

When one size doesn't fit all

The discursive construction of short contract counselling in
an Irish third level college

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Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctor of 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.

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Abstract

The discursive construction of short contract counselling in an Irish third level college

This study uses a Foucauldian discourse analysis methodology to explore the discursive construction of student counselling in general, and short contract counselling in particular, in an Irish third level college. Short contract counselling is defined as a small standard number, usually no more than six or eight, sessions of counselling which is offered at the outset to most student counselling clients. This is a widely accepted but little researched model of delivery in student counselling. This study seeks to understand the discourses involved when student counselling and short contract counselling is spoken about. It explores the operation of disciplinary power and how the effects of the short contract model operate in practice.

Thirteen students who had been offered more than the standard number of six sessions were interviewed. This group, who do not fit the 'norm', were selected based on the Foucauldian notion that it is at the margins of a phenomena that the elements which contribute to its social construction become more visible. A focus group was also held with student counsellors.

Participants drew on a number of discourses which included stigma, risk, recovery, consumer rights, professional knowledge, managerialism, productivity and surveillance. Different positions were adopted in response to these discourses. For clients there was oscillation between the position of being dependent and stigmatised and inhabiting the discourse of a rights based entitled consumer. For the counsellors the positions adopted moved between the role of the expert to one of being influenced by a protocol driven managerial discourse of accountability.

The discourse of productivity with its emphasis on promoting a rapid return to academic functioning suggests that student counselling functions in a Foucauldian sense, as a disciplinary practice. These developments suggest the increasing penetration of a neoliberal agenda into the sphere of student counselling.

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Chapter 1 Introduction

This thesis investigates short contract counselling in an Irish third level college. Short contract counselling can be found in many settings including the community and voluntary sector, employer provided Employment Assistance Programmes, and in Counselling in Primary Care (CIPC) the national programme funded through the Health Service Executive (HSE). For the purposes of this study the term short contract counselling refers to a standardised offer of therapy in student counselling services. It is common practice in third level student counselling services to offer the student a standard small number of counselling sessions (Wolgast et al. 2004; Hallett 2012). According to a Higher Education Funding Council for England (HEFCE) commissioned report the number of sessions offered in the majority of the universities covered by the report varies between four and seven (Institute for Employment Studies 2015).

This study uses a broad definition of counselling and psychotherapy, based on descriptions provided in policy documents by the Irish Government in Vision for Change (Expert Group on Mental Health Policy 2006) and by the BACP (British Association for Counselling and Psychotherapy 2016).

Vision for Change states that:

Counselling and psychotherapy may be described as interventions that, through the use of the therapeutic relationship and of psychological techniques, aim to reduce distress and symptoms, enhance coping skills and self-knowledge (p. 197).

The BACP policy says:

Counselling and psychotherapy are umbrella terms that cover a range of talking therapies. They are delivered by trained practitioners who work with people over a short or long term to help them bring about effective change or enhance their wellbeing.

These two definitions draw on different discourses. The first, from 2007, stresses the relational aspects of the therapeutic process and emphasises changes such as the relief of distress and the development of self-knowledge. The later BACP 2016 definition places the emphasis on the importance of professional skills and introduces the previously absent concept of time.

Since the 1960s and early 1970s there has been a shift in the Diagnostic and Statistical Manual of Mental Disorders (DSM) from its more psychoanalytical orientation when it first appeared in 1952 to its latest incarnation as DSM5 (Wilson 1993; Frances 2010; Grob 1991). It now includes a massive expansion of categories of mental disorder which are driven by the existence of psychopharmacological drugs, the rise of biological psychiatry, the influence of the insurance industry, and a fall in the provision of long term psychotherapies (Karp 2006; Appignanesi 2008; Layard 2005). Since the 1960s and 70s brief therapy has also

emerged in the field of psychotherapy and counselling. Brief therapy generally features a standard number of sessions (perhaps 12 to 14), has a solution focused approach, and may involve treatment protocols which were deemed suitable for different conditions (Malan 2013). However Barkham et al. (1996b) state that brief therapy as a specialism is largely disappearing; what was once seen as brief therapy has become the mainstream. Short contract counselling generally involves a smaller number of sessions. This model of delivery is not usually introduced as a response to research findings (Miller 1996; Wolgast et al. 2004; Wolgast et al. 2005). Fonagy and Miller both question why clinical practice appears to be relatively immune from influence by research findings yet is immediately open to influence by political, economic and pragmatic factors (Fonagy 2010; Miller 1996). Development of the short contract model has happened alongside other developments which tend to promote short term and frequently manualised therapy approaches in publicly funded settings (House and Loewenthal 2008; Layard 2005). This suggests that the emergence of short contract counselling has been influenced by more than therapeutic concerns.

There is an increasing demand for mental health provision as indicated by the HEFCE commissioned report which showed that there had been a 132 percent increase in students declaring a mental health problem. This was based on a study of nearly 18,000 students who said they had mental health problems in 2012-13 compared to 8,000 in 2008-09 (Institute for Employment Studies 2015). Alongside these developments has been the growing influence of a managerial discourse with a stringent focus on outcomes, targets, protocols and evidence based practice (Gilbert 2005; Chevannes 2002; Rizq 2012b; Rowan 2011). There is an increasing emphasis placed on value for money and the privileging of therapies which most easily fit into a numerically based paradigm (Pilgrim 2008; Layard 2005). These trends are very different from a philosophy of psychotherapy which suggests that it should respond to the needs and desires of the client as its primary role.

1.1 Rationale for the study

The practice of short contract counselling has not been explored in depth in published psychotherapy research, but has been referred to only as background context (Shapiro et al. 2003; Miller 1996). Its growth, while rapid and extensive, has not been researched in its own right to any great extent. This study looks at how short contract counselling has come to such a position of prominence in a relatively short time, how it is discursively spoken about, and how the effects and consequences of this are worthy of exploration.

It is intended that this study will add new knowledge and contribute to a debate about the short contract model in a university context. It will consider how this model might link to other social and political changes which influence student counselling and psychotherapy and contribute to a greater understanding of the discourses that affect the provision of counselling and psychotherapy. It is hoped that this exploration will contribute to improving

services, promote greater choice for clients and emphasise the importance of clinically based decision making.

1.2 Study Aims and objectives

The research question for this study to explore is how short contract counselling is discursively constructed in an Irish Third Level college. Posing the research question in this manner allows for a wide ranging enquiry which can consider a number of different contextual factors, historical, social and economic, and investigate how these factors might then influence and be reflected in the discourses of the study participants. Where there is greater demand for a resource, in this case counselling, than there is the capacity to meet it, there are likely to be issues of power differentials in allocating and accessing this scarce resource. This then is likely to have effects which are themselves constructed through discourse and have implications for counselling policy and practice. The practice of short contract counselling is now well established so that it has become a regime of truth which has become taken for granted. It is hoped that this study will help to illuminate how this has happened and what are the conditions and contingencies which have allowed short contract counselling to emerge.

The study objectives are:

- To understand the discourses involved when student counselling and short contract counselling in the third level college environment, is spoken about;
- To investigate historical, social, economic and theoretical factors which have created conditions which have allowed for the emergence of short contract counselling;
- To explore the operation of disciplinary power and power/knowledge constellations in responses to short contract counselling;
- To consider how the effects of short contract counselling operate in practice;
- To consider the implications of short contract counselling for future policy and practice.

1.3 Literature Reviewed

Two particular types of literature were reviewed. One explored contextual factors and the other concerned clinical practice. The context featured an overview of the theoretical basis and historic development of psychotherapy, counselling, and, in particular, student counselling. This exploration drew attention to developments such as concerns about the duration of therapy where demand for services outstripped the resources available to meet that demand. The role of managed and stepped care was considered. In research terms the issue was conceptualised in terms of how much therapy is required to affect therapeutic change known as the DOSE and GEL effects. Attention was then paid to research specifically about student mental health and student counselling. Clinical literature about therapeutic

practice was then considered with a view to identifying factors which might be significant in terms of students responses to short contract counselling.

1.4 Methodology

A number of considerations informed the decision to position the study in a qualitative methodological framework. The study was conducted in a setting in which students presented in a variety of ways and came with a range of difficulties. Some of these students had already received psychiatric diagnoses and had previously attended other services. Research in this type of naturalistic setting is different from studies which use quantitative methodologies based on standardisation either by diagnoses or some other criteria. Such studies can be seen as irrelevant to what actually happens in practice (Kennedy 2004; Aveline et al. 1995; Cooper 2008; McLeod 2011). Psychotherapy research frequently reflects the interests of the researcher and seeks to advance the case for the effectiveness of particular therapeutic approaches (Johansson and Werbart 2009). The client voice is rarely heard, with some notable exceptions (Bury et al. 2007). It has been observed that clients tend to rate their therapy experience more highly in quantitative studies where questionnaires are used, than where they discuss this in an interview setting (McLeod 2011). This was the rationale for using an approach which featured client interviews.

The study uses a Foucauldian discourse analytic approach in which the discourses of the study participants is the starting point but which also allows for an investigation of the historical and social factors which have created conditions of possibility for the emergence of short contract counselling. the operation of disciplinary power and the power/knowledge constellations which exist in this setting. Exploring the discourses involved in offering a standard number of sessions seeks to develop a more nuanced questioning of this current practice. It seeks to problematize phenomena that have been largely taken for granted, and will try to surface some of the dilemmas and complexities which emerge when a discursive account based on a social constructionist epistemology and ontology is used.

1.5 The study site and sample

The study site is an Irish University which has grown rapidly over the last fifteen to twenty years. A student counselling service is provided and can be accessed by all registered students. It is free and confidential and is part of a range of support services which are delivered independently of the academic programmes of the university. In order to obtain counselling a student attends a drop-in session during which a risk assessment is carried out and a clinical outcome measure is completed. This usually involves the completion of a questionnaire from which is derived a severity score. This is one of the key elements used to decide whether counselling is offered and if so how quickly. If counselling is deemed appropriate the student is put on a waiting list and is offered six counselling sessions which are timed to fit with the student's academic timetable. Further sessions can be sought if certain criteria are met. At its core the service has five full time staff, three counsellors and two administrators. Most of the counselling is delivered by sessional counsellors and by

counselling interns who are on placement with the service. During term time there can be up to fifteen sessional counsellors and fifteen trainees. It is a very busy service. Waiting times vary according to the academic cycle and tend to peak before exams.

The study participants consisted of a sample of students who received more than the standard number of sessions and sessional counsellors and interns. The student group had all attended either one longer episode of counselling, or had returned on a serial basis for further counselling, or possibly both.

Discourse analysis seeks data at the margins based on the understanding that discourses become more visible when there are exceptions to a particular rule, in this case the six session rule. The social constructions and discourses involved are highlighted and become more visible at the margins of a phenomenon. In this study the effects of the short contract counselling will be highlighted. Some of these involve responses to being the exception, having to seek additional sessions and changes of counsellor, which then highlights the difference between this and being the 'norm'.

1.6 Personal position in relation to short contract counselling.

The professional and personal dilemmas and challenges of operating a short contract counselling model provided the impetus for me to undertake this study. As the manager at the study site, I stand at a boundary where I have competing clinical, service management, strategy, policy, and resource allocation responsibilities. This means I have had to juggle competing discourses of manager, counsellor, lead clinician and researcher. Consequently arriving at a personal position in relation to short contract counselling has proved very difficult. The dilemmas and complexities I experience arise partially through a conflict in holding the role as a service manager and lead clinician. If my role in undertaking this study had been either student counsellor or researcher alone, I suspect it would be easier to adopt a clear position. In hindsight I realise I was looking for answers to these dilemmas which I could feel comfortable with. The experience of the research has strengthened my view that the standardising approach to mental health contained in the short contract model does not work well and undermines principles and values such as the importance of the therapeutic relationship which are the cornerstone of most therapeutic modalities. In arriving at this position I have found it helpful to reflect on my experience as a service manager and to consider the various factors which contributed to the development of the short contract model.

When I was first appointed to the role of service manager I became aware of the large demand from students for counselling and the limited resources available to meet this demand. I realised that senior managers expressed a preference for short term counselling. There was also an expressed preference for what were described as developmental programmes, which would support students to function academically, which would reach larger numbers and which were assumed to be cheaper to provide. An example might be the provision of psycho education group work programmes focusing on managing anxiety.

Concern was expressed about the possibilities of students becoming dependent on the counselling service. Put simply interventions which were deemed to be developmental were seen as good and those which were seen as support were viewed less favourably.

As part of my induction to the role I visited many student counselling services in Ireland and the UK, attended professional events and took part in email discussion groups. I realised that the whole sector felt under considerable pressure and that great anxiety was frequently expressed about the need to avoid waiting lists and to see students quickly during periods of particularly high demand. I recognised that services, especially the larger ones, had begun to operate with session limits. I realised that the numbers of sessions and the frequency varied from place to place and were seen as a pragmatic solution which allowed for counselling resources to be allocated in an equitable and transparent manner. Concerns were expressed that students would find it unacceptable if they became aware that others were receiving more counselling sessions than they were and so might complain. Research findings were not considered when decisions about numbers of sessions to be allocated were made. The core issue was always how to best to manage scarcity.

Within a few short years the discourse of service managers within student counselling accepted that sessions would be limited. Like many other managers I saw this as an inevitable and inescapable reality. I was aware of discontent expressed by some students on feedback forms or complaints about the length of the waiting list or the number of sessions they were able to access. There was also discontent among practitioners who found that the way they were expected to work within a student counselling setting was discordant with their training. The points of extreme pressure for the service occurred in the lead up to examination periods which saw students making urgent request to be seen, seeking support to manage anxiety but not necessarily being interesting in counselling after the immediate crisis had passed. I realised that this contributed to a subtle redefinition of the student counselling role by institutions and service managers which, I believed, focused on promoting academic success as the primary task. Alongside this there was an increasing recognition that ever greater numbers of students were presenting with complex mental health needs for which the HSE, were not making sufficient provision. Some student counselling services responded by refusing to see students whose needs were deemed to be too complex and who should be the responsibility of the health authority.

I was aware that student counselling service managers were very concerned to be seen to be delivering what the university required of them. Put simply this meant seeing students quickly, offering interventions which helped students to succeed academically and managing risk. The emphasis shifted to a concern with outcomes and measuring throughput. Technology based information systems became increasingly common. Numbers attending, the difficulties they presented with, and risk ratings could now all be reported back to the university. This approach came to be seen as standard practice. The ontological and epistemological assumptions on which this is based were rarely considered. Instead it

was seen as the only practical approach especially for the larger services if they were to continue to be funded.

Services, including the study site, developed policies whereby additional sessions could be made available to some students if they fulfilled certain criteria, outlined in a service policy. A case had to be made by the student counsellors and the additional sessions had to be agreed by the head of service. This was a task I dreaded in that it frequently felt like jumping through hoops. I usually agreed that the additional sessions could be made available and usually gave primacy to the clinical judgement of the student counsellor, rather than the rating scales which formed part of the case. My increasing discomfort with this role and the many complexities and dilemmas which were surfaced through the operation of this policy motivated me to undertake this study.

