeutic alliance*] taps into fundamental dilemmas of human existence, such as the negotiation of one's desires with those of another, the struggle to experience oneself as a subject while at the same time recognising the subjectivity of the other, and the tension between the need for agency versus the need for relatedness. (Safran and Muran 2003, p.15 italics added)

This more complex and dynamic understanding of engagement was reflected by participants in this study who described an ongoing, complex and dynamic navigation of risks that influenced the level and nature of their presence. This was impacted by various issues that participants faced both in therapy and outside therapy; for example, contact with family, friends, other mental health professionals or stressful life events. The study adds to this literature by highlighting how these risks, which were relevant to all participants although their relative prominence differed over time, were traversed in order to continue in therapy. Thus, while sometimes this involved

facing their fears, such as ridicule, judgement or annihilation, at other times it meant employing strategies that allowed them to defer confronting issues. This allowed them to remain in therapy by pacing their exposure in the context of the ultimate risk of annihilation. Thus, the findings add another dimension by pointing to the intrapersonal aspects of this process that occur alongside the interpersonal mutual negotiation suggested by Safran and Muran (2003). Acknowledging the complex and dynamic nature of engagement and the profound risks therein can assist therapist and client in anticipating and managing ambivalence and anxiety associated with psychotherapy. It can also draw attention to the importance of pacing the work for the client and to the often unspoken fear of personal and therapeutic failure inherent in the therapy process.

Thompson et al. (2007) propose that the process of engagement requires the building of an alliance between the client and therapist that could be further conceptualised as a task based and relationship focused alliance. These two aspects of the alliance are considered mutually complementary and dependent. The relationship focused alliance is viewed as serving to relieve the client's attachment anxiety by building a bond. Thompson et al. (2007) highlight the importance of the client's concerns for closeness and protection and their fears about the availability of therapist and their worth to the therapist. The current study adds to this by highlighting the key issues to be navigated by clients in order to build a bond. Initially this revolved around testing the safety of the therapist and the therapeutic process. It progressed to assessing the trustworthiness and competence of the therapist and the usefulness of the therapeutic process. It reverted to a primary concern for safety as new and perhaps more demanding risks were encountered, whereby the prominence of risks changed or uncertainties about one's capacity to manage threatened to overwhelm the psyche. Although the bond that evolves is co constructed by both client and therapist, each is concerned with gauging their own and each other's connecting capabilities.

Safran and Muran (2003) suggest that it is necessary for a shift to occur in the direction of hope and away from despair in order for change to occur and this requires not only faith in one's own ability to change but also faith that whatever or whoever one turns to for help will have the ability to help. My study elaborates this process by highlighting that participants who initially had little faith in their own ability to change, created hope by placing their faith in the therapist and the therapy process. These subtle movements of internal processes were minuscule changes that in turn facilitated them to trust the risks they had taken, thus building a sense of safety, enhancing their own sense of agency and developing faith in their own capacity to change. The study further elaborates how this was a delicate balance for participants. Movement in the direction of hope was not unidirectional but involved a wavering of faith, and a back and forth shifting of the balance between despair and hope. Shifting this balance could be viewed as an extreme challenge for the participants who initially lacked agency, previously encountered a number of disappointing contacts with clinicians and were stigmatised. Participants engaged in psychotherapy by taking a leap of faith, partially as they could not foresee the outcomes or what would evolve and also because they had to enter into the paradox of facing aspects of themselves or their experiences that once had been hidden because of their potential to destroy the self. Furthermore, it was difficult for participants to trust their own abilities when they perceived that they had contributed to their own life situation in negative ways. In addition, it was difficult for them to trust others when interpersonal trust had been broken, conditional or denied in previous significant relationships.

5.2.2 Engagement and the Active Client

The level and quality of active client engagement in therapy is of significance in terms of outcomes (Bohart and Tallman 1999; Hubble et al. 1999). The current study illuminates some of the key areas of client activity throughout therapy process pertaining to how the client comes to be more or less engaged from moment to moment. The study highlights that this is not a linear or sequential process as is

sometimes inferred in the literature, which frequently describes phases of therapy (Hill 2005).

As discussed in Chapter two Bachelor et al. (2007), in their study on client collaboration, suggest that over 70% of clients who have severe and chronic mental health issues could be described as falling within what they ascribed as the dependent collaborative category. This category is characterised by clients viewing the therapist as primarily responsible for collaboration and therapist facilitative activity as significant in contributing to collaboration. The current study suggests that for such clients there are multiple intrapersonal dilemmas to be navigated before he or she can be present in the therapeutic relationship. Perhaps, therefore, collaboration cannot proceed until these issues are navigated sufficiently for the client to establish a sense of safety to allow the self to become more present in the relationship with the therapist and consequently to be able to engage in a collaborative process. Thus, it could be hypothesised that the best way for the therapist to respond initially is to facilitate and take an active role in attending to what helps the client feel safe. Bachelor et al. (2007) also noted that clients had little to say about their personal contributions to collaboration, however, the current study suggests that when invited and explicitly asked participants contributed a significant volume of data related to their contribution to as well as their experiences of collaboration, which infers a capacity to be more active although perhaps this activity is more intrapersonal. This finding also strengthens the case for research that draws on client perspectives (Macran et al. 1999).

Rice and Greenberg (1990) suggest that particular change events occur with particular modes of engagement. They highlight that clients use different modes of engagement depending on the specific change event occurring in therapy. The present study concurs with this view highlighting how participants' attention moved across various areas of concern related to risks that entailed different fears and threats. The study adds that participants also actively, although not always consciously or explicitly, avoid

these modes of engagement at times to allow themselves to pace the change process. Thus, they engage with their inner self in order to engage externally with the therapy process.

5.2.3 Engagement and Presence

Akin to Rogers (1961) and others, Erskine, Moursund and Trautmann (1999) propose that involvement is about being rather than doing. Although speaking about involvement from the therapist's perspective they shed some light on what it entails.

> Being therapeutically involved means being fully present, fully contactful, an ordinary person with needs and blemishes and all the other baggage that comes with being real, while still being a therapist who is with and for the client. (Erskine et al. 1999, p.83)

Erskine et al. (1999) highlight the level of challenge for the therapist in being fully present in therapy as this entails being vulnerable and authentic. Although they speak primarily from the perspective of the therapist, they acknowledge that the challenge of being present is more difficult for clients who are faced with their own issues in addition to the therapist's imperfections, in a context where they must place trust in this person. This study concurs with this view and highlights the paradox of creating trust in a context of uncertainty, much of which is associated with the person of the therapist. The study also contributes by highlighting that presence with self is an active internal state incorporating subtle intrapersonal activities and processes.

5.2.4 Engagement beyond Psychotherapy

Beyond the field of psychotherapy, the field of human resources provides a rich source of information about engagement, particularly in the area of employee engagement. Macey and Schneider (2008) provide a review of literature in the area covering the problematic issues of definition and exploring a number of frameworks for understanding the complex area of employee engagement. They highlight that

common among understandings of employee engagement is the assumption that it is a positive and desirable condition relating to increased productivity and profitability.

Based on their review of the literature, they propose a model of employee engagement incorporating trait, state and behavioural engagement, although they only focus on behaviours and traits that are viewed as enhancing productivity, perhaps akin to psychotherapy's leanings towards positive outcomes (Timulak and Creaner 2010). They view trait engagement as a disposition towards positive views of life and work; for example, inner drive and conscientiousness. They propose that this trait is reflected in state engagement; for example, absorption, involvement, commitment and empowerment. They hypothesise state engagement as an antecedent of behavioural engagement. Behavioural engagement is viewed as related to extra-role behaviour such as role expansion and proactive and personal initiative. The nature of work (e.g., autonomy, challenge and variety) is proposed to have effects on state engagement and also moderates the relationship between state and behavioural engagement. Leadership in the workplace moderates trust and indirectly affects behavioural engagement through the creation of trust. Thus, employee engagement is a complex dynamic and interrelated process that is influenced by external factors related to the work environment. Of particular interest, the authors drawing on the work of Kahn suggest differentiating between the notion of psychological presence that is inherent in state engagement and engagement behaviour.

> People can use varying degrees of their selves, physically, cognitively, and emotionally, in the roles they perform...the more people draw on their selves to perform their roles...the more stirring are their performances. (Kahn 1990, p.692)

Macey and Schneider (2008, p.12) conclude that behavioural engagement follows psychological presence as the latter creates an experience of integration that entails "simultaneously drawing upon all one's skills abilities and other personal resources in order to respond to the demands of a role." This model is useful in that it draws

distinctions between different aspects of engagement, some of which are internalised and some of which are expressed through behaviour, and highlights the interrelatedness of engagement with the work environment.

The findings of the current study suggest that this theory could be usefully mapped onto the area of client engagement in psychotherapy and extended by incorporating positive and negative aspects of clients' processes and including the context and influence of the client's wider social world. This would provide an overarching framework to help make sense of the literature, which as yet does not explicitly distinguish various aspects of client engagement, providing a fragmented knowledge base.

Thus, engagement in psychotherapy can be construed as encompassing internal processes that are expressed through behaviour and are influenced to some extent by the therapist, the therapy and the client's wider social context. Trait engagement could be viewed as the client's disposition towards engaging in therapy and change, which is moderated by events occurring in the clients' wider social context. The study highlights that participants' outlook towards engagement changed as the prominence of hope or despair and the perception of risks as either gains or losses varied (the significance of this point will be discussed later in the chapter in the section on decision making and risks). State engagement could be conceptualised as participants' descriptions of being more or less psychologically present, committed and absorbed in therapy and change, feeling safe or unsafe, and more or less in control. By placing their faith in the therapist, they exercised moments of control and thereby created a sense of safety. The sense of safety and of being in control influences decision making in situations that are personally relevant and potentially lethal and facilitates risk taking behaviours (the significance of this will be discussed later in the chapter in the section on decision making and risk). The intrapersonal aspects of engagement described above could be viewed as moderated by the particular therapy, the features of which include the level of activity expected of the client, the change strategies typically used by the therapist,

the direct or indirect nature of the therapy, the level of challenge for the client and direction the therapy takes. This interaction of state engagement and therapy could be understood as being expressed through engagement behaviour, which could be viewed as actions involving revelation or concealment of negative aspects of the self and strategies to pace the change process. The therapist could be viewed as directly impacting trust and thereby moderating engagement behaviour. Thus, the client's behavioural expression influences and is influenced by the therapist's response and the prominence of certain features of the therapy.

The findings of the current study support a distinction between psychological presence and engagement behaviour. It adds an important dimension to the model, which is the potential impact on engagement of wider social factors outside the immediate therapy environment such as life events and interactions with others outside therapy. The study findings further contribute by indicating that engagement is not static, rather the nature and extent of it changes over time as important elements of risk are navigated. It incorporates dimensions wherein at times promoting change is more dominant while at other times maintaining safety and protection of the self are more to the fore.