I have come to the conclusion that I am not in favour of a standardised approach and do not think that it delivers the best results. A non-standardised approach in which clinical judgement and client desire are privileged is for me a better choice. This may seem counter intuitive given the level of demand and the current lack of resources and the fear that services will be overwhelmed if limits are not set. This position is based on the belief that counselling is a good thing which students will want to avail of as much as possible. While it is the case that in the popular culture and in social policy counselling has come to be seen as the answer to many of life's struggles, clients often see it as a last resort in times of desperation and generally only stay as long as they need to. The amount of time this will entail varies enormously. A small number need to be seen for a longer time, the majority attend for a relatively short time and there is another group who do not attend after making the first appointment or who only attend once.

What has struck me particularly forcibly is that profound changes can happen almost by stealth with little conscious awareness of the impact they might have. The role of technology is particularly interesting here. It might seem to be just good management and good sense to record interactions with clients yet it has opened the door to a requirement that records have to be standardised and as a consequence become denuded of all individual meaning. Rather it is numbers and tick box exercise. This is not to suggest that we can or should get rid of the need for record keeping or accountability, but to suggest that we have gone too far such that all the important principles and values on which counselling are based are under severe threat. The discourses of efficiency and the demand for evidence based practice, which relies on standardisation, has led to measurement and targets derived from measurement being privileged above all. One consequence is that there is little choice for students and increased pressure for student counsellors. It is time to trust clinical judgement. Any practitioner who has experienced working in the public sector will be very aware of the pressures and is highly unlikely to encourage students to remain in counselling if they do not need to be there. The decision about numbers of sessions should

be made in response to individual needs and circumstances, drawing on clinical decision making, expert practice and experience.

1.7 Overview of the thesis

This study is divided into six chapters. Chapter one provides an introduction and overview. Chapter two contains a critical appraisal of the relevant literature which informs the study. It describes how that review influenced the positioning of this study as a contribution to knowledge generation. Chapter three describes the methodology and methods followed in the study design. It provides a rationale for the use of Foucauldian discourse analysis and elaborates on how the ontological and epistemological assumptions upon which this approach is based make for a particularly rich and nuanced approach to the material. Chapter four reports on the findings in order to explore the particular discursive construction of student counselling in general and how this links to the particular model of short contract counselling delivery which is a common feature of student counselling in third level colleges. Chapter five discusses the findings and tries to relate them to broader contextual factors which are likely to influence the processes and rationales offered for the practice of short contract counselling. Chapter six begins by describing the main findings of the study and the conclusions which can be drawn from them, in particular implications for general psychotherapy practice. It moves on to look at possible future areas of research and continues with a discussion of the implications for theory development, student counselling, therapy training and mental health care. The chapter includes some further personal reflections and discussion of my personal motivation for undertaking this study.

1.8 Conclusion

This introductory chapter has explained the background and rationale for the study. It went on to describe the types of literature relevant to the topic, the methodology employed and outlined key features of the study site and sample. The research question from which the aims and objectives were identified was described. The chapter then outlined the considerations which led to the selection of a qualitative methodology and provided an overview of the study. The researcher's personal position in relation to the topic was described. This was followed by an overview of the thesis.

By focusing on a group of student clients and counsellors and utilising a Foucauldian methodology this study hopes to generate new knowledge which will allow for a nuanced understanding of the consequences and effects of a practice which is of growing significance to the field of psychotherapy. The implications of increasing domination of publicly funded counselling by the short contract model are far reaching. This study will identify some of the contextual features which are influencing this development while maintaining a focus on how these developments are discursively constructed through the medium of language by subjects, both students and counsellors interacting in settings in which this policy operates. The starting point is a literature review, exploring the wider background and overall theoretical frameworks that underpin short contract counselling and moving on to

considering whether psychotherapy literature in general offers a rationale for short contract counselling. This is addressed in Chapter two which follows.

Chapter 2 Literature Review

2.1 Introduction

A broad ranging literature review was conducted to provide context and justify the research question. The purpose was to consider how the topic has been conceptualised and how this might influence the discourses around short contract counselling and to consider previous research on the topic. One strand of the literature search involved material which could be broadly seen as describing the context within which short contract counselling developed. Other literature, focused on clinical practice, was examined with a view to exploring whether the clinical research literature identified factors which might be relevant to understanding clients' responses to short contract counselling and the discourses upon which they drew. To better understand the development of short contract counselling in student counselling it proved helpful to consider some of the theoretical models of psychotherapy and counselling which predated this practice and the social and economic factors which may have been linked to its emergence. This involved a brief consideration of the development of psychotherapy in the twentieth century, and, in parallel, the development of student counselling initially in the US but gradually spreading throughout Europe and to most parts of the world where there is a well-developed and rapidly expanded third level education sector. The development of managed care in the US and stepped care in the UK was explored in order to focus attention on the context for the development of brief models of psychotherapy and their extension into student counselling. Student Counselling has been researched in a number of ways which have been briefly described. Consideration was given to material which investigated the mental health of students, the demand for services and the effectiveness of student counselling. This is followed by consideration of research related to psychotherapy practice in order to explore whether it can illuminate therapeutic factors which could influence clients' responses to short contract counselling.

2.2 Literature search

Databases searched using the Summon tool included Psych Info, Social Science Citation Index (SSCI) and PUBMED. There was individual follow up of particular studies and authors whose work proved particularly influential for this research. Google Scholar was used to source citation details. It was then possible to find the full text by referring back to library databases. The criteria used for sorting and rejecting literature initially restricted the search to English language publications in the last twenty years, yielding 70 relevant articles. Books and government reports were also included in the search. When searching the databases abstracts were read. If the material seemed relevant then the whole article was read. The bibliographies of relevant articles were also checked and relevant references followed up as above. Additional material, particularly relating to the overall context, was sourced through professional journals and newspaper articles.

Much of this research literature adopts a quantitative paradigm. It was decided to use these quantitative studies as a starting point to help understand how the topic has been

conceptualised and to define themes which could be explored as the study methodology and design evolved. Defining the search terms proved challenging. Searches which used the term “discourse” and combined it with other terms such as “student” and “college” did not yield relevant material. Different terms were then used, such as “student services”, “student counselling services”, “session limits”, “managing demand”, “therapeutic change”, “attendance patterns”, “returning to therapy”, “relapse”, “retrospective and patient self-report studies”, “brief therapy”, “patient expectations” and “drop out”. These terms were also combined in different ways for example “managing demand” and “student counselling”. This generated a lot of research literature which, although relevant, did not specifically address the topic of short contract student counselling.

2.3 An overview of the theoretical basis and historical development of psychotherapy

Jacobs (2000) describes the twentieth century as the age of Freud in that nearly all of the major theories of psychotherapy have either descended directly from psychoanalysis or have been positioned as a critique of psychoanalytic theory and practice. Freud’s ideas were originally treated with suspicion. He initially sought to locate them within a medical model. The medicalisation of mental health predated Freud and is, according to Foucault (2006) rooted in the birth of the asylum. Foucault links it to the work of Tuke in England and Pinel in France. William Tuke founded the York Retreat in 1796 to contain and reform the mad, segregating them from the rest of society. Foucault identified during this and the subsequent period of development ‘madness no longer exists except as that which is seen’, suggesting that:

‘The science of mental illness, such as was to develop in the asylums, was only ever in the order of observation and classification. It was never to be a dialogue. This could only begin once psychoanalysis has exorcised the phenomenon of the gaze, so essential to the nineteenth-century asylum, substituting its silent magic with the powers of language’ (Foucault 2006, p. 488).

The power of language as a treatment tool allowed Freud and the subsequent theorists to develop a variety of forms of talk therapies. Freud’s theory of psychic conflict was used to account for the emergence of symptoms which were not available to conscious experience from which he developed theory of the unconscious and the technique of free association (Hamlyn 2007). Over the first half of the twentieth century psychoanalysis was seen as an approach which required considerable time and had goals such as bringing traumatic material into the patients consciousness. Paris (2013) suggests that the emergence of psychotherapy is linked to the development of modernity which required a shift in cultural values, a decline in traditional values and a rise in individualism. Psychoanalysis was gradually refined by Freud over almost half a century to become a structured intervention of interminable duration, although an exception later on in the century was Freud’s paper on ‘Analysis terminable and interminable’ (Freud 1937). The therapeutic goals of psychoanalytic treatment could be loosely described as insight orientated.

Freud's influential followers included Carl Jung, Albert Adler, Otto Rank and Wilhelm Reich, some of whose various contributions are particularly relevant to the later emergence of short term models of psychotherapy which were influenced by later developments such as humanistic psychotherapy and behaviourism. Freud's work was popularised in the UK by Ernest Jones. Adler was interested in the role of family, social relationships and the lived experience, which was to be later taken up by humanistic psychotherapy which emerged in the latter half of the century. Otto Rank was interested in briefer forms of therapy and issues to do with birth and mother child relationships. Jacobs (2000) points out that psychoanalytic ideas proved very helpful in treating what was described as war neurosis during World War 1. World War 2 provided the impetus for psychoanalytic group work. The Tavistock Clinic, founded in 1920, was independent of official psychiatry.

The Tavistock attracted the opposition of organically based psychiatry which was based at the Maudsley Hospital which became a centre for behaviourism (Jacobs 2000).

Behaviourism, which had its roots early in the twentieth century, was influenced by behavioural science, learning theory, cognitive and experimental psychology. As developed by Watson, Pavlov, Skinner and Eysenck behaviourism sought to use evidence based techniques with the aim of changing cognitions and behaviour. Albert Ellis and Aaron Beck went on to develop Cognitive Behavioural Therapy (CBT) which remains very influential. This approach, while acknowledging the significances of past events in the client's life, privileges symptom relief. It is considered to be evidence based as it has been the subject of research more frequently than other modalities. and time limited that it has a range of specific protocols which have been developed to treat particular conditions (Jacobs 2000).

In the 1960s other forms of therapy began to emerge. Jacobs describes these as a third force which developed as a reaction against both psychoanalysis and behaviourism. There was an emphasis on 'real experience', the curative experience of the here and now, and the centrality of the therapeutic relationship. Karl Rogers was a key exponent of this humanistic "person centred" approach. The importance given to personal responsibility showed the influence of existential philosophy. This orientation focused less on the unconscious and more on promoting positive, holistic change through the development of a supportive relationship with the therapist. The increasing importance of humanistic approaches was accompanied by the development and expansion of counselling, which did not require the same depth and duration of training as psychoanalysis opening the door for reorienting approaches to psychotherapy around a cost based model, discussed below.

Another significant approach which first developed in the 1950's was that of Systemic Family Therapy (Carr 2007). Here the emphasis was on the family as a system, with roles and boundaries and patterns of behaviour which were to be explored and challenged (Hamlyn 2007; Hobbes 2007). By the 1980s Family Therapy's problem orientation focus was being utilised in the development of Solution Focused Therapy. This approach was developed by de Shazer and colleagues (De Shazer 1985; Lewis and Osborn 2004; Iveson

2002). It is described as focusing on solution building rather than problem solving. It focuses on clients' strengths and resources and tries to orient the client towards the future. One associated technique is the miracle question, where the client is asked what they are already doing which might help achieve a solution to their problems. Rating scales ask the client to say where they think they are in relation to achieving their goals. This is a brief task orientated approach which has been used to treat a number of different conditions and for which is claimed by its proponents a convincing evidence base (Iveson 2002) This is one of the first occasions in which the duration of therapy became a feature of a particular approach.

Evidence based practice is a general umbrella term which describes the application of scientific research based findings to the treatment of patients, both in medicine generally and in mental health (Tanenbaum 2005; Shedler 2015). Tanenbaum says that orientation in mental health care is ubiquitous. She compares it to the outcomes movement which was concerned with the results of therapy and which existed beforehand. She describes it as being supported by groups such as public officials, funders, advocacy groups, some professional groups and patients. The desire is to create a new knowledge base in mental health care which privileges a certain type of empirical research, which in turn influences the research priorities of funding bodies. The period from the 1950s to the 1970's saw the expansion of funded mental health care. This was followed by the subsequent development of mental healthcare rationing and the growth of managed care funded by insurance companies in the US (Shapiro et al. 2003; Kirschner and Lachicotte 2001; Phillips and Alperin 2013). Two thirds of Americans with private health insurance are enrolled in managed behavioural health care organisations which routinely use efficacy research to limit types and duration of care (Tanenbaum 2005). In practice, in order to make insurance claims individuals have to receive a diagnosis which is recognised by the insurance company. They are then offered a treatment of a fixed duration which has been deemed appropriate for that condition based on findings from a particular type of empirical research.

During the latter part of the twentieth century and the early part of the twenty-first century mental health care underwent some profound changes. In Ireland the focus was on developing a model of provision as described in the policy document *Vision for Change* (Expert Group on Mental Health Policy 2006). Irish mental health policy from the dawn of the asylum system was orientated around a medical model and reference to psychotherapy as part of policy was largely absent prior to this period. However policy and practice in the United Kingdom and America had developed in manner which emphasised duration and cost of treatment. Although these influences can be discerned in Ireland as for example in the development of the Counselling in Primary Care (CIPC) model by the Health Service executive (HSE) which has adopted a stepped care and short term approach to service provision, it is helpful to consider the examples of the United Kingdom and America which represent models of delivery which have the potential to be very influential in Ireland.

Although public mental health care in the United Kingdom is provided by the National Health Service (NHS) and is free at the point of delivery the current dominant stepped care model has some similarities with the American managed care approach, which is privately delivered through private insurance. Stepped care was developed in the context of NHS provision where there is massive demand, extremely long waiting lists and many who receive no psychological intervention whatsoever (Layard 2005). There have been a number of critiques of stepped care in the context of mental health (Proctor 2015; House 2012; Dalal 2015; Bower and Gilbody 2005; Lees 2016). Some of its key features are:

- It seeks to provide minimal intervention which will have some health gain;
- It addresses the prime economic issue of how to meet demand with inadequate resources;
- It is justified the basis that it leads to a more efficient allocation of resources;
- It provides a single point of entry to a system of hierarchically arranged interventions, depending on diagnosis;
- Depending on severity patients are offered an escalating range of services, from self-help, bibliotherapy, computer based cognitive behavioural therapy (CBT) and one to one therapy (usually CBT) for a limited number of sessions.

In the most severe cases there may be referral to secondary services such as psychiatry. It makes the assumption that minimal interventions (for example bibliotherapy or computer based CBT) can provide the same health gains as traditional talk based open ended therapies. It assumes that anyone who achieves the same score on a grading system can be treated the same and will respond in similar ways to the same intervention. The role of clinical judgement is given less emphasis. Patient choice is eroded. Usually the only therapy on offer is CBT. The evidence base for CBT is contested. This is relevant as CBT is the main approach offered in the standard stepped care model. 'Evidence' is usually taken as code for brief, manualised and highly structured approaches. Some studies have suggested that the beneficial effects are exaggerated as the high drop out and rates of non-attendance (DNA rate) are discounted in some studies and that there are few longer term studies which would look at whether the benefits claimed, have been maintained over time. NHS resource deficits mean that it is not possible to ensure that clients are given the intervention which is the most appropriate. Instead low intensity interventions are being increasingly used with clients whose problems are more severe. This means that preventative work is practically impossible (House 2012; Proctor 2015; Dalal 2015).

The forgoing discussion of Stepped Care highlights many of the issues in an ongoing debate in psychotherapy about which approach is 'best'. This is driven by therapeutic, economic and scientific arguments and to date the economic and quantitative science arguments tend to have hegemony in determining the type of care offered. Publicly funded psychotherapy and counselling is now generally offered on a time limited basis. The focus tends to be on symptom reduction and funding on the basis that it is a cheaper alternative than the cost of

supporting those who are unable to work due to their mental health difficulties (Layard 2005). The context of rising demand and decreasing resources have been highly significant in the emergence of managed care and stepped care. These approaches have been very influential in terms of the growth and acceptability of short term counselling across a whole range of settings (Shapiro et al. 2003). This 'stepped care approach' has influenced the development, management and provision of student counselling. These are the discourses which have influenced what has been offered and how in student counselling, the evolution of which is now considered.

2.4 Overview of the development of student counselling in universities

Student counselling can be viewed as the application of psychotherapeutic approaches to an educational setting. There are a number of ways in which this setting both reflects and modifies themes found more generally in the history of psychotherapy and which are highlighted through a consideration of the historical development of student counselling and its relationship to the university.

There is a growing literature on student counselling. Attention has been paid to the emotional experience and unconscious dynamics involved in study (Bell 1996; Lees and Vaspe 1999; Rana 2000; Davou 2002; Salzberger-Wittenberg et al. 1983; Youell and Canham 2006). These books which are influenced by psychoanalysis provide case vignettes which illustrate the type of difficulties students bring to counselling. They use concepts such as transference and counter transference to explore the kinds of relationships to authority students experience, which can impact on their ability to learn. They describe the experience of being a student as beset with emotional challenges such as the need to cope with failure, rivalry, envy, perfectionism, procrastination and possible interference of anxiety with the capacity to learn and to sustain motivation. It has been suggested that student counselling services themselves have a particular role within the institutional psyche of the university. They contain and are associated with the shadow side of university life, the troubled and troubling students who do not represent the glossy success stories universities wish to portray in their promotional literature (Armstrong et al. 2005; Hallett 2012; Heyno 1999).

It is helpful in understanding student counselling to place more recent research into a historical context. Student counselling first developed in the US. The first college health programme was established at Amherst College in 1861. Student Health services focused on physical problems and healthy exercise was promoted as a means of avoiding emotional problems (Kraft 2011). In the early twentieth century American psychiatry was heavily influenced by the Mental Hygiene movement. This included both physical treatments for the mentally ill but also 'talking treatments'. In the first half of the century there was a large increase in the number of mental health professionals, and professions such as clinical psychology and social work developed. In 1920, at the first meeting of the American Student Health Association, the importance of mental hygiene was recognised (Kraft 2011). The

reasons given were to retain students, to forestall failure in the form of nervous and mental diseases, to minimise partial failure through mediocrity and to make possible the full use of intellectual capacity. More services offering counselling to students continued to develop up to the 1950's. During this time concerns were expressed about the shortage of psychiatrists to run these services. Out of necessity multi-disciplinary teams developed providing psychotherapy, medication, consultations with staff and faculties and prevention oriented mental health programmes (Kraft 2011). Further expansion occurred in the latter half of the century. In the 1960's the American College Health Association (ACHA) was founded. Its membership expanded from under 50 to 192 members in 1995.

In 1965 the University of Auckland commissioned a report on the support needs of its students (Brailsford 2011). The report argued that the introduction of ancillary services such as counselling would improve teaching effectiveness more than employing additional academic staff. It argued that students were vulnerable and ill prepared for university life. The rationale for the development of student counselling was couched in terms of concerns about student 'wastage' and its economic consequences. In 1970 the Association of Student Counsellors (ASC) was formed in the United Kingdom. Bell describes student counselling in the 1990's and stresses that the purpose of providing student counselling is to contribute to the productivity of the university, to help retention and to alert universities to the difficulties that their students experience (Bell 1996; Bell 1997). In addition to acting both as a professional representative body for student counsellors and an advocate for student counselling the ASC set itself the task of developing a good practice guide and accreditation criteria for student counselling services. Similar developments were occurring in Ireland. The Irish Association of College Counsellors (IAUCC) was formed in 1994. Student Counselling is today well established in the seven universities and over twenty Institutes of Technology in Ireland. There are strong links between IAUCC and the Association of University and College Counsellors (AUCC), the UK based successor to ASC.

The term student counsellor is used to denote all who work in this role but it is a job title and does not imply that a similar professional training has been undertaken by all counsellors. All the main therapeutic modalities are represented. There is variation between countries, some of which require an initial training in psychology and others which do not. For example in the 1970's psychoanalytically trained practitioners tended to be in the majority in the UK (Bell 1996). This has changed and now there is a greater representation of other therapeutic modalities such as CBT. Professional bodies are now developing their own systems of evaluation and seeking performance indicators and benchmarks for student counselling (Wallace 2012).

Many student counselling services offer a range of services (Mair 2015). Typically these would include face to face counselling, drop in sessions, group work, psycho education materials and various types of academic-related concerns such as exam support. Online programmes are also available at certain colleges. It is interesting that these interventions

are similar to those offered in the UK stepped care model. The critical difference is that they are not uniformly offered as hierarchically arranged interventions based on severity. However there are elements of a the more standard stepped care approach gradually now appearing within student counselling in the UK (Mair 2015).

2.5 Rising demand

Student counselling services have developed to become a standard part of the college offering. Furthermore they have become a major source of mental health primary care for young people in many places in Ireland. Numbers attending college have increased and the student body is now more diverse. This is reflected in the development of Access programmes which strive to cater for the needs of groups such as students from economically disadvantaged back grounds (See for instance (Halpin 2017)). Student counselling is operating in a rapidly changing context which influences what is provided and how it is offered. A 2005 study explored the counselling and support needs of what was described as 'non-traditional' students in Irish third level education (Maloney et al. 2007). It drew attention to the increased attendance at college of students who were mature or attended services such as Access programmes or were registered with college disability services and explored the implications of this for the provision of counselling in colleges. It argued that student counselling services needed to expand and adjust as a response to addressing this context. The research for this thesis was undertaken in Ireland but reflects broader trends. It is widely accepted there that demand has risen while the current climate is one of financial upheaval and spending cuts. These social changes alongside the changing discourses around help seeking have led to an explosion of demand for services such as student counselling (Coughlan 2015; Seldon 2015; Bell et al. 2015). One study which investigated the levels of mental illness in students found that the rates were equivalent to that of the general population but that only 5.1% of the student population were receiving treatment (Macaskill 2013).

Mair (2015) discusses various factors which may be implicated in this rise in demand for mental health services by students and lists a number of issues. These are:

- The wider acceptability of therapy;
- The suggested decreased resilience of young people who are over protected in a risk averse environment;
- The role of instant technology and instant solutions;
- The increasingly pressurised, competitive and under resourced academic environment;
- Developmental issues for young people particularly those focusing on identity;
- Cultural enfeeblement;
- The powerful medicalising discourse.

To this list Percy (2015) adds the increased costs of university education and hence greater expectations as to what that cost should cover as well as provision of counselling at second level, which generates the expectation that it should also be available at third level. Percy also describes the promotion of unrealistic expectations in social and other media that life should be trouble free and constantly happy. This is accompanied by increasingly protective parenting styles and over medicalisation of life's difficulties and struggles.

2.6 Research on student mental health and student counselling

The more recent student counselling literature features concerns about the increasing complexity of the mental health issues with which students presented, counselling programmes aimed at specific groups of students, and mechanisms to evaluate services. With a few notable exceptions (Mair 2015; Hallett 2012) very little material relating directly to short contract counselling was found. Mair describes the practice of short contract counselling and its development within student counselling as a primary means of promoting optimal academic functioning. Hallett draws attention to the ethical dilemmas involved in offering short contract counselling, which might lead to deterioration in the client's condition because psychological issues have been opened up but were unable to be adequately responded to in the time available.

The numbers of young people attending third level education has increased substantially, to the extent that third level education has become part of mass education provision (Mair 2015; Berg et al. 2016). The widening participation agenda requires and funds colleges to increase access to students from disadvantaged backgrounds and to students with disabilities including mental health difficulties. Education at third level is seen as an absolute prerequisite to obtaining professional employment as described in the recent higher education strategy paper for Ireland (Higher Education Strategy Group 2011).

Wolgast, whose research focused on students, suggested that students may differ from the general outpatient therapy population. He mentioned their age profile, higher socio-economic status, more ethnically homogenous profile and higher academic ability (Wolgast et al. 2004). It is not clear that those distinctions remain valid. With the widening participation agenda, the majority of the 18-plus age cohort in Ireland now go onto third level education. There are also increasing numbers of 'non-traditional' students at college. In the Irish Higher Education Authority consultation paper 'Towards the Development of a New National Plan for Equity of Access to Higher Education' (Higher Education Authority 2014) it was stated that 52% of 18 to 20 year olds currently attend higher education in Ireland. This figure rises to 69% if all age groups (such as mature students) are included (Keane 2015).

This means that the age profile, ethnic composition and other demographics are now likely to be closer to that of the general population from which the university recruits its students. As one extensive report based on the United Kingdom and produced by the Royal College of Psychiatrists into the mental health of students points out, epidemiological studies

conducted more than 10 to 15 years ago are out of date (Royal College of Psychiatrists 2011). In fact there are clear indications of increasing mental health difficulties within the student population (Apter 2001; Houghton et al. 2012; Mobley 2008; Rice and Mirzadeh 2000; Topham and Russell 2012; Harrar et al. 2010). One study compared the scores of both groups using CORE-OM, an outcome measure used by many student counselling services and used extensively in primary care. Those using the student counselling services showed severity levels only slightly below that of the general population with the difference being at the functional rather than symptomatic level and with similar risk profiles for both sectors (Connell et al. 2007). Another study which compared levels of distress at pre and entry and during university founds that levels were elevated during attendance and did not decrease to pre entry levels (Bewick et al. 2010). To place this in an Irish context a survey of 8,053 third level students aged 17-25 found that 40% were within a clinical range for depression, 38% were within the clinical range for anxiety and 43% reported that they had felt their life was not worth living at some point (Dooley and Fitzgerald 2012). This is the situation which has contributed to the increased demand for mental health services for students.

2.7 Research into the effectiveness of student counselling

One strand of research into student counselling is concerned with measuring effectiveness. One study, which used CORE-OM (an online questionnaire which is administered before and after counselling in order to measure outcomes and determine effectiveness), found that data from seven university counselling services in the UK showed that 70% of clients reported clinically reliable pre and post counselling improvement (Connell et al. 2008). An American study which compared treatment data from a university counselling centre with those of a group being treated in a mental health care setting using a self-report general symptom measure, found no difference in treatment efficacy (Minami et al. 2009). A study from 2015 updated and provided additional data from that contained in the Connell et al 2008 study (Murray et al. 2015). It used CORE-OM data for 305 individuals. There was a statistically significant improvement for 63% of the sample. However when the sample was differentiated to exclude those whose pre therapy score was outside the clinical range 49% still showed a clinically significant change. These authors suggest that the duration of counselling can impact outcome but do not research this aspect. While they refer to structural issues such as the length of terms, timing of exams and duration of programme of study, they do not consider the issue of standardised session limits as such. The study showed that students who attended more counselling sessions were less likely to show improvement. They suggest that the most likely explanation is that this was a group who had difficulties more resistant to counselling and who needed more sessions and so were less likely to show statistical improvement based on the results of a short term outcome measure. This study did not explicitly address the issue of session limits.

Another study (Wallace 2012) has sought to investigate the possible links between counselling and academic outcomes. These academic outcomes were defined as the counselling contribution to retention, to academic achievement, to the overall quality of the

student experience and to employability. This study involved over 5,000 students at 65 universities and colleges in the UK. In response to a questionnaire between 50% and 60% of the sample said that counselling was an important or the most significant contributing factor in their pursuit of academic achievement. In addition to the question of the effectiveness of student counselling, other research not necessarily specific to student counselling has sought to investigate the question of the duration of therapy and the effect of session limits.

2.8 Research concerning duration of therapy and session limits

Psychotherapy research in general has undergone a number of generational shifts since the 1950's. Research concerns initially were about outcome (is psychotherapy efficacious?) and process (how does it work?) (Dryden 1996; Dryden 2007; Wallerstein 2001; Tompkins and Swift 2015). These questions were refined during the 1960-1980 period so the outcome question became what works for whom, and which psychotherapy is more effective, the process question became what specific components are related to outcome. From the 1980s psychotherapy research became more concerned with cost effectiveness which became linked to a requirement for evidence based practice (Tanenbaum 2005). In the context of student counselling the most significant measures are those relating to outcome, in particular how outcomes link to student retention and academic progress.

2.8.1 The DOSE effect

The question then became what is a sufficient amount of therapy to effect therapeutic change and how does this relate to the number of sessions required. The topic of session limits was addressed in previous research using terms such as the DOSE and GEL effects. The DOSE literature conceptualises counselling sessions as analogous to doses of medication and tries to establish what amount is needed for change to occur (Hansen et al. 2002; Baldwin et al. 2009). The GEL (Good Enough Level) approach considers the question of differential rates of change (Barkham et al. 1996b).

Much research on how much therapy is needed to affect change comes from a medically influenced quantitative paradigm, in which therapy sessions are considered analogous to a dose of medication. This is the DOSE Effect model (Hansen et al. 2002; Howard et al. 1986; Kopta et al. 1994; Baldwin et al. 2009). The assumption is that increasing the number of sessions will progressively expose patients to whatever psychotherapy ingredients are likely to lead to change. Howard's meta-analysis of patient records across 2,400 patients over 30 years suggests that the relationship between dose and rates of change is negatively accelerating (Howard et al. 1986). This means that while patients improve with increasing doses, the benefits appear to decrease beyond a certain number of sessions. The Howard study suggested that by eight sessions 50% of patients had improved and by 26 sessions 75% had improved. Baldwin explains that this DOSE Effect interpretation of the negatively accelerating curve makes a crucial assumption. This is that the effect of additional sessions is averaged across all groups. This assumption may not be tenable. Previous research has

aggregated people who attended different numbers of sessions and thereby failed to differentiate between different presentations and different patterns of attendance (Baldwin et al. 2009).

This problem of how to account for variations is a long-standing concern when doing research into human subjects. In the naturalistic settings from which the original hypothesis (that patients will improve with longer exposure to therapy) was derived, the dose of treatment was not fixed. Patients were likely to drop out of therapy for a variety of reasons, some because they had improved and others for unknown reasons. This implies that patients may change at different rates or perhaps may not change at all. The rate of change is also likely to be related to the initial reasons, for which they sought therapy, for example the severity and chronicity of the difficulties with which they originally presented, differences in treatment provided, researcher bias, differential dropout rates and the divergence of choice of outcome measures applied (Shapiro et al. 1995; Hansen et al. 2002). Critics emphasise that the DOSE effect can only provide an overview and that further research needs to concentrate on particular populations, in specific settings who are offered specific treatments (Gray 2003). The proposition is that if all variables could somehow be standardised then the Dose-Response effect would be useful. If this kind of standardised approach is impossible to achieve then a different naturalistic and qualitative paradigm which can offer a different perspective is called for. Posing the question in terms of what amount of therapy is required to effect change is a significant reframing of what is deemed to be important in psychotherapy practice.