5.2.5 Summary: Engagement

Engagement in psychotherapy in a mental health setting is presence of the self in the three areas of: 1) the therapeutic relationship 2) matters of importance, and 3) the therapeutic process, embedded in a context of risk of annihilation and mediated by intra and interpersonal issues and the individual's social context. This conceptualisation goes beyond extant literature in drawing on understanding of aspects of engagement and proposing a framework for understanding engagement. The framework differs from Hill's (2005) work by situating the client's intra and interpersonal processes and his or her social context as central to engagement and the client as the driving force in engagement, as opposed to dominant role attributed to the therapist and the therapist's activities. It also diverges from Hill's four stages model of therapy that states that there is a sequential staged process that occurs as

engagement develops and therapy progresses. My framework proposes that throughout therapy clients expand and retract their engagement and thus this is a fluid and iterative rather than sequential process. The framework I am proposing extends Thompson et al.'s (2007) understanding of engagement as building a task based and relationship based alliance, the latter being mediated by attachment anxiety. The framework provides a basis for understanding the client's concerns or anxieties about attachment as it is embedded in risks about safety and survival of the psyche and physical self. As mentioned previously it elaborates the central role of the client in engagement, rather than privileging engagement solely as a mutually built alliance. The proposed framework substantially expands Macey and Schneider's (2008) model of employee engagement by including negative as well as positive aspects in the state, trait and behavioural aspects an individual's engagement and by incorporating the individual's wider social context as an influencing factor.

5.3 Risks and Psychotherapy

The study highlighted engagement as presence of the self in the context of risk. The risks centred around three themes of inner turmoil and desperation for change, a leap of faith and concealing and revealing. The first theme illuminated participants' deep and lasting unbearable inner pain that threatened their existence. Desperation drove them to engage in psychotherapy as a last resort to preserve the self and improve their experiences of being in the world. The second theme elaborated that with so much unknown about the self, the therapist and the therapy, participants had to take a leap of faith that engaging in psychotherapy would bring about desired change. The third theme elucidated the irony that in order to secure their survival, participants had to expose negative aspects of themselves that had threatened their survival in the first instance. They developed a range of strategies to protect themselves by pacing their engagement. This section explores issues that elaborate understanding of the issue of client risk by drawing on literature on existential dilemmas, help-seeking, informed consent, the therapeutic relationship, trauma, shame and decision making.

5.3.1 Risk and Existential Dilemmas

The venture to engage in psychotherapy involved participants experiencing and navigating intense dreads and fears associated with annihilation of the physical self and/or the psyche. This issue resonates with key aspects of existentialism that focus on what are viewed as the inevitable challenges inherent in being in the world (Yalom 1931; Tillich 2000).

Yalom (1931, p.13) views human suffering as universal and contends that "the difference between normality and pathology is quantitative not qualitative." He views everyone as having similar existential concerns that arise from being in the world, thus they are both an inevitable and a perpetual source of anxiety. The anxiety that Yalom describes is in the form of fear or dread, and he attributes Kierkegaard with making a distinction between a dread that is associated with a specific object or source and a dread that cannot be associated with a specific object or a particular source. The former dread can be understood or located, thus there is the possibility of taking action that will decease or remove the fear. However, the latter type of dread is associated with existential issues, such as facing one's ultimate non-being, aloneness and the meaninglessness of life. These fears cannot be understood or located and the anxiety provoked by them can be unbearable. Yalom (1931) proposes that these dreads are managed by utilising defence mechanisms such as splitting parts of the self or repressing parts of one's experiences.

> These existential sources of dread are familiar, too, in that they are the experience of the therapist as Everyman; they are by no means the exclusive province of the psychologically troubled individual. (Yalom 1931, p.12)

Everyone experiences these dilemmas and those who experience psychological difficulties, such as the participants in the current study, are seen to be both particularly sensitive to the associated anxiety and unable to cope with it effectively

(Yalmon 1931). Thus, they are more easily overwhelmed by these dreads and rely significantly on defence mechanisms to manage their intolerable anxiety.

> It is the anxiety of not being able to preserve one's own being, which underlies every fear and is the frightening element in it. (Tillich 2000, p.38)

Tillich (2000), similarly, highlights the inevitability of death or non-being as the source of human anxiety and fear. He proposes that psychological difficulties can be understood as pathological anxiety. This is a "state of existential anxiety under special conditions" (Tillich 2000, p.65) characterised by anxiety in the absence of courage to affirm one's being in the face of non-being. He asserts that this state can evoke hopelessness and despair. Thus, in his view, courage is essential to cope with anxiety and in its absence the alternative is neurosis. Neurosis is viewed as limited self-affirmation, as some aspects of the self cannot be acknowledged, because to acknowledge them would imply non-being and evoke the intolerable anxiety. Thus, it is necessary that aspects of the self are hidden and defended against to protect from such intolerable anxiety.

> The anxiety which is despair is not always present. But the rare occasions in which it is present determine the interpretation of existence as a whole. (Tillich 2000, p.56/57)

Tillich (2000) views neuroses as protective mechanisms, however, he also cautions about inherent dangers and risks, as when life changes other anxieties must be managed. Paradoxically, in such changing circumstances, if the defences protecting the limited self break down the self is faced with utter despair, while if the defences are strengthened the self becomes more limited and restricted. Thus, there are risks involved in changing or maintaining the limited self. This was similar to the study findings whereby to do nothing was not an option for participants because it entailed the potential for deeper and more entrenched pain and turmoil. The findings illuminated that taking a leap of faith also involved risks and the outcome of the risks

were similar to doing nothing. Either way participants had to face the risks of losing the physical self or psyche.

> Courage always includes a risk, it is always threatened by non-being, whether the risk of losing oneself and becoming a thing within the whole of things or losing one's world in an empty self-relatedness. (Tillich 2000, p.155)

Although this is a summary of key aspects of Yalom and Tillich's works on existential dilemmas, these existential lenses provide a means for understanding the depth of inner pain and despair participants faced and how at times they came to view suicide as a viable option for bringing an end to their persistent, intolerable and painful experiences of being in the world. The despair and desperation participants experienced was intense and seemed all pervasive and centred on anxieties about non-being. These frameworks also provide an explanation of how participants were caught in a vicious cycle of pain, despair and inner turmoil until, driven by desperation, they took a leap of faith into psychotherapy, hoping that this would improve or end the pain of their existence. They took a chance and entered psychotherapy, and part of this risk entailed not knowing what would happen or what the outcome would be. Although doing nothing and taking a chance to act entailed similar risks, taking action at least held some possibility that participants' circumstances might change for the better.

5.3.2 Risk and Help-Seeking

The intensity and depth of despair that participants experienced was striking. Although despair has been linked with existential dilemmas (Yalom 1931; Tillich 2000) and deactivation and helplessness (Gilbert 2003), despair has also been viewed more positively as holding within it the desire for positive change.

> The underside of this distress [the individual's subjective pain] speaks to the patient's intensely urgent desire to experience

> more positive and subjectively satisfying ways of being-in-the-world. (Anchin 2003, p.335)

This view of distress as a double edged sword resonates to some extent with the findings of the study, which illuminates that participants were driven by desperation to seek escape from their enduring pain and to search for ways of making more rewarding lives for themselves. However, contrary to this view, the study findings suggest that participants were significantly more focused on avoiding persistent inner turmoil than obtaining more satisfying and rewarding lives. This may be partially understood in terms of the severe and chronic nature of the distress participants experienced that lead them into having contact with mental health services and receiving diagnoses of several mental illnesses.

Participants in the study were aware of the stigma associated with mental illness and hid the parts of themselves that could be associated with mental illness, including their involvement with mental health services, from others in their social networks. The literature has linked mental illness with social stigma and negative help-seeking attitudes and behaviour, especially amongst men (Cleary 2005; Galdas, Cheater and Marshall 2005; NOSP 2005; Rogers and Pilgrim 2005). In my study it is interesting that four of the five participants were men and the study findings contradict the above literature. Having accessed and engaged in psychotherapy, participants valued that it allowed them to address their psychological issues and to do so privately, thus protecting themselves to some extent from further stigma from others and also countering self-stigma by having their suffering and associated coping strategies contextualised and accepted within the therapy process. They also viewed the professional nature of the help as important, as they held expectations that the therapist would be helpful by means of their skills and competencies. Thus, the study highlights the limitations of nomothetic approaches to issues such as help-seeking and gender, as they do not take into account specific contexts or individuals and thus run the risk of perpetuating stereotypical ideas and exclusionary practices. Idiographic

approaches, on the other hand, such as the one adopted in this study, provide more relevant information applicable to individuals in specific contexts and thus can better inform local needs.

5.3.3 Risk and Informed Consent

Participants attempted to manage the risks of engaging by seeking out information in order to diminish the uncertainties and the unknowns. Participants wanted to know as much as they could about what psychotherapy was, what it would entail and what the outcome would be. However, this can be a challenge for therapists and it raises questions as to the place of informed consent in any endeavour that is influenced by multiple and interacting complex factors such as psychotherapy. Therapists have expressed dilemmas about how much information is useful and when and how it might be imparted to the client (Goddard, Murray and Simpson 2008).

Literature relating to informed consent highlights discrepancies between information that clients seek about therapy and that therapists are prepared to impart (Goddard et al. 2008; Jensen, McNamara and Gustafson 1991). Psychotherapists are frequently less interested in discussing risks and benefits than clients. This has been attributed to therapists' concerns that information about risks, such as treatment failure or the potential for further distress, could result in refusal of treatment in circumstances where therapists considered therapy would be in the client's best interest (Goddard et al. 2008; Jensen, McNamara and Gustafson 1991). Some information was viewed by therapists as difficult and elusive to share with clients, such as the experiential and relational aspects of therapy and that it was an evolving process. Practice guidelines for therapeutic approaches suggest that clients "should be made aware of this uncertainty" (British Psychological Society [BPS] 2008, p.5). The guideline proposes that at times it is unrealistic to provide detailed information and at times it is also undesirable and theoretically undermining to do so. However, how these issues are decided and who decides them, are complex ethical decisions that highlight potential areas of difference between clients and therapists.

Subtle issues involving the relationship between power and knowledge are implicit in decision making about informed consent. This links with the literature on stigma that indicates that certain populations are categorised as vulnerable and thereby less competent to make decisions (Corrigan and Watson 2002). Children are deemed a vulnerable group and Lambert and Glacken (2011) indicate that they are typically treated differently when it comes to involvement in decision making about their own care and treatment. There is concern about their (in)competence to make decisions and concern among those delivering interventions to take on responsibility to ensure their protection. There are other groups of people who are deemed vulnerable and similar issues apply; for example, those with mental or physical disabilities and those who are suicidal (Corrigan and Watson 2002; Moore and Miller 1999). Thus, it is important to sympathetically and critically consider the implications implicit in informed consent so as to avoid reinforcing and perpetuating stigmatising practises that hinder engagement, and to account for the significance of information as a mechanism for clients to manage the risks inherent in engagement in psychotherapy. Hill (2005, p.435) reports that in the absence of information, clients have to "intuit the therapist's rules for interpersonal engagement, what to talk about, and how to proceed", thus hindering engagement.

5.3.4 Risk and the Therapeutic Relationship

Erskine et al. (1999) propose that involvement takes place in the context of the therapeutic relationship and cannot happen without taking some risks. Being part of the relationship means being open to being impacted by the other person and this may be in a helpful or unhelpful way. They postulate that for clients this is a significant threat and a frightening prospect as it requires letting go of habitual defences, thereby risking the loss of self or one's boundaries. They propose that it is essential that therapists hold these boundaries when clients take such risk (Erskine et al. 1999).