2.8.2 GEL effect

Critics of the DOSE approach have used a similar quantitative methodology and developed the alternative GEL (Good Enough Level) model. This assumes that patients who come for different numbers of sessions change at different rates (Barkham et al. 1996b).

While therapy may seem less effective over time the model is proposing that the patients who change rapidly and possibly experience less serious difficulties have left. Those who remain change more slowly and, it could be hypothesised, have more serious difficulties.

For the GEL model the rate of change will vary as a function of the total number of sessions and will not necessarily be related to the number of sessions attended. Patients who stay for relatively few sessions may in fact change at a faster rate but have less serious difficulties than those who remain for longer. Indeed those who leave earlier or stay a longer time may not have necessarily changed at all.

A further implication of the GEL effect is that 'one size does not fit all' in that there is a substantial variability in response to treatment, that the amount of counselling attended does not automatically lead to a greater degree of change and that imposing a standard time limit will not best serve a patient's needs (Barkham et al. 1996b).

2.8.3 Session limits

An important finding from DOSE effect literature relevant to the issue of short contract counselling is that the suggested doses of between 13 to 18 sessions (irrespective of the type of therapy involved) are considered desirable in order to effect change. Studies have suggested that 'doses' of therapy offered within the public sector fall far short of the amount required to achieve change (Hansen et al. 2002; Madill and Barkham 1997; Miller 1996; Wolgast et al. 2004; Owen et al. 2009). Hansen et al used data derived from a database of over 6,000 patients in order to derive data about the number of sessions attended by individual patients. In a study of 1,525 clients Wolgast found that clients needed fourteen sessions for change to be achieved by 51% of them. However he stated that most college counselling services had set session limits much lower than this. While there was no explicit discussion of why session limits are implemented he suggested that the likely reason is resource based (Wolgast et al. 2004).

This number bears little relationship to the number of sessions attended in many public health settings. Hansen said that the average number of sessions attended was five, significantly below the level required to achieve change. (Hansen et al. 2002; Wolgast et al. 2004; Wolgast et al. 2005). What is not explored is whether this is due to client behaviour or whether is it linked to session limits. From a quantitative perspective the limitations of the Hansen study are the variability of treatment settings, the level of experience of the therapist, the lack of follow up information and lack of knowledge about the reasons why people drop out.

Where sessions are limited early drop outs may not be seen as a problem at all. The emphasis in such settings is on client throughput rather than the achievement of change or the quality of therapeutic intervention. This allows services to avoid the question of what actual therapeutic change has been achieved. Many use outcome measure relevant to the short time frame, which is likely to lead to a focus on more immediate relief of distress. This may not be the same as more deep rooted change. Moving on from the question of therapy duration, the literature search turned to the process of therapy and explored factors in the therapeutic process which could be relevant to understanding clients responses to short contract counselling.

2.9 Factors which could influence client responses to short contract counselling

The literature search also involved consideration of various factors broadly related both to the outcome and process of therapy which were deemed to have potential to influence the client response to short contract counselling. Three issues were considered. These were the common factors approach, attachment theory and ways of conceptualising the therapeutic relationship in general. The focus was on psychotherapy research often from within a quantitative paradigm which did not necessarily distinguish between the particular therapeutic modalities from which the therapeutic interventions originated. This was the case when meta analyses were used which aggregated data from a number of primary

sources as in the case of the common factors approach. The common factors approach, which privileges client variables such as expectations and contextual factors (Wampold 2001) appeared to have the potential to offer insights which could be applied to understanding client responses to short contract counselling.

2.9.1 Research on the Common Factors approach

There are a number of different views as to the helpful ingredients leading to therapeutic effectiveness irrespective of therapeutic modality. These ingredients are likely to impact directly on client responses to therapy in general and could potentially be helpful in understanding responses in a context where the short contract model operates. Timulak (2008) attempts what he calls a cumulative assessment of findings about helpful features of therapy from qualitative psychotherapy studies while using an empirical methodology to analyse these. He concludes that not much is known about how these helpful impacts are linked to expected change in the patient's symptoms.

A body of work, generally from within an integrative psychotherapy paradigm, has been termed the common factors approach. This seeks to identify factors which lead to therapeutic change. These factors are not specific to any particular type of therapy but are largely concerned with the client. These studies are usually based on evidence from meta analyses of primary studies. A much researched topic has been that of therapeutic alliance which is described as one of the common factors. In one example two hundred primary studies using data from fourteen thousand patients were aggregated, corrected for bias and a correlational measure was used to identify effect size (Wampold 2001). Much less weight is attributed to the therapist intervention or the treatment modality (Asay and Lambert 1999; Carr 2007; Castonguay and Beutler 2005; Cooper 2008; Hubble et al. 1999; Lambert and Bergin 1994; Wampold 2001).

Hubble et al. stress that the client is the main agent of change (Hubble et al. 1999). Barber (2007) points out that, even if patients in different treatments do equally well, on average there is always a range of difference. This means that no one therapy is likely to be the best in all cases. A therapy with a high success rate among certain groups and for certain conditions may well not be so effective in other situations. This confirms what most clinicians would believe which is that it is necessary to suit the therapeutic approach to the patient presentation.

While considering that client attitudes and expectations of therapy are significant, there are also issues of life circumstances and the issues which first brought the client to therapy to be considered. The issue of client preference was identified as early as the 1970s (Devine and Fernald 1973). In exploring the question of patient expectations Greenberg et al. (2006) make the point that, while patient expectations are a common factor responsible for outcome equivalence among the major therapy orientations, it is the only one not emphasised in the training of therapists.

The topic of short contract counselling or even brief therapy was not addressed in this literature. The most important points to emerge relevant to this study were the emphasis on the variability of client responses to therapy in general and the significance of issues such as client preference and expectations. One avenue to explore this variability is provided by attachment theory which suggests that individual attachment styles are an important aspect of clients responses to counselling which are particularly relevant in an educational setting which involves a large number of different transitions which have to be negotiated.

2.9.2 Attachment Theory and research

Attachment Theory (Bowlby 1976; Bowlby 2005) provides a lens through which a range of behaviours and experiences relevant to the process of psychotherapy can be considered. The rationale for exploring attachment was whether it could provide an additional understanding of how clients in a short term counselling might respond to the relationship with the therapist, endings, transitions and the likelihood of clients returning again on a sequential basis for further counselling. These concerns are cornerstones of an attachment based approach.

Attachment Theory was developed by Bowlby (2005). It is a theory of human motivation which emphasises the importance of the early attachment between mother and baby. In his pioneering work on the experience of infants separated from their mothers Bowlby's work draws both from psychoanalysis and developmental psychology. Bowlby developed a classification of attachment styles which not only includes behaviour but also the development of internal working models of relationships which remain broadly consistent throughout life. There are four attachment styles identified in adults. One is secure and there are three types of insecure attachment style, dismissing, preoccupied and disorganised attachment (Bowlby 1976; Bowlby 2005; Allen and Land 1999; Bettmann 2006; Bettmann and Jasperson 2010; Bettmann et al. 2011; Fonagy 2005; Fonagy et al. 1996; Fonagy and Target 1997; Holmes 1993; Holmes 2009; Purnell 2004; Shilkret 2005; Steele et al. 2008).

Duquette (2010) provides clinical vignettes which describe how this evolved in a clinical setting. Her emphasis is on what she calls the 'real relationship'. This contrasts with other studies which take a more empirical quantitative approach.

Eames and Roth (2000) conducted a study which involved 30 patients who were treated by 11 experienced therapists. They used both patient and therapist self-reports and outcome measures to correlate attachment style and alliance quality. They found that fearfulness in attachment was associated with lower alliance ratings and that secure attachment was associated with higher alliance ratings. Preoccupied attachment tended to predict an improvement in alliance over time after initial lower ratings. They acknowledge that it may not be possible to generalise from a small sample and that the patient groups they studied may not be representative nor were standardised treatments offered. One of their

conclusions is that research needs to move beyond linking alliance to outcome and should focus on how the alliance is constructed.

Many researchers have used attachment theory to carry out quantitative studies. These studies tend to emphasise attachment measures such as the Adult Attachment Interview and other measures to predict therapy outcome and relationship with the therapist (Bartholomew and Horowitz 1991; Fonagy et al. 1996; Shorey and Snyder 2006; Strauss et al. 2011; Tyrrell et al. 1999; Woodhouse et al. 2003)

Research into the disorganised category of attachment is seen as having the potential to link psychoanalytic concepts, empirical research and a developmental theory such as attachment (Diamond 2004). However the literature search found no studies of how the attachment styles of the client and the therapist is affected by the short term setting. There has however been a particular focus in attachment theory about how students negotiate the many transition points involved both from the initial entry point to university, such as the starting and ending of terms and the final leaving of university (Perry 2009). Dealing with transitions is a core feature of studying at third level and one in which the relationship with a counsellor is likely to affect how the transition is negotiated.

2.9.3 Therapeutic alliance or relationship research

The role of the therapeutic alliance as a major contributor to the client's response to therapy and therapeutic effectiveness has been stressed by many researchers (Norcross 2002; Orlinsky et al. 2004). These studies did not explore what is meant by the term "therapeutic relationship" or "alliance". Clearly there are various interpretations from the conscious sense of both therapist and client engaging in a joint task to the more psychoanalytic interpretations which stress unconscious dynamics and the operation of transference. Other modalities of psychotherapy have developed their own understanding of the significance of the therapeutic relationship. In humanistic psychotherapy it is seen as a vital part of the curative action of therapy and depends on the therapists capacity to display qualities such as empathy, unconditional positive regard and congruence (Rogers 1951)s. Schema therapy an approach influenced by CBT stresses that everyone has certain life patterns developed in childhood which are repeated throughout life. Clients with the help of the therapist need to become aware of these and work actively with the therapist to change them (Young et al. 2003).

Defining a therapeutic alliance and its relationship to outcome has most frequently been considered from within an empirical framework. The therapeutic alliance is not necessarily a stable factor. It is likely to change during the course of therapy which adds to the difficulty of researching it from within an qualitative methodology. Some researchers emphasise identifying client characteristics that may contribute to making the alliance (Paivio and Bahr 1998). Other studies focus is on the therapist's role (Crits-Christoph et al. 2006; Safran et al. 2001).

The therapeutic alliance is conceptualised in these studies as a conscious interaction but reference is not usually made to unconscious dynamics which are difficult to research empirically. From a psychoanalytic perspective the therapeutic alliance is the prelude to the development of a dynamic working transference (Barber 2007; Crits-Christoph et al. 2006).

There are exceptions in which researchers have utilised psychoanalytic concepts such as transference and countertransference which adds a different perspective (Gelso et al. 2002; Hinshelwood 2010; Luborsky et al. 1990; Piper and Duncan 1999; Piper et al. 1998).

None of these studies make reference to the setting within which the therapy occurs or refer to the issue of the possible impact of session limits. This limits their usefulness for this particular study. It was the awareness of such complexities and the need to consider contextual as well as individual responses which led this study to adopt a discursive approach.

2.10 Conclusion

This literature review has pointed to a number of relevant issues for this study. These began with an overview of the theoretical basis and historical development of psychotherapy and counselling. Developments since the 1970's such as the increased demand for mental health services, the expansion of the third level educational sector and resource constraints have provided the background from which short contract counselling has emerged. Attention was given to the role of managed care in the US and stepped care in the UK in providing delivery models for counselling services which are influencing student counselling in Ireland and elsewhere. An overview of the development of student counselling in universities was given, followed by a discussion of research about student mental health and student counselling, including discussion of the context of rising demand for services, followed by research into the effectiveness of student counselling and questions such as the duration of therapy and session limits.

The literature on the DOSE Effect highlighted the difficulties which resulted from trying to average out attendance patterns and interpret what these patterns might mean. The GEL literature was helpful in so far as it provided a good case for differential rates of change and therefore the difficulties which would be generated by attempting to link short contract counselling with questions of therapeutic change. In order to generate meaningful correlations an impossible degree of standardisation would be required in terms of aspects such as client motivation, expectations, life circumstance, nature of presenting problem, type of counselling received, setting and therapeutic relationship to name only potentially significant factors. A finding particularly pertinent to the concerns of this study was that even if such correlations were possible the number of sessions attended in the public sector fell far short of this (Wolgast et al. 2004). The reasons for this are not known. It was not made clear what if any links could be made with the practice of short contract counselling.

The literature search moved from exploring this broad context to focus on clinical literature with a view to exploring some other key factors which might influence a client's response to short contract counselling. There was no body of literature which specifically addressed clients' response to therapy in the short contract counselling context. However the general psychotherapy literature which focused on topics such as the common factors approach, attachment theory and the therapeutic relationship provided very helpful background and orientated the study towards a number of factors which might be significant such as the focus on the client as an agent of change, the 'fit' between client and therapist and the importance of transitions. It has become clear that the topic of short contract counselling (as distinct from brief therapy models which tend to be of longer duration and are often offered as part of a treatment plan) has not received a great deal of attention from qualitative researchers.

The literature search, while providing much valuable information also highlighted gaps, particularly in the clinical process orientated literature, which has not paid much attention to this topic. This contributes to the rationale for how the research question, which explores the discursive construction of short contract counselling, led to the selection of the particular methodology used in this study. The biggest gap was the lack of material which explicitly addressed this topic. One exception is a recent book which is opinion based and which features accounts and descriptions of how short contract counselling has developed from the perspective of counsellors and service managers, but does not focus on the response of the clients to this model (Mair 2015).

The challenge of deciding how to locate this particular study did eventually lead the researcher to adopt a different perspective which offered a way into considering the individual and the context not as separate entities but as intrinsic to each other, both formed by and formative of the context and setting within which human interactions such as short contract counselling occur. In terms of the literature reviewed, that which provided historical and contextual background could be considered alongside literature concerning psychotherapy practice as both are key to informing a discourse analytic approach. This approach provides a potential source of new knowledge in relation to a dominant yet little researched aspect of psychotherapy practice, that of working within a model where session limits are imposed at the start. A detailed rationale and description of discourse analysis will be provided in the following chapter.

Chapter 3 Methodology

3.1 Introduction

This chapter provides a rationale for the choice of discourse analysis as the study methodology. It describes how the methodology adopted was translated into the specific research design and methods used. This includes participant recruitment, the data sources used, how the data was analysed, the ethical issues which arose and the strategies utilised to ensure rigour and transparency. The study objectives were:

- To understand the discourses involved when student counselling and short contract counselling in the third level college environment, is spoken about;
- To investigate historical, social, economic and theoretical factors which have created conditions which have allowed for the emergence of short contract counselling;
- To explore the operation of disciplinary power and power/knowledge constellations in responses to short contract counselling;
- To consider how the effects of short contract counselling operate in practice;
- To consider the implications of short contract counselling for future policy and practice.

The study explores the discourses of participants who were either clients of the service or counsellors who worked there. A group of client participants were selected whose attendance did not fit the standard six session model. Either they received more sessions or they returned seeking further sessions on a serial basis. This phenomenon has not been the subject of specific research except where intermittent psychotherapy has been adopted as a deliberate treatment plan (Drisko 2005).

3.2 Choosing a research methodology

Much of the literature reviewed that was particularly relevant to this topic used a quantitative methodology based on a positivist paradigm. Positivist based research paradigms look for standardisation, whereas this study sought a methodology which could engage with difference and variations. This difficulty of accounting for variation in response was also apparent in other studies which discussed the topics of DOSE and GEL effects (Howard et al. 1986; Baldwin et al. 2009), common factors in therapy, attachment and the therapeutic alliance. This led to a search for a qualitative methodology based on a social constructionist ontology and epistemology which could engage with individual meanings and explore how short contract counselling is constructed by clients and the discourses which are drawn upon, based on their experiences. However, a focus on experience alone, with its suggestions of an interpretive, meaning making, phenomenological mode of enquiry would not have been able to address the equally important issue of context and setting within which the interactions to be studied occurred (Burck 2005).

3.2.1 Rationale for the selection of a discourse analytic methodology

The study sought to explore a particular environment and practice in all its complexity and to highlight the discourses which are produced by the interactions and dilemmas faced by those who use and work in the Student Counselling Service.

The literature review highlighted important issues of context . For example one of the dominant discourses frequently drawn upon to rationalise the practice of short term contract counselling is scarcity of resources (Miller 1996; Wolgast et al. 2004; Barkham et al. 1996b). The 'scarcity' and the response to scarcity are 'taken for granted'. This raises the question of how scarcity comes to be described, by whom, what is being said, how is it being said, to what purpose, who makes judgements about how resources are to be allocated, who has a choice in this and who does not. The literature review also highlighted another significant feature of the organisational context, which is the increasingly dominant managerial culture of outcomes and targets in publicly funded counselling services. This has been critiqued by a number of authors (Chevannes 2002; Rizq 2012b; Gilbert 2005)

To explore these questions the theoretical framework clearly needed to be able to engage with questions of the pervasiveness of power and the resistance to this which must also exist. These considerations were highly significant in the choice of discourse analysis as an appropriate methodology. Discourse analysis provided framework through which to investigate these dilemmas and the positioning of the clients and counsellors in relation to discourses in this setting.

The study seeks to consider both the domain of the individual and the social, while acknowledging that discourse analysis sees this as a false distinction. Within discourse analysis personhood is not fixed and interior. The emphasis moves from individual meanings to how these meanings are constructed by discourses which are inescapably social (Kvale 1992; Parker 2005; Parker 1996). In discourse analysis the objects of investigation are not given in experience, but are constructed through discourse.

3.2.2 Approaches to discourse

Discourse analysis is a very wide ranging form of enquiry which has diverse intellectual roots and applications in a number of disciplines. It is part of a postmodern sensibility, with its focus on the constitutive role of language, a decentring of the subject. Notions of objectivity are challenged, meaning is evasive and elusive, binary meanings are interrogated so that which is hidden is revealed, and grand narrative and meta theories are eschewed in favour of consideration of surfaces and appearances (Kvale 1992; Parker 1996).

Parker distinguishes two broad strands of discourse analysis. The first is influenced by French structuralism. The other includes Critical Discourse Analysis (CDA) and other forms of discourse such as conversation analysis. Parker suggests that:

[French structuralism]....'tend(s) to favour a position within the ideological, historical or cultural discursive structures that transcend and determine the discourse analysed; on the other hand, the English speaking academic milieu of sociology and psychology that focus attention exclusively on the immanence, of concrete, clearly-delimited discourse analysed from without in a - supposedly – neutral manner' (Parker and Pavón-Cuéllar 2013, p. 3)

There is a growing literature on the application of discourse analysis to psychotherapy research. Avdi and Georgaca (2007) provide a review of this literature and describe the various ways it has been used. They consider that such studies fall along a continuum. There are studies which use a discursive approach to analyse the interactions between therapist and client. They generally accept therapeutic principles and see their purpose as improving therapist reflexivity and therapy practice. They consider processes of meaning transformation, the role of the therapist in this, and questions of subjectivity and agency through analysing the content of sessions. At the other end of the continuum are studies which are more oriented towards wider social and cultural discourses and adopt a critical stance towards the activity of therapy and its role in society. For the purposes of this study the focus is on investigating the discourses participants draw on in their response to a particular form of counselling delivery. but it does not seek to interrogate the social role or function of counselling directly. However the discourses drawn on by participants link back directly or indirectly to the dominant forms of accepted knowledge which inform the practice of a particular activity such as counselling.

For the purposes of this study it was necessary to decide which approach to discourse might be the most suitable to the objectives of the study. CDA was considered particularly as it has been well used in research (Wetherell et al. 2001; Willig 1999; Willig 2008; Wodak and Meyer 2009; Taylor 2001; Antaki et al. 2003; Billig 1991; Van Dijk 2009). However with its ontological and epistemological assumptions based on social realism it was felt that this could pre-empt consideration of the changing and dynamic processes likely to be involved in the development of the short contract counselling model. Instead a Foucauldian approach offers a rich conceptual framework which addresses many of the most pertinent issues for this particular study.

3.3 Foucauldian discourse analysis

What follows is a selective reading of Foucault which draws on aspects of his thought directly pertinent to this study such as the constitutive nature of discourse and disciplinary power. Foucault did not give a fixed definition of what constitutes discourse as that would be alien to his approach but he did illuminate how a discursive approach might operate. To quote:

'I am supposing that in every society the production of discourse is at once controlled, selected, organised and redistributed according to a certain number of

procedures, whose role is to avert its powers and its dangers, to cope with chance events, to evade its ponderous, awesome materiality.’ (Foucault 1971, p. 8).

He is concerned with what is prohibited, including the question of who has the right to speak and how. He continues by describing what he calls the rules of exclusion, the importance of identifying these key formative processes that allow particular discourses to emerge. Discourses emerge and transform not according to fixed rules but according to a vast complex set of discursive and institutional relationships. Foucault in *‘The Archaeology of Knowledge’* offers a description of a discursive event which:

‘...Must grasp the statement in the exact specificity of its occurrence, determine its conditions of existence, fix at least its limits, establish its correlations with other statements that may be connected with it and show what other form of statement it excludes.’ (Foucault 1972, p. 28).

Some of the critical Foucauldian concepts for this study are related to the processes whereby objects come to be formed. Discourse is constitutive, forming the object of which it speaks (Foucault 1972, p. 46). These discursive processes are described as the planes of emergence and the authorities of delimitation which are the institutions and professional bodies which are the site of certain discursive practices and formations. These are deemed to be the legitimate authorities who use, what Foucault terms, ‘grids of specification’, to back up this authority. In psychotherapy and psychiatry an example would be diagnostic categories. In his discussion of enunciative modalities Foucault speaks of issues such as who is accorded the right to speak and the institutional site from which he (in this example the psychotherapist makes his discourse. The position of the subject is defined by the situation it is possible for him to occupy in relation to the various domains or groups of objects. This description is pertinent to the participants in this study both as clients and counsellors (Foucault et al. 2008; Gutting 2005).

3.3.1 Disciplinary power

The study draws on Foucault’s configuration of power, his emphasis on the centrality of resistance and the operation of disciplinary power. Foucault identified three different configurations of power. These are disciplinary power, bio power and governmentality. In *Discipline and Punish* (Foucault 1977) he described discipline as a mechanism of power that regulates the thought and behaviour of subjects. Power is organised through institutions in modern society in contrast to earlier historical periods where power operated primarily through the use of physical means. Disciplinary power depends on techniques such as hierarchical observation and classification and the use of normalising judgements. It refers to the use of classification systems and through comparison with a norm. Surveillance is a very important part of disciplinary practice which operates from different sites drawing its authority from the power/knowledge constellations which construct subjects in particular ways. Foucault’s discussion of Jeremy Bentham’s Panopticon (Foucault 1977) provides a very striking visual symbol of how this works in practice. The panopticon is a circular structure in

which all the prisoners are in separate cells isolated from each other and kept under constant surveillance by a guard in a central tower. The prisoner can be kept under constant watch. He knows he is being watched but doesn't know from where, so control is total, insidious and internalised. (Foucault 1979). The theory of discipline is embodied in a building which makes this function easy to carry out. Knowledge of the person is necessary for the application of disciplinary power. This could be expressed in what he calls 'the gaze' (Foucault 2003). This describes the classifying and normalising power of the professionals and disciplines in determining what behaviour is appropriate and acceptable. The gaze becomes more hidden and pervasive in that it determines not only the behaviour but also the system for determining how we view the person. It is this professional gaze which contributes to configuring what personhood is about in any given context. For example the student is subject to the professional gaze of the counsellor who is an agent of the university. A related issue is how the subjects affected by these decisions position themselves or are positioned in relation to them. This draws attention to the subtleties of power relations which operate in a hidden way where decisions are made according to apparently defensible and accepted professional norms. A Foucauldian perspective can be drawn upon to provide a lens, allowing the researcher both to engage in psychotherapy research while also taking a sceptical view of the role of psychotherapy in society. However drawing on this understanding of how power operates provides a mechanism for examining taken for granted ideas and practices in student counselling. This can help to illuminate the operation of power through a consideration of what discourses students and counsellors draw on when they are not to be able to access something in this case counselling, they want more than is available to them.

Foucault did not perceive power to be an inherently negative oppressive force. Rather it is an inescapable facet of existence, as is resistance which is necessary for power to exist. Foucault developed these ideas further in his major works on the *History of Sexuality*, and *Discipline and Punish* (Foucault 1979; Foucault 1977). He later developed the concept of bio power (Foucault 1979).

'...the way in which one has the right to govern oneself, in order to take ones place among others, assert ones legitimate share of authority and in general situate oneself in the complex and shifting interplay of relations of command and subordination.' (Foucault 2012, p. 94).

Bio power concerns the technologies of power exercised over populations which operates through the regulation of bodies and the regulation of the individual body by the internalisation of the rules and ideas of modern science. For Foucault psychological practices are part of the exercise of bio power. It is through discipline that power is exercised. This highlights the tension between Foucault and the practices such as psychotherapy discussed below. Confession is described as one of the main rituals we rely on for the production of what is called truth (Foucault 1979). This is closely aligned with the

role played by modern day counselling and psychotherapy in that they have a confessional element with the counsellor acting as confessor and there is a concern for truth. However the truth which is being sought in counselling is that of the individual and the truth sought by the university may be different and focussed on issues such as outcome measures. Student counselling operates as a form of bio power, a technique of control part of the apparatus of governmentality, whereby the subject becomes self-regulating. The professional gaze of the counsellor allows self-regulation to operate. Compliance is sought through recourse to a scientific discipline which is the power knowledge constellation which supports the practice of counselling. This links to the concept of the Panopticon which makes subjects think they are being watched, so it is a physical structure which enables self-surveillance. Parker makes the claim that Foucault sees psychological explanations as part of the problem, a claim which is given weight by Foucault's own description of bio power (Parker 2007). Psychotherapy according to Foucault forms part of the exercise of bio power which constructs the person and establishes orders of truth, ruling in and out what can be said. Closely related to bio power is Foucault's concept of governmentality (Foucault 2011). Biopower makes power over the body possible by rendering it into the domain of the political, a technology of government to produce citizens which are best suited to the needs and practices of the government or Governmentality. Governmentality refers to the art of government both at an abstract level involving a wide array of objects and persons, entire populations at one level down to the way individual subjects in liberal societies self-govern by learning the rules of conduct required or expected of them. While Foucault's thought emphasises the discursive construction of subjectivity, this is not to suggest that this is a simple process he also stresses the role of resistance. Hanna suggested that although Foucault's work stresses resistance it gives little indication of how this works in practice. (Hanna 2014). To address this he turned to Foucault's later work concerning ethics and the production of the self as an ethical subject (Foucault 2012; Foucault 2011; Foucault 1979).

To quote from Hanna

'Foucault's later analyses allow for the exposure of the extent to which individuals are subjected to certain rules of conduct, regimes of truth and power relations whilst also exploring the extent to which individuals resist subjectivities; disrupt normalised ways of being; experiment with subjectivity; thus, they engage in ethical behaviour' (Hanna 2014, p. 147)

He draws particular attention to four aspects. These are the determination of the ethical substance, the mode of subjection, the forms of elaboration and the telos of the ethical subject. This involves consideration what it means to be ethical, the way the individual recognises himself as obliged to recognise his relationship to a rule and to put it into practice, the effort and work this requires and the establishment of a moral conduct and code which commits the individual to a particular way of being. These considerations are

especially apposite in the context of this study in terms of understanding the various dilemmas study participants struggle with.

3.3.2 Foucault and research

Foucault is primarily a philosopher rather than a researcher but he does describe methodological principles which are critical for this study. These are the principles of reversal, discontinuity, specificity and exteriority. Reversal brings to attention the negative activity of considering what is not being considered, what has been cut out. Discontinuity allows for the possibility of different manifestations which may clash or compete with each other. What may appear as continuity can break down on further examination. Specificity suggests that discourse does not exist independently, but is merely waiting to be found and named.

‘It is a violence that we do to things, or, at all events, a practice we impose upon them: it is in this practice that the events of discourse find the principles of their regularity.’ (Foucault 1971, p. 22).

The fourth principle is exteriority. This suggests that we should not look for internal meanings. Instead the focus should be on external conditions, what Foucault (1972, p. 40) elsewhere calls ‘surfaces of emergence’.

Parker (2005) elaborates on these principles. The principle of reversal leads us away from justifying research because it is a recognised topic or discipline. Rather we need to look for alternatives. Rather than thinking we can look inside we should look to the external conditions of possibility and contingency.

An example from this study is the practice of short contract counselling itself. It could be described as a particular response to a set of circumstances rather than a consciously designed procedure based on, for example, research findings. Parker (2005) suggests that we should not be concerned with overarching accounts, but should keep open the possibility of being surprised and should be prepared to highlight discontinuities and different possible interpretations of material.

A number of researchers have utilised Foucault’s work to identify what Graham (2005) calls a discursive analytic. She describes this as a journey rather than a set of rules. Interpreters of Foucault’s thought have suggested ways in which his insights might be appropriated to inform research (McLaren 2009; Kendall and Wickham 1999; Powers 2001; Powers 2007; Jansen 2008).

The Foucauldian concept of governmentality has been used in nursing research (Irving 2002). Governmentality is a term used by Foucault to describe the ways in which the government controls the bodies of the population (Foucault 2011). Irving’s study on the use of restraints in the care of the elderly looked at the dominant discourses which legitimised this practice despite it being widely considered as harmful (Irving 2002).

Using the concept of disciplinary power Keenan (2001) explores the power relations inherent in cross cultural psychotherapy with reference to an extended discussion of a clinical case, particularly the role of clinical supervision. In a study of the use of outcome measures in counselling Kelly et al. (2012) used Foucault to interrogate their own role as researchers who also used these measures. This is a pertinent issue for this study in that outcome measures are one of the criteria used in decision making about the allocation of additional sessions of counselling which leads into a description of the study design and methods used.

3.4 Study design and methods

3.4.1 The study site

The student counselling service which is the study site is part of an Irish university. The service is well promoted and easy to access by all registered students of the college. It is free at the point of delivery. It operates within the framework and ethical guidelines provided by the major accrediting bodies for the counselling and psychotherapy professions in Ireland. There are well developed best practice guidelines and protocols which deal with issues such as confidentiality and managing risk. It collaborates with other support services within the college.