This resonates with the study findings whereby participants were aware of the threat the therapist could pose to the survival of their psyche. Thus, they tested the

therapist's competence and skill in particular areas; their capacity not to judge or ridicule, their propensity to remain 'objective' while positioning themselves as an ally and their ability to respond helpfully and not become overburdened by the client. This study adds to literature in this area by highlighting the risks involved in engaging in the therapeutic relationship from clients' perspectives. The therapist is experienced as a considerable threat and clients actively test and manage the risk associated with the therapist throughout therapy. Clients have a number of strategies that they use to pace their engagement with the therapist in order to ensure their safety.

5.3.5 Risk and Trauma

Trauma theories provide a way of understanding the risks related to concealing and revealing negative aspects of the self. Unsavoury aspects of the self were too painful and unbearable for participants and threatened their survival. Experiences that are too painful or too unbearable and that are perceived as overwhelming one's ability to cope threaten the survival of the self (Rothschild 2000; Herman 1997). Such experiences are responded to as threats and result in activation of the protective fear system (Ogden, Minton and Pain 2006; van der Kolk 2006; Rothschild 2000; Herman 1997).

The fear system has been proposed to have three hierarchical lines of defence (Gilbert 2009; Ogden et al. 2006). At the most primitive level there are passive defences such as freezing or dissociating in the face of adversity. The next level involves active defences such as hitting, biting and kicking. The most sophisticated defences involve the social engagement system, utilising behaviours such as talking one's way out of trouble. Participants start therapy utilising primitive defences and by engaging they activate the social engagement system. The study highlights that participants, who perceive themselves as unable to cope with their level of desperation, create hope by placing their faith in the therapist and the therapy. In making these choices they generate a sense of control, which is associated with a developing sense of safety. Thus, engaging in psychotherapy helps deactivate the more primitive defences by initiating safety and then trust with the self, the therapist and the therapy process.

This in turn allows the more sophisticated and first line defence of social engagement to become activated. Thus, concerned about their own survival, participants built safety and trust and thereafter paced the therapeutic process to maintain their safety. This allowed them to engage more with the tasks of therapy, which required increasing disclosure to self and the therapist of hither-to-fore concealed and sometimes unknown aspects of their selves and their lives.

5.3.6 Risk and Shame

An alternative theoretical lens for understanding the risk associated with exposing or revealing hidden aspects of self was proposed by Gilbert (2003) in relation to shame. He views shame as an emotional experience evoked when an individual is nearer to the undesired self, which he distinguishes from being distant from the ideal self. Gilbert (2003) distinguishes between external and internal shame. External shame is experienced when an individual believes that he or she will receive a contemptuous or derisive emotional response from others and subsequently will be rejected or isolated, thus experiencing the world as a threatening place. Internal shame occurs when it is the self that has the contemptuous emotional responses and subsequent rejection toward aspects of the psyche. In order to protect the psyche from such unbearable outcomes, the aspects of the self or one's experiences that are believed to evoke these responses in others or in the self are hidden from view.

Such views resonate with participants' negative self-descriptions and palpable sense of self-scrutiny and self-disgust regarding their perceived failures and/or weaknesses in life and their fear of judgement by the therapist. It can be appreciated how such self-loathing can exacerbate shame. Viewing participants as experiencing shame also provides a way of understanding why they were more focused on moving away from inner turmoil and despair (the undesired self) than moving towards more satisfying and rewarding life experiences (the desired self).

Of particular relevance to this study, Gilbert (2003) hypothesises that psychotherapy can trigger and evoke shame as it inevitably involves awareness of and exposure to negative aspects of the self or one's experience.

> Shame motivates concealment but concealment inhibits the assimilation of negative information about this self and has detrimental effects. (Gilbert 2003, p.125)

From Gilbert's (2003) perspective everyone is motivated not only to hide negative aspects of the self but also to promote positive representations of the self. Thus, shame is related to one's own perceived self-value and requires self-awareness. This view resonates with participants' awareness of moving between concern with how the therapist might view and respond to them and concern with internal self-scrutiny and their own ability to see and be themselves. The study adds to this literature by highlighting that while participants had concerns about promoting themselves positively in their social networks, they were also able to overcome their tendency to hide negative aspects of themselves in the context of therapy, despite its capacity to evoke shame. The findings also illuminate that various mechanisms can be utilised by clients such as intellectualising experiences, emotional distancing or talking about irrelevant material, which allows them to pace the therapeutic process in order to safely manage exposure to shameful aspects of the self.

Additionally, as the concealment associated with shame is at times automatic and at times deliberate and shame itself intrinsically involves self-awareness, this suggests that pacing strategies are used either inside or outside the individual's awareness. They are used to assure the survival of the psyche by respectively protecting through concealment and promoting change through revelation of the self at an acceptable and tolerable pace. The use of defence mechanisms and avoidance strategies are frequently viewed as problematic or pathological (Lazarus 1983), whereas the study suggests that in the context of psychotherapy such processes may serve to preserve

the self and safeguard therapy. Thus, therapists are challenged to consider how they interpret such processes over the course of therapy.

5.3.7 Risk and Decision Making

Throughout the therapeutic process engagement involved participants navigating substantial decisions that carried with them interconnected risks and dilemmas. These decisions were made in the context of uncertainty and fear of failure that entailed the possibility of annihilation of the psyche and/or the physical self.

Current literature on decision making and risk is relevant to the study and helps to elaborate the issue of risk in psychotherapy engagement in more depth. This body of literature has been enriched in the recent socio-political context of the threat of terrorism to national security, particularly in the United Kingdom (Maule 2008, 2004). This has facilitated exploration about decision making in real life circumstances where risks are both personally relevant and potentially lethal, as in this study. In this regard, Maule (2008, 2004) highlights the role of personal perception and emotional responses in the assessment of risk and decision making. Two key aspects of his work help further understanding of how participants navigated risks and made choices about how they engaged throughout the therapy process.

First, Maule (2008, 2004) proposes that risk related decisions are influenced more by personal perception than by the likelihood of an event occurring and that such perceptions are influenced by how information about the risk related situation is perceived. He asserts that the crucial issue that influences decision making is whether individuals perceive the outcome to involve losses or gains. Decision making tends to be more risk seeking when losses are the focus of the outcome and more risk averse when the outcomes focus on gains. In this study, it is interesting that while participants hoped for desired outcomes their focus was more on the potential loss associated with failure. Thus, decisions that were seen to avoid making their situation worse were significant drivers for taking the risks involved with change and engagement. Hence,

despair and desperation for change could be understood as focusing participants' perceptions on what was at stake thereby facilitating risk seeking decisions and behaviours that were characterised by revealing and exposing aspects of the self. Maule's (2008, 2004) work also highlights that perception is influenced by how information is presented, perhaps pointing to how psychotherapy literature and information for clients could be presented in helpful and relevant ways in the context of the risks to be faced. This will be discussed further in the next chapter.

Second, Maule (2008, 2004) highlights that emotional responses shape decision making in risk related situations. Thus, individuals in such circumstances tend to make decisions based on what makes them feel more in control, even though this might actually increase their exposure to risk. In this study participants paced their engagement with themselves, the therapist and the therapy processes and this was important as a means of mitigating the risks of revealing negative aspects of themselves too quickly, yet ironically having a sense of being able to control the therapeutic process to some degree also facilitated them to become more engaged and to expose more of themselves thereby increasing risk. This idea also offers a way of understanding issues related to the known and the unknown. Participants, particularly at the initial stages of therapy, placed importance on having as much information as possible about the therapy, outcomes and the therapist and this can be understood as seeking to obtain knowledge to enhance their sense of empowerment, as ironically they realised over time that therapy is an interpersonal process that evolves and therefore is unpredictable from the outset.

5.3.8 Summary: Risk and Psychotherapy

Engagement in psychotherapy in a mental health setting is presence of the self, embedded in a context of risk of annihilation and mediated by intrapersonal and interpersonal issues and the individual's social context. The extant literature provides useful frameworks for considering engagement as risk.

Safran and Muran (2003), Tillich (2000) and Yalom (1931) provide a means of making sense of how participants experienced deep despair that drove them to try to do something to change their situation. Drawing on these frameworks also facilitates an understanding of the risks involved at the level of survival of the psyche and the physical self when profound change is sought. The literature related to informed consent (Goddard et al. 2008; Jensen, McNamara and Gustafson 1991) and the therapeutic relationship (Erskine et al. 1999) provides a context for understanding how participants managed the risks by seeking information and pacing therapy, in order to engage safely and ensure survival.

A number of theories provide frameworks for understanding the risks involved in revealing and concealing negative aspects of the self that influence engagement with the self and therapist the tasks of therapy (Gilbert 2003; Rothschild 2000; Tillich 2000; Herman 1997). In order for psychotherapy to progress clients must make some decisions, either intentionally or outside their awareness, about their willingness and capacity to face what they have experienced as a threatening world. The depth of fear and risk involved in either staying as one is or changing perhaps offers a way of understanding why some people do not attend or drop out of psychotherapy. In a threatening world, where clients have already experienced some form of injury to the psyche, safety is a primary concern. The extant psychotherapy literature does not provide a framework for considering how aspects of risk in engagement are interrelated and navigated, which this study provides.

5.4 Summary

A range of literature from the field of psychotherapy, mental health and beyond has been presented that resonates with and elaborates the issues of engagement and risk in psychotherapy. Engagement was experienced as the presence of the self in the therapeutic relationship, with issues of significance and importance, and in the therapeutic process. A number of frameworks were drawn on to help build an

understanding of engagement that accounts for how intra and interpersonal issues and contextual factors interrelate dynamically. Engagement comprises processes located in the individual and these interact with the therapist, the therapy and the client's wider social context.

Engaging in psychotherapy is a risky venture wherein the risks are personal, interpersonal and potentially devastating. Despair and desperation for change focus perception on further potential loss, activating risk seeking decision making and behaviours that in psychotherapy are characterised by increasingly revealing negative aspects of the self and one's experiences. The increased exposure to risk that this involves is mitigated by decisions and behaviours that generate a greater sense of control and these are characterised in therapy initially by seeking practical knowledge and thereafter by utilising mechanisms for pacing the therapeutic process and ironically enact more risk seeking behaviours.

Over time, participants in the study had concealed aspects of themselves that were too painful to live with and once they began to engage in psychotherapy they found themselves starting to reveal these parts. Ironically, psychotherapy required them to be present, as it was not a venture from which the self could be excluded. Engagement in psychotherapy required them to begin to show themselves and specifically to show those very aspects of themselves that had been hidden and limited in order to protect themselves. However, the risk remained that they would be overwhelmed and unable to cope with change, confronting them once again with the risk of failure and threat of non-being. Thus, from this perspective, the study echoes psychotherapy literature that highlights the client's role as active healer (Hubble et al. 1999; Tallman and Bohart 1999; Orlinsky, Grave and Parks 1994).

This study illuminates the magnitude and intensity of the risks that participants faced and this puts in perspective the enormity of the gamble they take when they engage in psychotherapy. Risks were present throughout therapy, even when an initial

engagement had been achieved. Risks in the three key areas (inner pain and desperation for change, a leap of faith and revealing and concealing) were prominent to varying degrees and at different times for participants. The risks were multidimensional, interrelated and complex and particular aspects of them shifted in and out of the foreground as participants navigated their way with themselves, the therapist and the therapy process. Thus, the study highlighted engagement as a complex and fluid intra and interpersonal phenomenon.