The service sees approximately 1000 clients every year. This figure is based on material generated by the study site itself in the form of reports. At various times of the year, usually reflecting the academic cycle, there are long waiting lists for appointments. There can be up to 100 students waiting to be seen especially in the period prior to exams, which means that they are unlikely to be seen before the end of term. The service has a target of offering an appointment within ten working days, however during these busy times of the year it is not possible to maintain this. The service is accessed by attendance at a daily drop in. At this session demographic and other background information is collected and risk is assessed by the combination of clinical judgement, use of a standardised clinical outcome measure and by the completion of a risk assessment form designed for use within the service and based on what is seen as best practice in student counselling. In the majority of cases six sessions of counselling are then offered. The most urgent cases will be seen more quickly. If the counsellor deems it appropriate there is a protocol in place whereby additional sessions can be requested after that. The criteria upon which decisions about further sessions include risk of self-harm and suicide, academic risk which is defined as risk of academic failure and/or drop out, recent traumatic events and addiction issues. It is acknowledged within the service that this is not an exhaustive list and that flexibility must be used in the interpretation of these criteria.

3.4.2 Sample selection of client participants

While it is possible that the six session policy may have impacted on all clients, this study involved interviewing a number of those who received more than the standard number of sessions. This fits with a Foucauldian approach as much of his work focused on those at the

margins of society, who were outside in some way, like those whose attendance did not fit the standard model. For example when one focuses on the margins of a phenomenon its operation and the basis on which it is constructed becomes more visible. The theme of how the subjectivity of those at the margins is constructed by the dominant discourses in particular historical periods and contexts is one of the most well-known aspects of Foucault's work. (Foucault 1977; Foucault 1988)

All clients attending the service had previously agreed in the terms and conditions for accessing the service to the possibility that they might be invited to take part in research. Their response either positive or negative had no impact on their therapy offer

The inclusion criteria were:

- Clients who have attended more than the standard number of six sessions.
- They would not have had any contact with the service for at least three months.
- The group would include a mixture of male, female, undergraduate, post graduate and mature students.

The exclusion criteria were:

- They were not current clients of the service.
- Students who had attended the researcher in her counselling role.

Ninety nine potential participants met the inclusion criteria for the study. Twenty of these were excluded because of previous contact with the researcher. Of the remaining 79 participants 13 who had responded positively to the invitation to participate were interviewed.

Of the 13 interviews carried out, 10 were female and 3 were male. Seven were postgraduates and 6 were undergraduates. Proportionately this is a larger number of postgraduates than would be expected if the sample was consistent with the makeup of the student population which consists of 17,000 overall. Three of the postgraduates had attended the service both as undergraduates and as postgraduates. Two attended the service only in their final year. Eleven were Irish, one was from a European country and the other non-Irish participant had lived in Ireland for many years.

Table of demographics of clients interviewed:

Male	3	Female	10
Postgraduate	7	Undergraduate	6
Final Year	2	Other Years	11
Irish	11	Other EU	2

3.4.3 Sample selection of counsellor participants

The service currently has the equivalent of six full time therapists. This is made up of a group of up to forty term time therapists who work between three and five hours per week. An externally moderated focus group was conducted with nine of these therapists who responded to an invitation to participate. Four of these were sessional counsellors and five were unpaid therapists who were on placement at the service.

3.4.4 Data collection client participants

During a three month period between October and December 2014, 13 semi structured interviews were carried out with participants who had attended for longer than the usual standard six sessions. Semi structured interviews were used in that they provided sufficient structure to enable focus on the research topic but provided flexibility and allowed participants space to develop their contributions in a spontaneous manner (Brinkmann 2014). The timing is significant as the aim was to try to capture participants' interest at a point in the year where they were not heavily involved in exam preparation and where there was the greatest likelihood that at least three months would have elapsed since their last contact with the service. The student participants were identified using information from the service database, which tracks interactions with clients and records their attendance. These student clients were mailed in six groups requesting their participation in the study. As it was not clear what the likely response rate would be, it was decided to send the mails in small batches of about 15 to 20 to ensure that, if there was a high response rate, the researcher would be able to respond promptly and offer interview times very shortly after the initial contact. This mail is included as Appendix D.

The first two mails were sent using purposive sampling techniques to ensure a spread of male/female and undergraduate/postgraduate participants. This was not maintained in the subsequent mailings as there were insufficient numbers in each category for this approach to remain viable. About 20 mails came back as undeliverable. This was unsurprising as the contact details were from the previous semester and had not been updated. Another six responded with reasons why they were unable to participate. Three students had moved and offered to do telephone interviews. There were sufficient participants available to be interviewed face to face so the option of telephone interviews was not pursued.

It became clear that it was important to capture recipients' interest very quickly; responses came rapidly on receipt of the initial mail or not at all. Reminders (Included as Appendix H) were sent to the initially unresponsive cohort until it became clear that requesting participants in batches was generating sufficient participants. This practice was then discontinued. The participant information sheet was not sent out until there was a preliminary positive response. These were then sent out with consent sheets (Appendices E and F). Participants were told that they did not need to be signed until the interview.

One unintended consequence of the mailing was that four students who were included in the mailing afterwards re-contacted the service and in some cases sought additional

counselling. It seems likely that receipt of the email may have played a role in this. The individual student interviews were carried out and recorded in a secure and confidential environment on campus which was separate from the service itself. The interview schedule is included as Appendix G. The interview was designed to explore a number of topics in as open a manner as possible. These were:

- Information about how and why the participant had sought help from the service;
- What their expectations were when they first attended;
- How they learned about the number of sessions they would be offered;
- Their responses to this;
- The process whereby additional sessions were agreed;
- The eventual ending of their sessions;
- General responses to their counselling experiences;
- Thoughts about how they understood the rationale for the six session model;
- Alternatives to this model they might be interested in suggesting.

3.4.5 Data collection counsellor participants

A participant information sheet was sent to all counsellors working at the study site (included as Appendix A). From this a self-selected group formed a focus group which was facilitated by a colleague from another institution. The focus group was asked to explore how they found working with a short contract model of counselling with a view to exploring what discourses they drew on to position themselves in relation to this.

The main topic for the focus group was the experience of working in a context where clients were offered a pre-set number of sessions which could only be exceeded if the client met a number of criteria such as are part of the service policy (Included as appendix I). The main ones were:

- The perceived benefit from the sessions already attended;
- Deterioration in the client's circumstances;
- Risk, which could include academic as well as self-harm or suicidal ideation (the 'At risk' and 'Request for extra sessions' policies used by the service are included as appendix I).

Using these criteria counsellors are able to request further sessions in addition to the initial six. The focus group schedule is provided as Appendix C.

The focus group was facilitated by a counsellor colleague from another institution. Consent sheets were collected at the start of the group (included as Appendix B) and the session was recorded and later transcribed. The researcher was in attendance but did not take an active part. The rationale for this approach was that the discussion might flow more easily if the group was facilitated by an external person who was knowledgeable and had an interest in the topic under discussion but not a line manager central to the delivery of the service. The

researcher was able to provide any clarity needed and to promote a context which was neutral and appropriate to the discussion of an issue which they were all dealing with as a group in any case.

Counsellors already knew that short contract counselling had been discussed within the service in a flexible way. It was also made clear that participation in the study would be completely separate from their work with the service.

The material from both the individual interviews and the focus group were transcribed as quickly as possible after the interviews. The rationale for using a mixture of individual interviews for client participants and a focus group for counsellors was based on the different issues which might arise for each group and to gain an understanding of the range of discourse these important groups draw on when discussing short contract counselling. The clients were interviewed individually in order to protect their confidentiality. This was not an issue for the counsellor participants. However it was felt that, given the dual roles occupied by the researcher, the counsellors were likely to feel more comfortable discussing the issue in a group context.

3.4.6 Data analysis

Thematic analysis was used as a foundation method. Braun and Clarke (2006) stress the flexibility of thematic analysis in that it can be used with a number of qualitative research methodologies, including discourse analysis. Discourse analysis is a theoretically driven approach, so the discourses sought in the data set would tend to be more latent and based on a social constructionist epistemology, rather than being found in the content alone. The question was then how the themes identified might relate to or form discourses. Parker (2014) provides a cautionary note here. He acknowledges that thematic analysis can be used to groups sets of statements in relation to a topic and that this would fall within a 'social representation' tradition of research. However social representations tends to focus on similarities and continuity whereas discourse emphasises difference and discontinuity. An approach which focuses on the interpretation of these representations rather than seeing them solely as emerging from the content can allow them to be seen as configurations of discourse. In this way both thematic analysis and discourse analysis can work together.

Lupton (1992) makes a useful distinction between textual and contextual analysis, two dimensions of discourse analysis. She describes textual as operating at a micro level, whereas contextual refers to a more macro level of analysis. Themes tend to emerge directly from the text. Discourses endure over time and to draw on social and cultural understandings which will be recognisable to the reader, but may come from outside the text itself. (Braun and Clarke 2006; Alvesson and Kärreman 2000).

Janks (1997) describes texts (from which themes are identified) as instantiations of socially regulated discourses. She says that it is not possible to read meaning directly from the text. Rather the different discourses available to readers in different contexts will influence how

the text is understood. Discourses may be linked with certain areas of knowledge for example, medical or legal discourses. In the case of this study it was important to explore what current wider contextual discourses may be utilised by counsellors and clients when they talk about short contract counselling.

Discourses are about effects rather than causes. For example, in interrogating a discourse it is important to look at the purpose it appears to serve and the consequences that may follow from its existence. What may be effectively excluded by the existence of a dominant discourse? What is not present, what is taken for granted, what is assumed, what is not considered are all vital ingredients in recognising the existence of a discourse. In describing how to carry out a Foucauldian genealogical discourse analysis Carabine (2001) recommends identifying themes which form the categories of objects of the discourses, looking for inter-relationships between discourses, identifying the discursive strategies and techniques which are employed, looking for absences and silences, followed by resistances and counter-discourses and then identifying the effects of the discourse. Foucault's genealogical approach to history has developed from his earlier archaeological work. The archaeological approach explores the processes which lead to the formation of objects of knowledge which are governed by rules which define a system of conceptual possibilities in any historical period and are outside the conscious intention of individuals (Foucault 1985). In his genealogical approach this is further developed to suggest that systems of thought and knowledge uncovered by archaeology become seen as true or false through the operation of disciplinary power and are the result of contingent turns of history.

The volume of data generated by these methods was large and presented a challenge in terms of analysis and how to do justice to all the contributions received. The researcher's first step was to familiarise herself with the material by repeated readings of the interview transcripts. In keeping with a discourse analytic approach the aim of the interviews was not so much to identify consistency as to reveal diversity. There were follow up questions which posed alternative or problematic views. Close attention was paid to linguistic nuances. The key issues to consider were the transformation of meaning, the negotiation of agency, the role of the therapist in shaping accounts, issues of power and resistance and the role of hegemonic discourses in shaping clients problems (Avdi 2009).

The counsellor material was analysed first as the focus group was carried out during the summer months when the counsellors were present. The individual interview happened once the academic term started. Both sets of data were initially analysed separately but the inter-relationship between the discourses drawn on by both groups were such that it became clear that a more cohesive account would be achieved by analysing them together.

3.4.7 From themes to discourses

A large number of initial themes were identified. Alternative readings of the material appeared to challenge some of these initial themes, which were then revised. The themes were broadly grouped in terms of their relevance to the study objectives. The themes

provides a means of clustering the data into units which were more manageable for further closer analysis. This was a complex process. On successive readings it became clear that many contributions did not fit into one theme alone. This suggested inter-relationships between themes suggestive of the workings of the different discourses upon which participants drew. This accords with the approach previously discussed and suggested by Carabine (2001). She advises moving from the themes which form the categories of the objects of discourse onto a consideration of the inter relationships between discourses.

The themes were revised in order to identify which of them could be said to represent a discourse and which were descriptions of how discourses operate. Themes are taken to refer primarily to content and are descriptive. Discourses draw on broader social and cultural meanings can come from outside the text, but should be clearly recognisable. For example power and positioning is a description of how discourses operate, which is different from being a discourse. These groupings represented a helpful means of distinguishing between discourses which appeared to be drawn on or attributed to the participants in their position either as clients or counsellors. An important aspect of the study in addition to data collection and analysis was the consideration of ethical principles and guidelines which are integral to the study design..

3.4.8 Ethical issues

A number of ethical principles are common to most research. These could be summarised as the preservation of confidentiality and anonymity, the avoidance of harm to participants, and the gaining of informed consent. Hammersley (2014) makes the point that these are not so much absolutes as principles which the researcher uses to negotiate her stance in relation to dilemmas and situations which arise.

3.4.9 Confidentiality and anonymity

Confidentiality and anonymity was ensured throughout the study. The measures taken were described in the participant information sheets. Confidentiality is different depending on whether the interviews are with individuals or with a group. This issue was mentioned during the focus group and it was agreed that the content of the group would be confidential to the extent that individual contributions would not be identified outside the group, but the general discussion and topics which came up would not be subject to this restriction. The topic did not necessitate the sharing of personal data unless the participants made an explicit choice to do so. The group members were all professional counsellors who worked together and were familiar with questions such as the importance of confidentiality and so were familiar with and respectful towards the request for confidentiality.

Demographic markers were removed or edited so that participants could not be identified. Interview data and recordings were labelled in a way that no link was made between the material and any individual. Electronic and hard data was securely locked away in a safe location.

The digital audio recordings were secured safely on a computer, password protected and encrypted. Access was strictly limited to the researcher and the supervisors of the study. The material will be kept for five years after the completion of the study and then destroyed.

3.4.10 Avoidance of harm

In relation to avoiding harm, there is always a degree of vulnerability when sensitive personal issues are being researched. Participants could become distressed if asked to recall experiences associated with the reasons they sought therapeutic help. Literature on interviewing suggests that this is rarely the case (Kvale and Brinkmann 2009).

As a student counsellor the researcher was aware of the potential challenges and stresses of the student experience. She was able to provide information on local sources of help had the interview process created stress. The study featured retrospective self-reports and the participants' therapy treatment was not be impacted. During the interviews the researcher was vigilant about the potential for conflict between the role of researcher and therapist and so was careful to guide the interviewees to maintain a focus on the research topic and did not explore issues she would have done in her therapeutic role. For example discussion about current functioning since the end of the counselling was not explored in any depth.

3.4.11 Informed consent

It is reasonable to differentiate between agreeing to participate in research and agreeing to treatment. The treatment contract generally includes some desire or wish to change and the possibility of the client receiving interpretations about themselves, whereas a research participant assumes they are being asked for their views only. This can be confusing in a context where a participant has also been a client of the service where the research is being conducted and is likely to influence the decision as to whether to take part. Some of the actions taken to establish a boundary between the two experiences of participant and client involved excluding clients where the researcher had previous contact and conducting the interviews in a separate place. The best approach is to be as aware as possible of the potential for role conflict and to be transparent about the dual role occupied by the researcher (Sanders and Wilkins 2010; Gabriel and Casemore 2009; Bright and Harrison 2013).

From a discourse analytic perspective the issue of consent has generated a lively debate. Hammersley makes the point that as the focus is on discursive constructions based on culture; these interpretations might prove unrecognisable to the participant themselves. He suggests that participants are likely to be operating with different assumptions and are likely to assume that their accounts of their experiences are being taken at face value. He goes as far as describing this as a deception and suggests that participants are being asked to perform (Hammersley 2014).

In their responses Hammersley (2014) and Taylor and Smith (2014) consider that interpretation of participant's accounts is a feature of all qualitative methodologies. In discourse analytic studies participants are recruited as types rather than as individuals. In the case of this study the type are clients and staff who share an experience. Participants are not being invited to perform as such; rather the assumption made by discourse analysts is that life is a performance mediated through language, in which the researcher is also a part of the interaction.

Willig (2012) has used this debate to encourage researchers to interrogate their epistemological and ontological assumptions. She makes the point that informed consent is complex and is a process which can change as the situation changes (Willig 2012).

3.4.12 Position of the researcher and the potential for role conflict

The researcher works as the manager in the study site. This brought its own challenges. There is a growing literature on the role of participant researchers who can bring a particular perspective to the activity of research drawing also on their professional background in particular fields (Sanders and Wilkins 2010; McLeod 2011). The advantages are in depth knowledge of the study site and access to a number of relevant data sources. This needed to be balanced this against the risk that pre-existing insider knowledge might create bias.

In relation to participant autonomy the researcher is mindful of the potential for role conflict for the study participants and for herself in her dual role as a researcher and head of service. She used her research supervision and reflexivity to keep this issue constantly in mind (Bolton 2010). The term reflexivity is a means of describing the personal, emotional and intersubjective processes a qualitative researcher uses to reflect on their research and to acknowledge their own role and therefore the situated nature of the research itself. The manager/researcher is openly committed to achieving the best possible service quality, which involves flexibility, a curious approach and openness to changing practice and policy should relevant evidence suggest that this would lead to a better experience for clients. The manager/researcher was constantly aware nevertheless of an inevitable power imbalance. For many of the student participants these dual roles were not known and every effort was made to ensure that clients personally known to the researcher would not be involved in the study. These concerns should be balanced against the possibility that the researcher's personal position could enhance the depth of analysis which can be provided and will help to avoid simplistic interpretations of the material generated by the study.

The researcher's dual roles were discussed with the counsellor participants before they agreed to take part. All the therapists are experienced professionals or are therapists in training who are on placement with the service. They were aware that as a manager the researcher was involved in the allocation of resources. In relation to counsellor participants, potential role conflict was mitigated by making clear that the purpose and aims of the study

did not include reviews of clinical work. The focus group was solely concerned with the experience of working within the short contract session model.

However reflexivity does not exist independently of discourse. Researchers also operate from within discursive formations and are socialised into adopting positions which come from those formations (Loxley and Seery 2008). Foucault's principle of reversibility prompted the researcher to consider the possibility of alternative explanations which as an insider could be ignored and unrecognised. There is related danger that issues of power could be neglected if reflexivity and the subjectivity upon which it is based, is seen as offering 'truth' rather than a particular understanding of events (Parker 1994).

3.4.13 Evaluation criteria

In identifying appropriate evaluation criteria to ensure the quality and rigour of the study, it is important to ensure consistency with the epistemological position adopted in the methodology. Northcote (2012) suggests that the criteria used in quantitative studies that of objectivity, reliability and validity are not appropriate. She suggests criteria such as contribution to advancing knowledge, rigour in the conduct of the investigation, defensibility in the sense of adopting a research strategy which can address the research question, credibility in its claims and affective in nature (acknowledging the excitement associated with the research discoveries). Other criteria suggested have been plausibility (Taylor 2001) coherence and fruitfulness (Wetherell et al. 2001) and robustness (Van Dijk 2009).

A summary set of criteria from within a discourse analytic perspective is remarkably similar in scope (Avdi 2009; Georgaca and Avdi 2011). They say research should be internally coherent, demonstrate rigor, transparency, reflexivity and be useful. The contribution of research supervision and use of reflexivity are very important. It is hoped that this study can contribute to what Polkinghorne (1992) describes as expert knowledge which is utilised particularly by practitioners.

Discourse analysis is a wide ranging field of enquiry which does not have specific research protocols which are to be followed. This allows the researcher both considerable freedom but also considerable responsibility. Yardley (2000) gives broad criteria which she feels are relevant to all qualitative health research and which are of particular relevance to this study. These are sensitivity to context, commitment and rigour, transparency and coherence, impact and importance. Sensitivity to context has been demonstrated by the attention given in the study to issues of the changing nature of higher education and the role of student counselling within this environment. Commitment and rigour can be demonstrated through the descriptions given of the steps which were taken to identify participants and the process which was followed with them.

In terms of transparency in addition to the material quoted in the findings chapter, further extracts from the transcripts are given in Appendices J and K, accompanied by the

researcher's comments made during the process of listening to the material. A challenging stage of the analysis was the question of distinguishing between themes, categories generated to organise this material and the underlying discourses. In this process of analysis the researcher has tried to be transparent so that alternative readings of the material are also possible. In terms of impact and importance the attention given to these criteria is most clearly available in chapter six which is concerned with the implications of the study. The impact of short contract counselling has not been researched to any significant extent despite its growing prominence as a mode of delivery for publicly funded counselling and psychotherapy services. In order to ensure that the concerns of researchers and practitioners are seen as relevant to each other it is changes in counselling policy and practice such as this one which have developed relatively unnoticed by the research community which should be investigated.

3.5 Conclusion

This chapter has described how the research methodology used was selected. It went on to justify the selection of a discourse analytic methodology and explain the rationale for this choice. A broad overview of discourse analysis was provided and from that exploration how Foucauldian discourse analysis provided the best fit with the research question. The concept of disciplinary power and the associated configurations of power described as bio power and governmentality were explored as being particularly pertinent to the research question. Some of the ways Foucault's thought has been utilised in research relevant to the practice of counselling and psychotherapy was investigated. The study design and methods were described. This involved a description of the study site, how the sample of participants was identified, how the data was collected and analysed. This was followed by a discussion of the ethical issues which arose and how these were addressed. For example the position of the researcher and the potential for role conflict was considered. The final issue addressed was the evaluation criteria to ensure the quality and rigour of the study. Essentially this chapter has outlined a methodology and methods which are deemed appropriate to a qualitative study on student counselling which is reported in the "Findings" chapter which follows.

Chapter 4 Findings

4.1 Introduction

In presenting the findings of this study it is helpful to restate the research question which asks how short contract counselling is discursively constructed in an Irish third level college. This chapter describes the findings which reflect the aims and objectives of the study. These are an exploration of discourses utilised by study participants in relation to student counselling in general and short contract counselling in particular. These are the discourses of stigma, recovery, consumer or patient, productivity, managerialism, surveillance and risk. This is followed by a consideration of how these discourses become visible through the operation of disciplinary power, which is to say that it is disciplinary power which defines what is constituted as discourse. Two topics are considered which are the positioning of the counsellor and the student and the production of the ethical subject. The chapter moves onto to consider the mechanisms whereby the short contract policy is implemented and how exceptions to the standard rule of six sessions are managed. Findings concern seeking and obtaining additional sessions, dealing with endings and changes of therapist.

Details relating to individuals are not given in order to protect their identity and to focus attention on the identification of the discourses which are drawn on. This approach is in keeping with a discourse analytic approach in that the focus is on the expression of discourses by types of subject, (Taylor and Smith 2014). There are some approaches such as the use of a psycho discursive accounts (Hodges 2002; Gough 2009) which utilise individual histories for the purpose of the analysis, but in this case as the study concerns the operation of a policy and responses to this, it was felt that a focus on the discourses rather than the specific history and background of the individuals voicing these responses would be the most appropriate approach to adopt. There are two groups of participants. The student participants will be designated as student participant 1,2,3 (SP1, SP2, SP3). Counsellors who formed the focus group will be referred to as Focus Group Participant 1,2,3 (FGP1, FGP2, FGP3).

4.2 Discourses

Eight discourses were identified. These were all interrelated. Participants generally drew on a number of these which were utilised in different ways by different participants. The first three those of stigma, recovery and patient or consumer, tended to be drawn on by the student participants. The discourse of expert knowledge was drawn on by the focus group participants in order to position themselves in relation to short contract counselling, but was also spoken about by the students. The discourse of productivity was drawn on extensively by both groups but was understood in different ways. For the students it was about the need to return to being productive in an academic sense as rapidly as possible. For the counsellors in the focus group the issue was how to achieve this outcome through the mechanism of counselling as required of them by the university. The expression of disciplinary power through the operation of managerialism and surveillance was felt particularly strongly by the focus group counsellors.

4.2.1 Stigma

Many of the student participants referred to the stigma and sense of shame they feared would be the response if their mental health difficulties were known about by others. This took a number of forms such as worries about being seen accessing counselling and being unwilling to acknowledge to others that they had sought help. This is relevant in relation to the research question in that the operation of stigma is likely to play a role in how short contract counselling is discursively constructed by the participants, especially in the context of whether or not they feel they can be critical of the policy. The stigma surrounding mental health and the sense that it could be seen as shameful to seek help was expressed in anxieties about being seen on the counselling service premises and were cited as reasons for delaying seeking help. In the following extract the student is responding to a question about their expectations in attending counselling,

SP6

‘I was nervous about going because I thought, you know, only crazy people go to, you know, counselling’

Or again later in the interview

‘I was like nervous the first time. You know? So it was great when I went in there, yeah. Like ‘Ah, it’s fine, you know, relax.’ You don’t feel ostracised or strange, you know, it’s a nice environment. You know?’

There is hesitancy about expressing the view that going to counselling is difficult, as indicated by the sentence construction and pauses. The speech indicates that an unpopular view might be being expressed, by the repeated use of ‘You know’ after the uses of the terms “crazy”, “ostracised” or “strange”. This extract illustrates a rhetorical device used to express a certain type of subject position (Billig 1991; Potter and Wetherell 1987). In particular the use of an interpretative repertoire and the various qualifiers suggest checking back with the other, before opinions are clearly stated (Edwards 2003).

Willig describes how some clients position themselves within a moral discourse and construct themselves as desperate for and deserving help, sought only as a last resort (Willig 2012) which suggests that they need to overcome the barrier posed by the operation of stigma before taking this step.

The following quotes are from students responding to a question about why they had sought counselling,

SP 12

‘Counselling made me put things in perspective that, yeah, I had a lot on my shoulders and it wasn’t just me, it was like everything was kind of caving in around me. So like I felt...even though my counsellor kind of helped me put things in perspective a little bit, that like, yeah, like things weren’t that easy, do you know?’

Powerful visual imagery such as 'A lot on my shoulders' and 'caving in' is used in order to justify why counselling was sought in the first place and to convince the researcher of the urgency of the situation. This also suggests that initial reluctance possibly due to the awareness of stigma associated with mental health difficulties had to be overcome.

SP 2

'I just had everything bundled up and everything was on top of me. And I wasn't sleeping and I wasn't eating well and em...I just knew I had to do something about it so I went to counselling and I suppose my only expectation was that hopefully I'd be able to sort out my issues and not feel the way I was feeling.'

Here again is the sense of urgency and desperation, that suggest that seeking counselling was the last thing to try, but also the sense of personal agency is contained in the phrase 'I'd be able to sort out my issues'. This links to a recovery orientated discourse which appeared frequently in the findings about the personal responsibility of the client, that they are the agent of change and the expert in relation to their own mental health. In the following extract from a student participant student counselling is seen as a very acceptable and usual source of help which is contrasted with the how it might be viewed in other environments outside college.

SP 9

'I think it's more accepted in the college environment so it's easier to go, whereas I think if you're out in the general public, it's probably harder, although there's a lot more talk on it, you know em...but it's definitely, because people study counselling and you talk about it, I know loads of people in college who've been to counselling, even though I wouldn't tell them I've been. But I know a lot of...

In relation to the research question on how short contract counselling is discursively constructed in an Irish Third Level college the college environment appears to normalises counselling, yet attending an outside mental health support is seen as stigmatising. This ambiguity is also present when the participant makes it clear that telling anyone else about one's personal attendance at counselling would not be acceptable. In the following quote the student is responding to a question about their experience of counselling,

SP 2

'it just kind of made me more able to talk to...about...about things like, with people like. I only talk to maybe two people about stuff. But that kind of helped me along. Like I wouldn't talk to anybody about things if it wasn't for that.'

The initial expression of this idea is hesitant with pauses and repetitions as if there is uncertainty about how this opinion will be received by the researcher. Later in the interview mention is made of the shame which had been lived with but by learning how to talk to others, shame and stigma became less powerful. That which was hidden could now be expressed and a new position of personal agency became possible. The processes by which

this is achieved depend on particular constellations of power and knowledge which enable the role of counsellor. That part of the encounter encapsulates the discourses of stigma and the development of an agentic position.

4.2.2 Recovery and personal responsibility

This discourse emphasises the role of the client as the one who knows and who is responsible for their own recovery. It is represented in the Recovery Movement (Cleary and Dowling 2009) which sees itself as resisting the psychiatric discourse. This discourse of recovery and personal responsibility appeared frequently in the findings. In the following quote the student is responding to a question about the ending of their counselling:

SP 4

‘...at some point you come to the point where you say like, you know, you can get as many counselling sessions as you want but, you know, it’s not...you have to make yourself better...do you know what I mean? Like yeah, I’ve always seen the counselling service as a kind of a facilitator for you, you know, helping yourself if that makes sense?’

Although the participants adopted different positions when they first sought counselling, most of them described it as a transformative experience which is expressed in the following extracts from the findings. They were responding to a question about their current functioning and the effects of counselling they had experienced,

SP 2

‘It’s like...like my expectation when I went into counselling was that, you know, I wouldn’t feel the way I was but I didn’t expect that I’d feel new things and just look at things...just a new person when I came out of it.’

SP 12

‘Yeah, definitely, because I was just...I was kind of just oblivious to em...what would go on inside me, you know, and I’d just focus on getting through things and just the fact that I was just starting to look at myself more and see how, you know, look at different things. I think that was definitely something new that had come out of it.’

(Georgaca 2011) sees this development of an agentic position of change by the client as a consequence of linguistic processes which are adopted by the therapist. To quote:

‘the therapist is positioned as conveyor of the client’s words, attributing thus the authorial position of his statements to the client, b) that the therapist constructs a common position of understanding and managing the clients problems, co-opting thus the client in an authorial position with regard to his problems, c) that the therapist constructs himself as the witness of the clients past problems and current change, thus validating the client’s new position’(Georgaca 2011, p. 164).

The research question about how short contract counselling is discursively constructed in an Irish Third Level college generated responses which illustrated a range of responses some of which gave more prominence to the operation of stigma, others to the significance of recovery and personal responsibility. This development of a more agentic position linked to the recovery movement can be further linked to a consumer discourse in which there are clear entitlements, rather than a patient discourse which stresses dependence on a master professional discourse. This implies a contractual exchange in which the consumer of services is expected to take a degree of responsibility for their own mental health and recovery and in turn the counselling service should be able to provide what is required in terms of appropriate interventions to facilitate this exchange.