Reflexive Notes

Drawing on the extant literature has enabled me to appreciate the value of the study and what it has added to my knowledge. I realised in talking to my colleagues from the field of human resources that there were resonances for them in my findings and this prompted me to review literature in that area. It was exciting to discuss the findings with people in the field of psychotherapy and also with people from other fields, particularly as the findings make sense to others and resonance with their experiences.

Chapter 6. Conclusions: Moving Beyond the Study

6.1 Introduction

This chapter briefly summarises the key contributions of the study, the implications of it for psychotherapy and mental health practice and psychotherapy research and recommendations for policy and training. I also examine the strengths and limitations of the study, evaluate it using Yardley's (2000) quality framework for qualitative research and reflect on some of my own learning as a result of engaging in this study.

6.2 Contributions of the Study

The study contributes to the field of psychotherapy by highlighting that engagement in therapy in a mental health context is about the self being present in the context of immense and numerous risks. Engagement is a complex multidimensional and evolving process fraught with risks for clients. The nature and depth of such risks are profound to the level of one's non-being and this provides a basis for appreciating the extent of the risks clients take, given that the outcome is unknown and potentially devastating. The study provides a framework for understanding engagement as interrelatedness of intrapersonal, interpersonal and social contextual factors.

The study also contributes to the field by highlighting the central role that clients take in monitoring and managing risk and directing the therapeutic process. Clients undertake a significant amount of work to sustain therapy. They gauge and manage their own safety and adjust the presence of the self accordingly; for example, by utilising information seeking and pacing strategies. Clients in mental health settings have to navigate barriers to engagement that are inherent in the system. They have to manoeuvre their way around hierarchical power relationships and stigma that contribute to marginalising and objectifying them, so that they can risk exposing the self in order to achieve desired and lasting change. The study provides a framework for

understanding participants' experiences of navigating the risks inherent in engagement in psychotherapy.

6.3 Implications for Practice

The study highlights the complex and fraught nature of client engagement in psychotherapy in a mental health setting and draws attention to some key issues for psychotherapy and mental health practice across a range of domains. In psychotherapy these can be illuminated and addressed at different stages of the engagement process, from referral to termination of therapy as described below.

6.3.1 Referral

Desperation drove participants to engage in psychotherapy as a last resort. Although it is not clear at what point desperation becomes sufficiently intolerable to instigate engagement, what is evident is that it was a venture permeated with fear and this was rarely addressed explicitly by referring professionals. Sensitively naming and acknowledging both their level of pain and the risks of engagement may help validate clients' experiences and facilitate them to make sense of it and to prepare them for therapy. It may also help them be more explicit about particular risks and fears that they perceive and ultimately face as they traverse the therapy process, thereby instigating uniquely tailored therapeutic responses from the therapist.

The manner in which psychotherapy is presented to potential clients is also important. The study highlighted that apart from the practical arrangements of therapy there is much about the process that cannot be known in advance. However, the fact that it is an unknown process can be highlighted and the importance of engagement with the therapist and the tasks of therapy can be made explicit. The study suggests that giving information to clients at an early stage facilitates them to make an initial engagement.

6.3.2 Screening and Initial Assessment

Many psychotherapists, in an effort to streamline services and manage waiting lists, screen referred clients for suitability and readiness for therapy. Others meet potential clients to undertake an initial assessment to define therapeutic needs. These meetings are typically the first opportunity the potential client has to talk with a therapist. The therapist usually provides the client with some information about the service and the kinds of therapy available and practically what that will entail. Information about the risk entailed in psychotherapy and about how progress can be gauged provides clients with useful and pertinent information. The study highlights that opportunities therapists have through dialogue with clients to foster a sense of agency are important, as they enhance the client's sense of control. This supports the risk taking decisions and behaviours entailed in engagement in psychotherapy (Maule 2008, 2004).

6.3.3 Engagement throughout Therapy

The study suggests that clients navigate key complex interconnected risks that are more or less prominent at different moments and that this process is ongoing throughout therapy. The risks identified, relating to inner pain and desperation for change, a leap of faith and revealing and concealing, are multidimensional. Having an understanding of the complexity and fluidity of this process is important for therapists in deciding where best to focus their intervention at any given moment and to do so in a manner that facilitates client risk taking behaviours. Therefore, while full awareness of self and other can never be achieved (Carroll 1996), the therapist's reflection can assist him or her to be attuned to the inevitable ebb and flow in the therapeutic process.

Thus, while the study indicated that hope was important for participants, paradoxically it also pointed to the significant potential loss if therapy did not bring about desired change and if clients' defences are stripped away prematurely. Thus, therapists who

attend to instilling hope and who help clients focus more on what they have to lose rather than potential gains may better facilitate the risk taking involved in engagement (Maule 2008, 2004). This is a complex and sophisticated process for the therapist that involves balancing contradictory needs and strategies, such as instilling hope for improved circumstances, acknowledging risks, offering realistic information about the unpredictable nature of therapy and attending to fears and desires.

6.3.4 Evaluation in Psychotherapy

In psychotherapy there are many ways that can be considered to measure outcomes as the therapy progresses and at termination. Given the significant element of risk involved in engagement, the client's felt sense of safety and trust could be usefully incorporated to evaluate the success of therapy. If despair and inner pain are considered in the light of existential dread then perhaps fitting outcomes are reduced fear of annihilation, increased self-affirmation and enhanced courage (Tillich 2000).

Engagement in psychotherapy involved facilitating previously hidden aspects of the self to emerge. Thus, ways of noticing how these aspects of engagement become enacted in life could be incorporated more routinely into evaluation. My research has aimed to place client experiences and understandings at the centre of the study endeavour and this emerged as important for therapy also. Therefore, it is suggested that evaluation proceed along similar lines, with clients being considered experts in their own experience and as capable of contributing to the knowledge base for evaluating psychotherapy and treatment in general. Thus, the study concurs with the case for building on the emerging qualitative outcome studies to move beyond measurement of symptom reduction and incorporate outcomes that value the personal relevance and diversity of change that can occur for individual clients (Timulak and Creaner 2010).

Non-attendance, in the form of early termination and missed appointments, has been viewed negatively by therapists and is frequently associated with factors such as poor

alliance and motivation. However, it could also be interpreted as the risk being too high for clients to take at a certain point in time, whereby they skilfully pace the therapy and themselves to protect themselves. Such an understanding might influence the way therapists respond to such client behaviours. Based on the study findings, such events could be viewed as opportunities to extend warmth, understanding and validate self-agency and choice, which in itself can enhance well-being and may promote engagement in the future.

6.4 Recommendations for Training

Increasing awareness of underlying dilemmas that clients have about engagement in psychotherapy and beyond is crucial to therapist training so that such issues can be incorporated into his or her approach to and active involvement with the client from the outset through to completion of therapy. This study has highlighted that in the context of mental health, particular engagement issues arise that the therapist could usefully attend to in order to enhance the therapy experience and process. Thus, training might include modules that privilege clients' views and experiences of treatment and psychotherapy; for example, by inviting service users to deliver such training and by incorporating relevant literature based on user experience.

Training in psychotherapy could be enhanced by inclusion of theories that inform understanding of the role of fear and safety, and highlight the imperativeness of the security afforded by an attuned empathetic therapeutic relationship. Trainings across disciplines in mental health could usefully also attend to the issue of stigma, thereby anticipating and explaining normal human reactions to concerns that one might expect clients to grapple with in engaging with any form of mental health treatment. This can expand clinicians' sensitivities to the impact of these issues on engagement. Such awareness might also serve to challenge some taken for granted assumptions about therapist influence in unilaterally creating safety and managing the therapeutic process, as this study demonstrates that this is an intra and interpersonal process.

Training programmes that incorporate theoretical frameworks that help understand why psychotherapy may exacerbate risk (Gilbert 2003) and explain why sometimes the risk is too great for the client to take (Tillich 2000) can enhance therapist confidence in working with moments of tension in therapy. Knowing when safety is a primary concern can focus the therapist's intent and interventions towards reducing activation of the more primitive threat response systems.

6.5 Recommendations for Policy

This study highlights some of the challenges for users of mental health services in terms of stigma and hierarchical power relationship and thus raises questions about the constraints and affordances of situating psychotherapy within or outside mental health services. Thus, the location and context of providing psychotherapy for people with mental health issues needs careful consideration. Mental health policy that advocates psychological therapies be available to service users through local multidisciplinary mental health teams, for example *A Vision For Change* (Department of Health and Children 2006), need to consider if this creates an unnecessary obstacle to accessing psychotherapy as it requires a diagnostic label, which may be undesirable to individuals who may want to seek and indeed may benefit from psychotherapeutic interventions.

Clinicians in mental health services operate within professional guidelines that draw attention to ethical issues such as client autonomy and informed consent and justice; for example, how much information to impart. The trend in general medicine wherein patients are deemed entitled to know about the exact nature of their problem, the proposed solution and the likely outcomes may set an unrealistic precedent for mental health practices and psychotherapy. Imposing practices from general medicine on to mental health has been critiqued (Bracken and Thomas 2001) and this type of information about psychotherapy is not always available (Goddard et al. 2008),

therefore the issue of what constitutes informed consent requires consideration in collaboration with service users.

6.6 Implications for Future Research

This study was conducted in the context of a mental health service with participants who had a minimum of five years experience of severe mental health problems and suicidality. They had been involved with several psychotherapists from different therapy orientations over time, had attended psychiatrists, had multiple diagnoses and were on medication. Thus, the participants were typical in terms of high users of mental health services. Further research could usefully explore engagement with clients who are first time users of psychotherapy, clients whose problems are less severe and enduring and clients who have not been suicidal, in order to explore possible similarities and divergences related to the phenomenon of engagement as risk and to investigate more specifically factors that interact in the therapy and/or in the client's world that help or hinder engagement. Additionally, as most psychotherapy in Ireland is conducted in the private sector, it would be useful to explore the phenomenon of engagement among this client population as they may not have experienced the stigma associated with mental illness that participants in this study were exposed to.

It would also be useful to explore specifically the application of Maule's (2008, 2004) theoretical framework for understanding decision making in high risk situations and Macey and Schneider's (2008) theory of employee engagement, as a means of accounting for various dimensions of engagement and incorporating divergent approaches to researching engagement in psychotherapy.

Literature indicates negative help-seeking behaviours among men with psychological problems and suicidality (Cleary 2005; Galdas, Cheater and Marshall 2005; Rogers and Pilgrim 2005; Corrigan and Watson 2002). Additionally, the ability to name and process

emotions has been considered essential in psychotherapy and research has suggested that socialisation to the masculine role may limit men's experience and expression of emotions and this may be problematic in psychotherapy (Cleary 2005; Galdas, Cheater and Marshall 2005). The study findings diverge with the literature in this area and hence it would be useful to undertake more in-depth exploration that specifically seeks to illuminate gender and engagement in psychotherapy in specific contexts.

6.7 Quality: Strengths and Limitations of the Study

It is important to critically examine the strengths and limitations of any study and this has been done in a number of ways regarding this IPA study on psychotherapy engagement as outlined below. Based on the guidelines discussed in Chapter three, the trustworthiness and credibility of the study is described in the following sections. The quality of the study is evaluated later in the chapter using Yardley's (2000) criteria, as described in Chapter three. Finally, theoretical transferability of the findings has been outlined.

6.7.1 Strengths

A strength of the study was that it achieved its aim, which was to illuminate how clients experience and make sense of their engagement in psychotherapy in a mental health setting. The objectives were met as the study elaborated a number of key issues that influenced the level and nature of their engagement and highlighted resemblances and divergences in participants experiences of engagement in psychotherapy and in the broader mental health system, thereby producing an elaborate, comprehensive and complex account. Another significant strength of the study was that it illuminated novel aspects of the phenomenon of engagement. Thus, the depth of pain and despair was highlighted. The study also highlighted the enormity of the gamble that psychotherapy required. The study brought the issue of navigating profound risk to the fore, hence the study title of engagement as a risky venture. Finally, it drew attention to the centrality of client activity in managing risk and

directing therapy, and the barriers that those in the mental health system can face in engaging in a mutually collaborate therapeutic relationship.

6.7.2 Limitations

A possible limitation of this study was that although participants were homogenous in relation to mental health service expertise, they used the same mental health service and that context is likely to have a unique culture and idiosyncrasies that would not be similar in other mental health settings. Thus, organisational issues and clients' relationships with the organisation may have had a greater influence on participants' accounts than if they had been attending different services at the time of the research.

It is also notable that four of the five participants had experienced suicidal thoughts and two had attempted suicide. This may have influenced the findings as they perhaps experienced more intense despair and hopelessness than clients who were never suicidal. This may have fuelled a greater and more urgent desire towards change and their perception of the risks involved.

6.7.3 Validity of the study

Smith (2010) contends that establishing the validity of an IPA study is necessary and can be achieved in a number of ways, for instance, through supervision, description of the method and the reader checking for a coherent, sustained and evidenced analytic report. The latter typically demands that "each theme presented has been supported with sufficient extracts from participants to illustrate both convergence and divergence in how the theme is manifest" (Smith 2010, p.190). This has been demonstrated in Chapter four. Typical processes and components involved in an audit trial include the researcher's notes about the research question, the research proposal, transcripts of the interviews that include notes of analysis, draft reports and a reflexive journal as discussed in Chapter three.

There are a number of ways that an independent audit of these materials can be achieved and in this study several methods were used including regular critical feedback and review from research supervisors at each stage of the research process, discussion of data and my analysis at IPA workshops with expert IPA researchers and with peers, and discussion of emerging study findings with others working in the field of psychotherapy and beyond to assess potential impact.

6.7.4 Quality of the Study

The quality of the study was evaluated using Yardley's (2000) quality guidelines, which have been deemed appropriate for use with IPA studies (Smith 2011). The study has been considered under the four areas described by Yardley (2000); sensitivity to context, commitment and rigour, transparency and coherence and impact and importance.

6.7.4.1 Sensitivity to Context

Sensitivity to context involves giving adequate consideration to the uniqueness of the study topic, population and setting, and the socio cultural influences within which all are embedded, including the literature that informs knowledge in that particular area and the methodology that guides how the study is conducted.

Engagement was an area of interest to me for some time and since deciding to research it I undertook to explore different methodologies to find a fit with my aim of illuminating clients experiences of this phenomenon. This was facilitated through coursework, qualitative research workshops and research supervision. IPA emerged as the methodology most suitable and fitting with the aim and objectives of the study and it guided my decision making and positioning throughout.

This study incorporated a broad range of complementary and contrasting literature relevant to the area of engagement in psychotherapy situating the study in terms of what was empirically and theoretically known about engagement and identified my

preconceptions. It also attended specifically to the literature pertaining to the influence of mental health involvement, such as diagnosis, stigma and the possible (mis)fit of psychotherapy within the arena of mental health.

Awareness of the local context was demonstrated by my attention to and explication of the potential influences of being an insider researcher, psychologist and psychotherapist working within the research setting. I also gave due consideration throughout the research to the particular concerns of the study context for the participants and the organisation. These issues are demonstrated most obviously in the sections dealing with ethical concerns.

6.7.4.2 Commitment and Rigour

Commitment is about demonstrating an in-depth immersion with the topic and with previous knowledge and dedication to develop research skills in the particular methods used. Commitment was shown by a systematic critical review of literature that allowed me to make informed choices about the selection of relevant literature for integration, cognisant of the aim and objectives of the study and persistently following through with the methodology.

Rigor requires production of a completed account of the analysis that includes similarities and divergences. The rigour of this piece of work is best demonstrated in the detailed descriptions of the systematic approach adopted at each stage of the research study from development of the research question to presentation of the research report. The findings presented in chapter four are a comprehensive account of the data analysis that incorporates complex, interrelated, dynamic and multi-dimensional key issues into an integrated narrative.

6.7.4.3 Coherency and Transparency

Coherency requires that a persuasive account is produced. This was a challenge given the volume of data, the vastness of the extant literature related to the issues that

emerged and being both immersed in this while also repositioning myself to take an overview of all. However, the study has illuminated new aspects of engagement and added to existing literature in the area by noting the centrality of risk in engagement in psychotherapy in a mental health setting. The superordinate theme 'a risky venture' demonstrates coherency as in this study it operates as an overarching organising device, denoting the synergy and interconnectedness of the subordinate themes.

Transparency requires that all aspects of the research process are detailed with particular attention to the reflexive processes. Transparency was enhanced by provision of detailed accounts of the methods utilised to gather and analyse the data. The use of interviews as the main data gathering method required significant consideration, as it was important to distinguish between the research and therapeutic encounter, which was challenging when participants recalled painful events. However, being empathic and drawing on my considerable experience and expertise at engaging people in dialogue was useful alongside keeping my research agenda to the fore. This required training in research interviewing skills, preparation prior to each interview and external review.

The application of the data analytic method entailed making notes on individual transcripts (Appendix 8). Clusters of emergent themes, subordinate themes and the superordinate theme were mapped onto a table (Appendix 9) and relevant quotations were included in the text to provide a clear trail of analysis. Transparency was also facilitated by presentation of the findings in a manner that connected individual accounts through the use of selected quotations to my interpretations and the use of notes based on my reflexive journal.

6.7.4.4 Impact and Importance

The impact and importance of the research refers to its utility in relation to its findings. The research set out to gain understanding of the topic from the perspective of the participant thereby enriching and revising existing understandings rather than verifying

previous findings or existing theory (Elliott, Fischer and Rennie 1999). The current study illuminated the phenomenon of engagement in a way that has not been brought forth to date, thereby adding to the body of knowledge in psychotherapy. It highlighted that engagement was presence with the self and the therapist and this was a risky venture that involved navigating a number of key risks related to participants' inner pain and desperation for change, a leap of faith in the therapeutic process and revealing and concealing hidden aspects of the self. The study has detailed the implications of these issues for practice, training, policy and research, demonstrating the relevance of the study to the field of psychotherapy.

The findings have been discussed with psychotherapy colleagues who have found them illuminating and fitting with their experiences of working psychotherapeutically with clients in mental health settings. They have begun to consider how they can incorporate the issues of engagement as risk and its various dimensions into their work. The study has already influenced how I and some of my colleagues conduct screening, assessment and therapy sessions with clients, by explicitly including information about the therapy models available, about the way that we work, about the uncertainties involved in therapy and exploring and validating the client's fears, uncertainties, hopes and questions.

6.7.4.5 Theoretical Transferability

Although this study was conducted in a mental health setting the issues that arose can theoretically be applied to other settings. Engagement as a continuous process of decision making and managing risks about the potential gains or losses of being present in therapy can be applied to other settings, for example private psychotherapy or counselling, court mandated psychotherapy and therapy arranged as part of an employee assistance programme. The issue of engagement is also relevant for mental health treatment, general health treatment, and a range of interventions, supports or activities that seek to improve or develop the person; for example sports, meditation, yoga, hobbies and interests. These areas involve navigation of the intensity of

involvement of the self with the self, the task at hand and typically with at least one other person.

Having discussed the findings of the study with colleagues working in the area of human resource management, the concept of engagement as risk also has resonances with areas beyond psychotherapy and mental health, such as staff appraisal, performance management and mentoring programmes. It provides a deeper understanding and appreciation of the significance, complexity and interrelatedness of the risks involved for employees who engage in such processes. Thus, it has provided them with a framework for understanding the defensive positions that their colleagues sometimes adopt towards them, which from the perspective of this study can be framed positively as self-protection. This suggests theoretical transferability beyond psychotherapy and mental health.

6.8 Personal Learning

The study involved significant personal learning throughout and a number of key issues that stood out for me are discussed below. Significant learning took place for me by noticing the natural process of recursive knowing that occurred. This was a relief as starting the study I wondered how I would manage the hermeneutic circle. In doing this research study I was challenged to move from my previously more positivist approach to a more phenomenological approach. In doing so I became more aware of the interconnectedness of ideas and phenomenon and began to appreciate how language can be used to delineate and categorise phenomenon whereas I now see that language can be used to punctuate what is known and this carries with it a responsibility for me to look at how I punctuate my knowledge.

The study also impacted on my own understanding of embodied experiences. The research interviews impacted significantly on me and highlighted the different roles I held as a researcher and a psychotherapist. As a psychotherapist I realised that the

psychological and emotional impact of clients and their stories is partially ameliorated by a sense that I am in a position where I can help in some way. However, in my role as researcher this option was not immediately available to me. As I progressed through the various stages of the research I was challenged to avail of opportunities to engage in my own self-care as a researcher. While I could discuss issues with supervisors and peers, it was not enough as the impact of these experiences and my sense of helplessness felt caught in my body and required a physical embodied response. Thus, it became crucial for me to engage in sustained physical activity through the research process, which I did by going to the gym, walking, playing tennis and yoga practice.

The findings of this study have increased my sensitivity to the notion of risks inherent in engaging in psychotherapy for clients and the enormous and various fears they face. This has influenced my thinking about clients and I find myself more sympathetic and attuned to listening for this aspect of their story particularly when they are at the point of starting therapy and more ready to acknowledge, validate and hear their fears and concerns. The study has also impacted on my work with clients who have been in therapy for a while. I am more sensitive to the ongoing nature of risks they face inherent in the process of therapy and am more likely to pay attention in session to their sense of safety inside and outside therapy and to look at how we can manage to pace the therapy and the work they do outside therapy so that they feel safe enough to continue. I have learned that engagement as presence is as it is at any moment in time and it waxes and wanes for many reasons and that this movement is usual and at times it is a coping strategy.

6.9 Summary

This chapter identified the wide-ranging implications of these issues for practice, training, policy and research. It suggests that risk is mediated around a number of key issues to which referring agents, therapists and indeed clients need to be attuned in order to make therapy engagement a more real, collaborative and humane endeavour.

Although some theoretical literature has alluded to these issues, this study challenges us to rethink the therapeutic process, relationship and outcome as more influenced by client factors and the interaction between client and therapist and therefore as less influenced by the therapist and therapist related factors.

I also evaluated the validity and quality of the study demonstrating that it has met with the guidelines and criteria outlined by Smith (2010) and Yardley (2000). Finally I have noted how engaging in this study has enhanced my sensitivity to the issue of client engagement in a mental health setting as a risky venture and how this has already begun to influence my thinking and practice as a psychotherapist.

This study has contributed to the field of psychotherapy and mental health by illuminating the complex, dynamic, multidimensional, multifactorial and evolving nature of engagement in psychotherapy. Engagement in psychotherapy in a mental health setting can be construed as the risks of being present with the self, when facing the self and the therapist in the therapeutic process, as they recursively influence each other throughout therapy. The study highlights the precise nature of the risks around the drive for change that requires exposure of the self in a context of uncertainty and fear of failure. It elaborates the profound risk of annihilation of the psyche that enduring and persistent inner pain entails that engagement also necessitates. The study illuminates the extent of the leap of faith engagement in psychotherapy involves. The study also draws attention to the centrality of the client in managing the therapy process by navigating those risks and the sometimes subtle barriers to engagement in a mental health setting.

Reflexive Notes

I have been excited, energised and challenged throughout this research process. Ironically, semblances of the participant struggles are very much present in my mind as I bring this study and account to a close. Thus, having outlined some of the implications

of the study I am aware that this requires me to reflect upon how to incorporate these into my own practice and to disseminate the findings more widely.

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Appendices

Appendix 1: Recruitment Poster

Can you help?

My name is Maeve Kenny and I am doing a research study to find out about how clients engage and participate in psychotherapy. I would like to talk to people who have experience of being in psychotherapy in a mental health setting and who are prepared to talk about their experiences of engaging in psychotherapy. I am looking for people who have attended for at least 6 appointments so they have some experience of what it is like to be involved in psychotherapy.

What to do next?

If you think you are in a position to help or you want to find out more information please contact me by phone at ###### or ask you psychotherapist or mental health clinician to pass on your name and contact details to me.

Your participation will be confidential and will not be discussed with anyone else.

Thank you

Appendix 2: Participant Information Leaflet

Name of the research study: Clients' experiences of engagement in psychotherapy in a mental health setting

Who is doing the study?

My name is Maeve Kenny and I work as a psychotherapist and clinical psychologist at XXXX, XXXX in Dublin. I am studying for a doctorate in psychotherapy at Dublin City University (DCU) and this research is being done as part of my coursework. I have two research supervisors who are based in DCU: Dr. Pamela Gallagher and Dr. Mark Philbin.

What is the study about?

The purpose of my research is to get a better understanding of how clients in a mental health service become engaged in their psychotherapy and the kinds of things that help and hinder their involvement and participation. I am interested in finding out more about this in order to help professionals in the mental health services know more about how they can best support clients to participate and be involved in their psychotherapy. This is important because it makes positive outcomes more likely.

How can you help?

To understand clients' views about their involvement in psychotherapy I need to talk to people who have been involved in psychotherapy and in mental health services. I have displayed posters in the waiting area of the psychotherapy service and have asked my psychotherapy colleagues to bring this research to the attention of their clients.

What will it involve?

If you decide to participate I will ask you to meet with me to discuss your experiences of engagement in psychotherapy. We will decide between us what is the best time and place to meet.

I usually allow 1½ to 2 hours for the meeting so that there will be enough time for me to explain about the research and for you to ask any questions you might have about it. If you are happy to participate I will ask you for your permission to record our discussion so that I can concentrate on what you are telling me, rather than having to concentrate on writing everything down. If you do not want to be recorded I will keep notes of our discussion as we go along.

I will be asking you about your experiences of;

- Participating in psychotherapy and how involved you feel.
- What you think has been important in influencing your level of involvement and participation in psychotherapy.
- Similarities or differences you may have noticed in your level of involvement in psychotherapy and in other parts of the mental health system; for example, when you go to see your psychiatrist or mental health nurse.

What to do next?

If you think you would like to contribute to this research please contact me directly by phone on #######. If you are interested but still have some questions about what the study involves you can phone me to discuss it further. If you chose not to participate you do not need to do anything. If you prefer, you can also ask your mental health clinician or your psychotherapist to pass on your contact details to let me know you are interested in participating.

Participation in this study is voluntary. You can decide to withdraw at any time during the study without explanation and this will not affect the treatment that you get from the mental health service. I will not be informing anyone else in the mental health service about whether or not you chose to participate.

What are the benefits and risks in participating?

Possible benefits include:

- Having an opportunity to voice your views and experiences to an interested person, and identifying your current needs and wishes in relation to psychotherapy
- Having a part in informing professionals about what helps or hinders clients becoming involved in psychotherapy.

Possible risks include:

- Sometimes people get upset during interviews for lots of reasons and if this happens we will discuss what is best for you to do. This might involve taking a break from the interview, finishing the interview or if you would like I can contact a professional involved with you or someone else; for example, a family member or friend.

Who will have access to the information that you share?

After I have recorded the interviews I will type them out. I will not include your name or any details about you in the typed interview. Only I and my two research supervisors will have access to the interviews. During the research I will be taking steps to ensure that you cannot be identified and that the information you give me is stored safely and confidentially. All paper work related to the research will be kept safely in a locked cabinet in my office. The computer that I use to store the interviews on will require a password that only I will have so no-one else will be able to access your recorded interview. When I am writing up my research I will not use any names including the name of the service you attend.

Letters about this research have been sent to the psychotherapists based in XXXXX and the community teams and day services so that they know about the research. You can discuss it further with them if you want to.

Like other information you give to other people in the mental health service, there is a limit on what can be kept confidential. However, I will only break confidentiality in very particular circumstances; for example, if someone is at risk of being harmed, or to protect a child or if a court ordered that information be released.

Yours sincerely

Maeve Kenny

Appendix 3: Letter to Psychotherapists about Study

Dear colleague

I am conducting a research study exploring clients' experiences of engagement in psychotherapy. I need to interview clients who have attended at least 6 sessions of psychotherapy. I have placed posters and information leaflets in the waiting room and I would be grateful if you would point these out to clients who have been attending you for at least 6 sessions.

It is important for my research that clients do not feel unduly influenced to participate, so I would be grateful if you would point out the posters and then leave it up to clients whether or not they contact me. I am aware that sometimes it is difficult for people to pick up the phone and make first contact and because of this I have invited potential participants to give their name and contact details to clinicians they work to pass on to me. Some clients may be in contact with you about this. It is part of my agreement with potential participants that I will not discuss their decision to participate or not.

I plan to meet participants for one interview, which will last between 1½ to 2 hours. In my study I will not be using any details that may identify participants. In the interview I will be asking them about their experiences of engaging in psychotherapy, what they think has helped or hindered and how this is similar or different to how they engage with other clinicians in mental health. Although I do not expect the interview material to be distressing, it is impossible to predict what may be evoked in participants. In the event of a participant becoming distressed the interview will be paused while the participant's needs are addressed.

Thank you for your ongoing support and your assistance with this study.

Yours sincerely

Maeve Kenny.

Appendix 4: Poster to Terminate Recruitment

Thanks for helping

Just a brief note to let you all know that I now have enough participants for my research study about engagement in psychotherapy.

Thanks to everyone who took the time to consider taking part.

My appreciation to those who took time to meet with me and share their views.

Thank you

Maeve Kenny

Appendix 5: Letter to Psychotherapists to Terminate Recruitment

Dear colleague

Many thanks for your ongoing support of my research study. I have now recruited enough participants for my research and have concluded the interviews. Thank you for facilitating me to display the posters in the waiting room and for passing on information about the study to your clients.

Yours sincerely

Maeve Kenny

Appendix 6: Written Consent to Participate

Study Title: Clients' experiences of engagement in psychotherapy in a mental health setting.

Participant Confirmation: (Please answer each question)

Have you read or had read to you the Information Sheet?	Yes/No
Do you understand the information provided to you?	Yes/No
Have you had any opportunity to ask questions and discuss the study?	Yes/No
Have you received satisfactory answers to your questions?	Yes/No
Are you agreeable to having your interview audio taped?	Yes/No
Or Are you agreeable to the researcher taking notes of the interview?	Yes/No
Are you agreeable to further contact from the researcher?	Yes/No

Participant Signature:

I have read and understood the information in this form and the participant information leaflet. The researcher has answered my questions and I have a copy of information sheet. I consent to participate in this research project.

Participant's signature:_____

Participants printed name:_____

Researcher's signature:_____

Date:_____

Appendix 7: Semi-structured Interview

1. Tell me briefly about how you came to participate in this research about engagement in psychotherapy?

(Prompt – how did you find out about it? What did you think about it?)

2. What is your experience of engagement in psychotherapy?

(What does it feel like, look like, how do you know when you are engaged or not?

3. What ideas do you have about what effects how you engage?

(prompt - role of the therapist and client, what you do or are asked to do, what you avoid doing? Where did these ideas come from? Give some examples)

5. What was your experience of being involved, contributing and participating when you started in therapy?

(Prompt - How did you see yourself?)

6. What were some of the things that influenced you to get involved, participate, contribute in that way?

7. Did your experience of this change these ideas change over time?

7a. If so, what do you think influenced these changes

7b. How do you see yourself now in psychotherapy

(Prompt - How much and what kind of involvement, participation and contribution?)

8. What are you like when you go to the clinic/hospital/day centre?

(Prompt - In what ways is this similar or different to the way you are in other treatment setting? When you go to see your psychiatrist, CMHN?)

9. Is there anything that we have not covered that you think is important to say about engagement in psychotherapy or is there anything that we have touched on that you think would be useful to go back to talk further about?

Appendix 8: Interview Extracts with Analysis

This is an excerpt from my interview with Jim.

Emerging themes	Interview	Initial comments
	What was it about the different times that you've gone that has kind of helped you be more involved this time?	
Previous therapy. Beneficial or maintaining status quo? - Known/unknown. Knows: Needs more than support. Outcomes unknown. Not knowing. Blind faith. Hard to make sense. Active. Misery. Need to know/make sense. Found something useful – knows it. By chance. Knowing increases over time. Enduring, life-long. Need to know. Persistent across identity, behaviour, emotions. Worthwhile, meaningful, self	Its two things. It's the type of therapy for a start because the previous types of therapy, although they were a support at the time, seemed to be only concerned with delving into my deep past and my childhood, which is fine, but I was finding it very hard for a long long time to make any connect between that and the fact that I felt depressed today and the fact that I was finding it difficult to get up in the morning. It's hard to make the connection between the two and I had to have blind faith that if I dug around in the past for long enough I might be able to come up with something that would help me understand why I'm as miserable as I am today. There was many times when I was just as bad going into those situations as I was going into this situation but the difference is that I discovered CBT first of all and wanted to approach things in a CBT style. I'm older as well I'm a bit more… my first depressive bout was when I was about 16 or 17 so that's 20 years of kind of trying to find out why I behave the way I do, how I am the way I am, why I feel the way I do for 20 years. And only in the past two or three years have I really discovered proper meaningful tools for helping myself and I put that	Knowledgeable. Wants more than support, not what he needed, too much delving. No connections - understanding is NB. Debilitating. Blind faith, digging around, chancing, believing, hope, searching. Needs to make sense to himself - Understanding is important. Self-agency is important - he discovered CBT, by chance, years later. Maturation. Enduring, persistent, commitment. He is persistent his problems are persistent. Change has occurred. Has skills, tools to use himself – got that from

agency, independence. Unknown, magical therapist. Competence/skill. Making connections – knowing the unkown. Honesty. Revealing. Ambivalence. Reluctance. Irony of therapy. Knowing and doing what works. Exposing self – revealing. Involved, honest. Reluctant. Help-seeking. Irony of therapy. Revealing self. Concealing. Shame. Depth of fear. Relationship with self. Change and faith linked. Change/progress is important. Hope, faith.	down primarily to the psychotherapy service definitely. **That combination has been important?** I don't know how (therapist) does it. It seems like magic sometimes but (therapist) has the ability to directly link experiences as a child with ways that I currently think still. **And do you think that you contribute to that ability that [therapist] seems to have?** I think I contribute to it by being honest first of all. I think that you have to be able to go in there with the feeling even if you might... there's plenty of weeks when I just did not want to go in actually but I'd know that I'd feel worse if I didn't go. You go anyway and I would frequently start with the line 'I really don't wanna be here' because if you're completely honest from the word go that's your best chance of getting help. And you might say things you really don't want to say, like there's times when I'm gonna just say this because it's how I feel or it's what my deep down fear really is or something like that. For whatever reason you really don't want to say it to yourself. It's embarrassing, you're mortally afraid of it or whatever. So first of all being honest and secondly, oh I don't know it's kinda hard for me to have faith in a process unless I actually see results of it. That's one of the reasons I had faith in this because I did see results earlier on. Because of the way I think, I was constantly leaving with	therapy. Unknown, magical. Desperation. Therapist role. Takes a chance. Hard sometimes, push yourself, requires faith. Doesn't want to make things worse. Decisions and choices. Shares experiences. Have to do what you don't want to. Exposure to self. Honesty will get you places but don't want to do it. Deep fear, risk of overwhelming self. Wants to hide self from self. Embarrassment, shame, Mortified of self. Have to see results. Faith builds over time.

Self scrutiny, judges self. Desperation for change. Driven. Self-agency. Faith in therapist. Takes a risk. Self perception evolves and relationship to self changes. Faith in self, therapist, therapy develops. Proof. Short and long term goals. Values self. Move away from inner pain. Self-agency. Values it. Self important to self. Driven in life. Commitment. Life-long process. Not to blame. Knows what needs	the thought that ok I've made some good progress here and I've come to a few good conclusions here and I have to write them down. I have to go home and save these somewhere or else I'll forget them and (therapist) began to suggest that you don't have to, you will remember these things. This need to kind of save things and record things and write them down isn't really necessary and that also lets you off the hook and you feel that you know you have more faith in yourself that you remember these things and you're kind of good to yourself because of that. **Tell me more about those kinds of early changes that you noticed and how they were related to engagement?** Well it convinces you pretty quickly that what you're doing is quite important and that the effort is a means to an end. Feeling better at the end of the day is your goal and feeling better long term is your goal. So you start to go, well hang on if this is a quite important element in my life now I need to put as much effort into this as my job or my you know relationship or you know my friends or whatever like. It's a core element of my life now and it's something that needs constant attention, just like all the others. For me anyway it's not something I'm going to do for a year and then go off and learn guitar you know. It's a life-long process for me 'cause I genuinely believe that there are people out there who didn't really get what they needed to give them a solid foundation in	Monitoring progress. Takes it seriously. Afraid of losing progress. Active Takes direction from therapist, trusts and tries out things. Takes a chance. Off hook – more faith in self – more control / influence. Active role, more compassionate to self. Wants to feel better – feels awful now. Takes it on. Effort. Job, duty, mission in life, commitment, effort Has resources. Core – central. Constant basis. Life-long, mirrors enduring pain. Knowing does not make it easy.

to be done. Psychological perspective / understanding. Faith. Recovery possible. Values self. Duty to self. Scrutiny from others. Dependence v self-agency. Belief about life. Loss of control, fear. Pervasive. Depth of fear immense. Inner pain. Desperation drives to seek help. Desperation - will look anywhere. Committed. Matter of life/death. Unknown process. Faith in therapist - Trusted stranger Ways of pacing self - safety.	themselves and they will spend the rest of their lives trying to look for that or rebuild it. That's no tragedy really if you look at it like it's my job to give myself a lot of the things that I didn't get when I was younger and it's worth it. **Ok I'm curious about that. Do think other people in psychotherapy think like that? Or what is it about you that you think this is what your job is?** I think one of the things that's been said to me is that I have no problem with asking for help and that's because one is my mindset is that surely if you know how to do something and you apply yourself you'll figure it out but secondly depression in particular scared the hell out of me and still does scare the hell out of me - what's it's capable of doing to you is very very frightening so it's no stretch to me to turn to the people I love the most and ask them for help or turn to professionals and ask for help or try and get help from absolutely any source that I can possibly get it from. I think I approach it frequently like too hard. I go at it too hard like it's a business plan for a business that my life depends on or something. That's one of the things that [therapist] has helped me understand that this is more of an organic process and not a business plan (laughs). That it's possible to learn these things but not have to kill yourself learning them.	Tragedy – level of disaster he faces. Childhood adversity. Blame outside self. He's worth the effort. Seeking help – what outcome? Doesn't know what to do. Helplessness, has to depends on others. Depression – bigger than self, pervasive. Depth of desperation and pain. Do anything to survive it. Dependence vrs independence. Understands self. Business – venture is about survival. Organic process, can't be predicted, takes its own time, no control, Solution could become part of problem.

This is an excerpt from my interview with Ann.

Emerging themes	Interview	Initial comments
	What ideas did you have about what you wanted to achieve?	
Knows what she needs. Information to help choices. Lack of direction / control /collaboration. No explanation / understanding. Can't see the point. Unknown. Her expertise / knowing not included/valued. Undermined. Some knowledge about different types of therapy. Therapist involved, client involved.	What I really needed I think was... to talk as well, but this is your aim for this week and if this person calls are you going to behave like this, are you going to let them in? And even if something had happened I could come back and say that I feel bad about it. But I didn't achieve that and we could talk about it and talk around things. But that is what I needed I think. I don't know, I can't see sitting in a room with someone maybe for an hour or an hour and a half, I mean just kind of talking and it doesn't seem focused. Like if you said something and somebody would say something like, 'did that upset you or were you expecting that to happen,' or things like that, but when it is just free flow talking. I kind of feel like I would never go into psychoanalysis, I would feel like bloody Woody Allen having psycho analysis on standby. I mean psychoanalysis for hours every day? **What was your involvement like with the different therapies or therapists? How would you describe it?** Involvement, right, I felt equally involved with [first therapist], I felt she was involved with me, right, some of them people up in [private therapy centre]....now don't get me wrong there was probably more coming from my side as the sessions went on.	Knowing what she needed. Not getting it. No space to ask. Lack of agency. Lack of collaboration. Structured. Practical. Help to work things out. Practical focus. Going around in circles, missing the point. Wants focus, direction, active therapist. Knows what she needs. Uncertainty as it's not what she gets. Talk needs direction. She needs direction. Frustrated. Some things she wouldn't do. Mutual. Has had positive experience of engagement. Gave up. Desperation.

Lack of agency. Kept going despite lack of progress. Lack of commitment. Passive. Poor fit. Misunderstood. Concealment Needed to see some progress. Talking not meaningful. Disconnected from self, therapist, therapy. Agency. Responsibility. Recovery. Active. Positive experience. Obvious progress. Understands progress isn't always feeling better. Evaluates own progress. Confusion about therapy. Lack of knowledge. Lack of connection. Unknown. Lack of trust. No choice.	I was not involved. And I was just talking and one person asked me to bring in pictures or something belonging to my husband, that was a kind of involvement but I didn't want to do that at the time. But I wouldn't say because I didn't feel things were going somewhere, like I wasn't really involved. Like when I was there I was just talking, I didn't actually feel involved. **What did it feel like to be involved? What is that like? Can you describe it to me?** It is kind of like you are taking control of your own life. You are playing a part in your own life. I am looking for words here... **Sounds like it's hard to describe, take your time, that is what I am interested in**. Well I would feel when I'd walk away and say, that was good. Now by the time I go back next week I will be able to say what I have done. And even if I had left the session feeling low, that wouldn't stop me going back because maybe it was good for me to bring up them things. But sometimes I felt disconnected from what the therapy was and I was confused. You know the lady explained to me there is this form and there is that form and there is this form and that form. Well I never knew what form I was getting. **And when you say disconnected?**	Despair. Noticed lack of involvement. Some involvement not welcome. Not the right time. Didn't feel able / willing to say anything. Angry. Confused. Didn't make sense to her. No direction. Jarred / misattuned. Can be there in body but not emotionally / psychologically.Control. Assertive. Self - agency. Power. Active. Empowerment. Responsibility for self. Can make things happen for herself. Sees progress. Progress is important regardless of mood. Sees progress can trust the process. Has own sense of progress – markers of change. Lack of information. Confusion related to disconnection.

	I'm not really sure..... **Was that maybe disconnected from yourself when you were there? Or maybe disconnected from the person you were with or disconnected from something else?**	
Presence with self and therapist. Lack of agency. Self-scrutiny. Concealment of self from self and therapist.	Sometimes disconnected from the person I was with. Sometimes disconnected from myself. I don't mean that in a sort of a mental way. I would have been sitting in a chair watching me talking...I would feel my voice was here talking to this person but over there was the real me just sitting down just watching all of this. **So like not really there?**	Disconnected from therapist and self. Notices disconnect and maintains it. The real me looking on.
Confusion. No map. Lack of trust. Knowing what she needs. Lack of assertiveness / agency. Misattuned. Lack of continuity with therapists. Disconnected. She was not valued. Disconnected. Reacted negatively. Help – seeking negatively impacted. Disappointed.	Yes. And like I said all I would be doing would be talking and jumping from one subject to another. And I think at times I would have needed to be grounded and pinned down, you know, do you want to talk further about that or whatever? And now and again I felt getting changed from psychotherapist to psychotherapist and another psychotherapist didn't help and that was how disconnected. When I cancelled that last appointment at [therapy centre] it was months later I said to myself "oh I never rang them up and told them I'd be back" and that is not like me. So I was disconnected. **And when you were starting psychotherapy again this time, did you come in with any ideas or did you start off with any ideas about**	Lack of direction. Confusion. Wondering if / how this is helpful. Knows she needed something else. Unable to say it. Lack of agency / assertiveness. System not taking care of her. Swapping and changing. Let down. Gives up. Not her usual self. Impacted by her experience of therapists. Lack of follow though by therapy centre.

Hope. Knew what had worked for her. Knowledge about therapy model and what suited /benefitted her. No choices. Passive. Lack of assertiveness. Lack of agency. No trust in self. No answers. Magical. Therapist skill. Knows what needs to be done. Needs more from therapist - specific information about therapy and what to expect.	**how you would get involved in it?** Well actually I was very pleased when they told me there was a psychotherapist in the service here that could see me. I was hoping it was my first therapist but it wasn't. But I kind of think now there was a notion I was going to be doing cognitive behavioural therapy again but then it wasn't. And I don't know how many sessions I have had with my therapist and I have yet to ask her how does this actually work? It sounds strange, but fair play to her, sometimes she just picks up on things I say but I think what I really need is for somebody to say, "you see this is the sort of psychotherapy you are getting, this is how it works and this is the way it works and this is the way we hope it works." Because at this stage I don't know how it works, I don't know why it works, you know.	Attached to current therapy centre. Pleased to be reconnected there. Disappointment. Knew what she wanted / needed. Passive. Knows what she needs to know. Lack of assertiveness. Lack of agency. Has questions she needs answers to. Lost in not knowing.

This is an excerpt from my interview with Dave.

Emerging themes	Interview	Initial comments
	What is therapy like now?	
Fear. Commitment. Active. Revealing self. Safety strategy – avoidance. Concealing / pacing. Engagement took time.	I am still frightened. This is now six months into psychotherapy with [therapist]. I have been every week since October bar three, two for Christmas and one for illness, so I have been every week. I do open myself up and I do talk and I say how I feel, if that is engagement then I feel engaged. In the beginning I was going in and I was skirting around the edges and I was thinking I'll just talk about the weather or talk about this and then the hour will be over and that will be great.	Frightening – even after initial stages. Serious. Commitment. Invested. Remembers details. Doesn't miss therapy lightly. Exposes feelings. Exposes self. Passes the time. Took time. Changed over time. Means of avoiding.
	So you were skirting around the edges...?	
Ambivalence. Procrastination. Keeps self safe. Pacing. Known – shared strategy. Control. Agency. Power. Overwhelming. Terror, fear of the unknown process. Progress unknown.	I was just buying for time. It is like you have got an essay to write but you find housework to do first. I was like that initially in psychotherapy and maybe sometimes when I am feeling a bit vulnerable I still do that in psychotherapy. I kind of skirt around the edges. The therapist knows now, she steers me away from doing that kind of thing. But it is because I don't want to face the reality or I don't want to face the pain or I don't want to bring it back up again. So she explores different ways. So if that is engagement, then yes I do feel I have engaged with this process. I still have trepidation, fear, I am scared of the process, I have a lot of anxiety about the whole process, even now. Not	Putting off the inevitable. Buying time for what? Personal style or anticipating what's ahead.Avoidance still used – ongoing. Mutual, shared, common knowledge. Reality coupled with pain. Actively trying to avoid revealing and confronting. Fear of being overwhelmed by own experience. Dread. Terror. What will it entail? What will happen? Will it work? Doesn't want to make things worse – retraumatisation. Is it / I

Faith. Unknown process. Risk. Facing self and experiences more frightening than unknown of therapy. Expects change. Self agency. Important. Choice. Agency. Driven. Evaluates progress. Expectation / desire for change. Engagement – fuller life, living life as it is. Facing the past and accepting it. Shared endeavour. Engagement is with heart and head of the self. Known / unknown. Therapist skill / competence. Unknown - magic. Safety. Shock that it might take longer than expected. Resignation.	about it working but about just bringing it all back and rethinking it all again and trying to make sense of it all. That is the really frightening part. But I have forced myself to keep going every week with this belief that, and my belief has changed in the sense that my initial belief I think I said was that I would come off all medication after psychotherapy. Now I kind of have realised a bit since then that maybe I will never come off my medication but that is fine. Well it is not fine, I want to come off my medication, I don't want to be on medication but I might have to accept that that is going to be the case. But if I can have a fuller life and if I can accept what has happened and live with that rather than letting it bring me down, that is when I am engaged. **Tell me more about your engagement? What does it feel like to be involved?** It is a very difficult question to answer. I go for psychotherapy, I get asked questions and I see how I feel and I see it from my heart how I feel and not just my head. So I do feel that I don't go with any prior agenda to the meeting, I go, now there might be thoughts in my head or things I might think about, well we should talk about that or we shouldn't or what about that? But I kind of go in and the psychotherapist has a way of turning it around so that it is safe so you can go there. But it is still early for me, six months is not a long time and I was quite shocked because I thought in six months of psychotherapy I'd be right	worth it? Expectations – making sense of his life. Driven. Has outcome in mind. Facing it is frightening. Forced self. Expectations of change evolve over time. Progress = acceptance, fuller life and living life. Coming to terms with the past. Moving on. Reflective. Thinks about self and situation. Collaborative. Heart and head. Preparing. Some unknown and known is acceptable. Therapist turns it. Therapist does something unknown. Safety is important.

Acceptance. Expectations adjusted. Self agency. Active. Collaborative. Therapist reassures – trust, safety, understanding. Facing self. Critical self. Black or white. Self-scrutiny. Dislikes self. Way of being is problematic. Making sense - knowing is important. Making connections between past and present. Revealing self. Enlightened. Control. Power. Agency. Realisation. Engagement is about understanding. Tasks of therapy.	as rain but in actual fact I am looking at 18 months to 2 year of psychotherapy. **And is that something that you have discussed?** Well I think she brought it up but it was kind of me prompting in a sense of I am looking for a quick fix and she is reassuring me that it is not a quick fix, it is a process and it is about assimilating all the information. And it is about then being comfortable with yourself. I mean I am very critical of myself and very, you know for me it is success or failure, there is nothing in between and all of that is very hard to acknowledge in psychotherapy, which is why it probably will take time. Because what I have found is in these six months is that really what happened in the end, in a sense the breakdown and admission to hospital was just a cumulating of my life and the way I lived my life. And this extreme success or this extreme failure in everything that I do and the perfectionist streak in me. So it is very enlightening for me to finally... it is almost like a jigsaw for me, which started to fall into place that I thought I would talk about trauma and then that would be it. Now I realise that everything has to be put together as a picture and then you start to go that way. So I feel that is me being involved and psychotherapy is helping me to understand myself better as a person and understand what motivates me and understand what drives me as well. There is also a healing aspect to it as well, which is	Collaboration. Unrealistic expectations about time frame. Expectations have changed. Expects himself to be 'better' right as rain. Mutual – responsive. Explicit discussion of timeframe and expectations. Wants quick fix. Understands it's a process. Have to face self and be comfortable. Revealing what he is like. Takes time. Making sense of his experiences. This is important. Sees connections. Extremes of being in the world. Perfectionist. Making connections / making sense is enlightening. Quick fix. Expectations changed of what would be required. Therapy helps understanding of self. Healing – spiritual, growth. Confession. Magical – unknown how it works. Goes beyond rationalisation –

Driven. Magical. Unknown. No explanation. Honesty – facing self and therapist. Revealing self. Anxiety – comfort. Safety allows novel to be explored. Trust in therapist. Ally. Faith in therapist. Accepted by therapist. Trust therapist strategies. Choices. Control. Active. Agency. Strategies. Agency. Assertiveness. Choices. Too difficult. Facing the pain and anguish. Giving up on concealment. Having / being in control. Learning how to do it – pacing. Managing uncertainty. Pacing is safety.	really nice. It is a bit like going into confession. **How do you think that happens, the healing?** The healing helps because I am honest in the session. It does because if I go into a session and I am anxious about something or I am thinking about something there is something very nice about feeling safe to talk to someone that you have never been able to say to anybody else before and that you are not going to be judged and they are going to look at the whole picture rather than whatever. And also when being asked a question, I could do two things, I could avoid the question... I could probably do two or three things, I could avoid the question, I could deflect the question, I could half answer the question or I could say, no I am going to say what I think and I am going to say what I feel and I am going to see where it leads. Now sometimes that is really hard to do because you start off down the road and you start to feel the anguish and the pain and you want to stop and you want to go back and you are allowed to do that. Whereas other times you want to continue. So it is nice because I feel I am able to dip into something, to touch the water, see what it is like, explore it and just be aware of it and then come out without yet truly actually understanding the whole process or what is going on. But just to be aware. Like for me, the awareness in my life, which is what keeps me going in psychotherapy, is	experiential. Honesty is important. Anxiety. Trust. Safety. Comfort. Confronting self. Facing the previously unsaid. No judgement. Looking out for you. Strategies: avoid, deflect, half answer. Honesty. Pain is scary and off-putting. Have choice. Sometimes stop sometimes go forward. Important to have the choice and control. Pacing is comforting. Takes time that's ok – feels safe. Things start to unravel / reveal themselves in time when he is ready.

Important to feel ready. Self-scrutiny. Ways of being in the world. Extreme – problematic. Understanding / compassion towards self. Agency. Action. Change. Divergent views but can work with this. Trust. Confronting self. Trusting the therapist. Trusting the process. Dealing with the in between – uncertainty / unknown. Revealing brings relief and pain / hurt. Regret. Facing responsibility for situation and self. Engagement as participation with self and life.	this success and failure in my life. It has been one extreme or the other. Whereas that is not the case. And I think that that for me, that is a healing part as well, to understand well how did you get like that, why do you think like that? And at the moment for me it is about what can I do about it? For the therapist it is more about just be aware of it, we will worry about what to do about it later. But just become aware of how you think and how you feel on certain situations and today's psychotherapy session was about this feeling of failure, success and nothing in between and all of those issues. And what she is saying is just be aware that you have these thoughts, that this is how you react, this is how you cope in situations. And I think that that it is a relief to kind of understand what makes you tick, what makes you think that way. But it is also quite painful as well because then you have things like regret and you could have done it this way, could have done this, could have done it that way and it's not just regrets, it is about the whole thing of if I hadn't been so extreme I could have enjoyed life better, could have participated in life rather than just being driven.	Awareness is empowering. Healing to understand how and why he is like this. Empowering to feel he can do something about his situation. Different agendas. Different timeframes. Socialisation to therapy? Trusts the therapist's view of how change can happen. Being in the world is affected. Shame, guilt. Relief = understanding. Doubled edged sword. Sees how he has contributed to his painful situation. Implicated. Responsible. Made the wrong / unhelpful choices. Painful. Loss. Regret. Lost out on life. Was disconnected / disengaged from life.

Appendix 9: Master Table of Themes

Superordinate theme	Subordinate themes	Clusters	Emergent themes
A risky venture	Inner pain and desperation for change	The black pit	*Depth of pain. Darkness. Despair. Unbearable. Unwell. Turmoil. Terror. *No way out. Hopelessness. Darkness. Helplessness. *Never changes. Persistent. Endurance. *Absence of life/living.
		Getting off the merry-go-round	*Do anything. Good or bad. Risk. *Change imperative. Last resort. Confusion. What to do? *Self-agency v help-seeking. Last resort. Control. Commitment. *Instant relief/longer lasting.
		A matter of life or death	*Survival. Suicide. Last resort. Out of options. No-win. Do or die. Risk. *Overwhelming. Shame. Loss of self.
	A leap of faith	Dealing with the known and unknown	*No answers. Outcome. Harm. *Making uninformed decisions. Choice. Commitment. Uncertainty. Self-agency. *Safety. Faith/hope. (Dis)Trust self. *Unpredictable. Dangerous/Risky.
		The trusted stranger	*Unknown. Burden/worry. *Misunderstandings. Re-enactments. *Magic. Competence/skill. *Trust. Faith. Risk. Compassion. Helpful. Ally. *Takes time. Reading responses. Testing.
		The dreaded stumble	*Strategies. Mixed blessing. *Fear. Surprise. Trust. Faith. *Exposure. Unpredictable. Risk.
	Concealing and revealing	Hiding from self and other	*Shame. Loss. Terror. Dark side. Dangerous/risky. Confronting self. *Ridicule. Rejection. Past experiences. *Self-agency. Failure/devastation. Success. Protection.
		Skirting around the edges	*Various strategies. Pacing. Avoiding. Thinking. *Vulnerable. Protecting. Able. Willing. *Exercising choice. Control. Self-agency.

Appendix 10: Demographic Information

Name:

Gender:

Age:

Marital status:

Work status:

Length of time in current therapy:

Number of previous therapies:

Types of therapy received:

Length of involvement with mental health services:

Usage of private mental health services:

Diagnosis:

Suicidality (ideation and/or suicide attempt):