4.2.3 Patient or Consumer

Whilst the discourses of stigma, recovery and being a consumer of services were present different participants gave differing degrees of importance to each and all three could be found in the same interview. For example those of the dependant client versus the entitled consumer who has rights and expectations about how a service should be delivered and what can be expected from it. An example of these different discourses appearing together are given in the following extract. The question being responded to was about the reason for seeking counselling initially,

SP 9

‘I suppose really, em...I just had...I felt I needed counselling for a while anyway and I just felt that since I was in college I should try it..... I thought (after) those sessions, I would never have to go back again but as I did [inaudible] I thought I would be okay but it’s...there’s a lot I suppose. Then I went em...I went back, I think it was after...it was after third year I went, but she kept me, she said I could, like, it was around Easter I went back to them and they were busy so it kind of dragged into May or June and she said she could take me on during the summer. So I think that was more than six sessions that time.’

A number of the discourses already described can be seen in this quote. The therapist is positioned as the master who must be obeyed who made the decisions (‘She kept me’ ‘It kind of dragged on’). This is mixed in with client as consumer (‘I thought that I should try it’, ‘I did not know what I wanted’). There is a reference to the college discourse which normalises counselling in that particular setting (‘I felt since I was in college’). The doubt about seeking help possibly influenced by stigma discourse and the expectation that it would be a quick fix is expressed. This is followed by the dawning realisation that this was not the case and a more active stance on her part which fits with a recovery discourse, would be involved. Drawing on these different discourses is mirrored in her change of position from dependence to that of a more active agent of her own recovery.

This discourse of personal responsibility fits well with market discourses and practices which have increasingly encouraged patients or help seekers to view themselves as service consumers with entitlement (Plastow 2010a; Goldstein and Bowers 2015).

What is taken for granted and is not questioned is that counselling is good and desirable, but there is no automatic entitlement to it even within the University scarcity is accepted as normal which in turn normalises the delivery of short term interventions. This in turn creates dilemmas and difficulties particularly for counsellors in the focus group who spoke about the dilemmas they felt as professionals trained to work in a particular way which could be different from what was expected of them in an environment where short term counselling was the dominant mode of delivery.

4.2.4 Expert Knowledge

Claims to expertise are generally legitimised with reference to a particular body of expert knowledge and skills which relate to a particular area of activity in this case student counselling. The question of expertise was very important to all participants both counsellors and students. Counsellor participants spoke about their training, the importance they gave to the development of a therapeutic relationship and the desire to work at depth rather than what was seen as the 'surface' in order to fulfil the requirements of the college discourse. They discussed issues such as the evidence base for their work. This was contrasted with descriptions of the pressure they felt under in the study setting and the sense that their professional identity was now being linked to issues such as speed of intervention rather than quality. They talked about having to become gatekeepers and advocates while feeling relatively powerless themselves.

The context of short contract counselling means that claims to expertise based on role need to relate to that context. This creates a dilemma for the counsellor participants in that the professional discourses they drew on were developed in a different context and with the expectation that counselling contracts would not be predetermined by the setting itself.

In the following extract from the focus group a distinction is made between working on the surface or in depth and is contrasted with a previous role as a coach:

FG1

'I could feel it in the first session that it's...it's...it's more underlying, you know, and that we can work with the six sessions on the superficial level but I feel sometimes frustrated because I feel, you know, the work that would probably be more beneficial long-term would be on deeper layers, and em...yeah. '

That distinction between surface and depth itself causes frustration because, as counsellor rather than coach, there is an awareness of what isn't being addressed. She points to the therapeutic implications of only addressing the surface. The suggestion is that counsellors work in a different way, which is more desirable and more sophisticated. This view was shared by other counsellor participants. The effect of this short term contract model on the

therapeutic relationship , a factor emphasised in many professional trainings, is emphasised in the next extract from the focus group:

FG2

‘...and the amount of time it takes to build up a relationship sometimes with somebody. And I thought in six sessions I mightn’t even remember...you know, there’s a lot of stuff that you wouldn’t have done in six sessions. And then I know, having been there a while now, some students are only able for six sessions and they only want six sessions. But it would be very good to have the option, freer option, to see them for longer. But it’s just that thing of relationship with the client that takes a lot longer than six hours with all we’re talking about, you know? So, my initial thing was, “God, that’s really short. What would you get done in six sessions?” you know?’

This view was supported by other members of the focus group. The fear that the pressure of the time constraint will undermine the quality of the counselling was described. This is contrasted with the realisation that some clients may not want or be able to cope with anything other than short term counselling. This is an example where a professional discourse (longer is better and the therapeutic relationship is important) may be at odds with a client one, the discourse of the client as decision maker and consumer. It speaks from a professional discourse of knowing what is best and from the desire of the counsellor to feel freer, to have more options, while also recognising that this is not possible. The contributions from counsellors while expressing doubts and reservations about the six session role did not at any point challenge it directly.

When help is sought from a therapist an asymmetrical relationship arises. One party supposedly has knowledge while the other seeks to avail of expertise. Within a medical/professional discourse the therapist is clearly in the more powerful position. This is a master discourse which positions the therapist as the master to whom expertise and credibility is attributed. If the patient does what they are told, in the case of this study to recover in the allotted time frame for the counsellor, then they will be cured (Verhaeghe 2008). This position is elaborated in the following extract where the student is responding to a question about the relative importance of getting seen quickly or waiting to recommence with their original counsellor.

SP1

‘Well I guess kind of like the only way I can think of right now is kind of to take the...take the choice out of the patient's hands because at that time they're not exactly going to be thinking very clearly, are they? They're going to be going into counselling like thinking 'I need help' and just 'I want something done right away’.’

Later in the same interview the participant was more sceptical and questioning of the status of mental health professionals and expressed uncertainty about the reliability and dependability of its treatments:

‘The thing about mental health as well is like it's a relatively kind of modern thing as well isn't it? Like it's not exactly a big historical basis. So like, I don't know, I'm guessing there isn't exactly, you know, any kind of perfect procedures in place to do it like because it's a relatively new discipline. Well, not necessarily relative...yeah, it's a relatively new discipline like’.

This comment which challenges the professional basis of student counselling is not inconsistent with another discourse which is that of productivity in which all participants whether students or counsellors have to get on with what the university requires of them as the first priority and that that takes precedence over other considerations such as professional expertise.

4.2.5 Productivity

The utilisation and provision of counselling has become the norm in most Irish third level colleges. Alongside a number of other college based support services this is the socially legitimate and accepted means of gaining support and dealing with crises and emotional upset. One discourse about student counselling describes it as promoting and supporting academic functioning, in other words to promote student productivity. This approach tends to be favoured by funders and some student counselling services (Mair 2015) and fits with a productivity discourse, in which the purpose of the university is to produce well-functioning, productive and resilient citizens (Aubrecht 2012). Another discourse is the professional discourse, which stresses the importance of therapeutic principles as developed through initial counsellor trainings and which has become enshrined in government policy towards education (Ecclestone 2004; Ecclestone and Hayes 2009b).

The tensions between these discourses of productivity and professionalism can be discerned in the following extract which poses these two issues.

SP 1

‘And, yeah, it's just the college mentality, that you have to sort of...you're here for college, you're here to learn. Everything else can supplement that, including the counselling. So it's a means to an end rather than, you know, something to make you...well it's a means to an end in the academic sense rather than something to make you feel better about yourself and better about life.

You almost like...I may be wrong in assuming this but, [inaudible], in a sense you might feel as...feel as...feel it is like another class or like feel like the counsellor is another lecturer that you have to kind of..... towards the end of my degree, that I'm thinking 'If I'm not in great form, so what's the point of a degree.' I could have the best degree, I could have a 1.1, I could have a hundred percent in everything but, you know, if I'm depressed half the time then what...what's the point of it really?

Yeah, that is true because you're actually like given a kind of a timetable when you first go into the...to the service, to the student counselling like saying what time your lectures are on so like they know not to make an appointment for that time.'

This speculation about commodifying students addresses the university discourse of productivity. Counselling is described as just another part of the required learning. This belief is supported by the experience of appointment scheduling which highlights how the actions of the student counselling service in trying to make attendance fit in with the academic timetable is interpreted as a processing the student through the college system.

However this view was not shared by all. For others their involvement with the counselling service was described as something quite separate from other aspects of college life.

SP 12

'They were there for the student. I really felt like that. I didn't feel like they were...they were involved with the college.

I'd probably fall on the side of they were trying to get a general holistic, you know, trying...for the well-being of the student not for your academic life.'

A contrasting position suggested that the separation of student support from academic achievement was problematic and that counselling would have been more helpful had it been integrated into the academic aspects of college life.

SP 13

'Mmm, probably it would have helped maybe a bit I...I suppose. I never thought of it before but yeah, it probably would have helped to kind of talk about it academically to em...it could have maybe...maybe I could have learned some more ways to do my assignments and focus on lectures and maybe as well I could have been able to talk about when I was finding something really hard and they could get into contact with the college. But we didn't really talk about it.'

These accounts demonstrate that a reading of student counselling solely as an activity geared only to process students would miss the complexity of the responses. Some participants were critical of the focus on academic productivity, while others said that insufficient attention was given to this by their counsellors. The degree to which student counselling and academic performance were described as separate was, for them, a negative factor. What was clear from all the responses was that there was a clear need to function well and be productive; while scepticism was expressed by some they were all very clear that they understood that that productivity was expected and was a discourse widely drawn upon.

The practice of offering short contract counselling was described by the participants both counsellors and clients as a response to the level of demand for counselling relative to the resources available to meet that demand. The positions adopted by participants ranged

from outrage that their needs were not met to describing themselves as powerless. Attention was given by all participants to concerns about the factors which might be contributing to this increased demand, but the main emphasis was placed on what is seen as the scarcity and lack of supply of counselling resources to meet demand. For example the next extract draws attention to some possible consequences of the expansion in third level education and is offered in response to a question about possible alternatives to the six session model.

SP 7

‘Just em...reflect a little bit more on the college, on counselling in college because I was just thinking that, you know, in the em...in the past I suppose people who had long term difficulties might have found it harder even to get to college, now it can be that people can get into college but it can be hard to necessarily get the support once they are in there and I don’t know whether you kind of agree with that or not or you feel that you’ve...what you would need from the college end or...’

There is awareness of the changing composition of the student population and its more diverse needs, but hesitation is expressed about expressing a view which might be contested. The extract draws on the discourse of scarcity but challenges it and suggests that resources need to be increased in view of third level expansion and so scarcity is not inevitable and can be responded to by structural change. This view was relatively unusual. Most participants did not challenge the apparent inevitability of scarce resources. In response to a question about whether there are any other possible ways of dealing with scarcity the following response was given

SP 4

‘It’d be kind of...it’s hard to pick out which ones are the most deserving of it, you know?

No. No, well not...the choosing part is not a job I’d fancy. [Giggling] You know? That’d be a difficult one. I can understand how they use the six sessions because that’s a cut-off point that’s arbitrarily decided before they start, you know?’

Value laden terminology such as “deserving” and “choosing”, implying a moral discourse is used. It is suggested that the imposition of a rule even an arbitrary one is the most likely outcome.

In the following extract the implication is that more should be available for those who need it. Some counselling services (excluding the study site) manage this by excluding those who it deems would need more than the standard number of sessions (Mair 2015).

In response to a question about whether to offer a standard number of sessions or to tailor the number of sessions to individual needs, the following extract describes a dilemma:

SP 10

'I have no idea what the demand is like so...eh...you know it's...I think it is a difficulty. I mean, let's say they didn't...the university has this...this limitation policy, are there other universities that don't have?'

The participant expresses doubt then tentatively raises the point about limitations, going on to wonder is there any alternative, a question which was rarely raised by other participants in the study. The invisible unquestioned assumption is that scarcity and imposed limitations are a result of decisions and choices made elsewhere. This is so taken for granted that - other alternatives barely surface as possibilities. The question asked was about their thoughts in relation to the six session model such why they thought that it existed,

SP 3

'Talking to other students around the college and I've heard many good things about the service, particularly coming up to exam times with em...stress of exams often bring out other stresses and it seems to do very well for people who have that...those kind of issues, where it's just, it's just procrastination or 'Oh I'm never going to learn all this in time' or whatever and I mean it seems to work very well for that. But for other situations em... it's not nearly sufficient.'

This participant is drawing on a discourse which emphasises academic functioning and productivity, but also draws on a professional discourse which suggests that is not adequate in terms of mental health needs and is alluding to the provision of a service driven by what the client needs/wants which reflects a recovery discourse.

In the following extract the response to limited sessions is described as similar to a dose of medication. The participant contrasts this with a more relational approach which would require the build-up of trust and would seem to reflect the influence of a professional discourse which emphasises depth of therapeutic engagement.

SP 13

'It kind of felt less personal or something. It felt more em...like em...like a clinical kind of...or something. It felt like a prescription of like you go six times and then that's it or whatever as opposed to like, you know, that you build up a kind of trust and...'

Here the dominant bio-medical discourse has colonised a more psycho-social mental health discourse, which the client would have preferred.

Another participant adopted quite a fatalistic position, in response to a question about when they first became aware of the six session policy, It was taken for granted that it was not possible to have what he needed.

SP 6

'No, I didn't really mind. I thought it was just normal, yeah. I...I didn't know...I suppose I kind of thought sure their time is probably limited and it's a free services so, you know, there might be a queue of people lined up waiting, you know, so...'

Counsellors were aware of the impact of scarce resources on students and echoed the comments made by client participants on this topic.

FG3

'But at the same time, I know I've had students that were sick and they said "Oh, I missed a session. That means I've only got three left" and, you know, getting...and I'm trying to reassure them "If you're in need, don't worry about it. You can...you'll be...you're going to be supported..." you know, "...you're not going to be kicked out if you're not ready to leave." That...that...maybe I'm wrong supporting them. It's not like I've had loads of extensions. I think I may have had three or four in the year, but some of them can get quite anxious about that.

In this quote there is an attempt to mediate the potentially harsh effects of the six session policy. Reassurance is given to the client mixed with uncertainty that there is the ability to deliver on these reassurances. The emotive term "kicked out", an act of violence is used. While uncertainty about the ability to obtain an extension exists for the counsellor, this anxiety is attributed to the client only. The anxiety expressed by the counsellor is in terms of justifying that she does not often request extra sessions which suggests the influence of a managerial discourse which result in her actions being under surveillance.

SP 1

'...there's a lot of cutbacks and everything there. So like they have to kind of like really prioritise what they can do. And I was actually talking about this in class with some of my classmates and we wondered that like would they have to get rid of some services and only do some other services because it's what the college wants them to do. Rather than it being like what's in the best interests of the students. And I wonder could that...could there be a similar situation with the counselling?'

The scarcity discourse is used but broadened to include the invisible presence of the college authorities who are both removed from the immediate effects of their actions and are suggested as not having the best interests of students at heart. The processes of decision making are not visible to the participant but the assumption is that they are hidden and mysterious. This is a potential site of conflict which is diffused by being attributed to an external powerful 'other'. Participants drew on a number of discourses in their responses to scarcity. For some there was a sense of outrage that their needs and entitlements were being ignored which links to the discourse of the client as consumer or 'patient'. Others focused on their own particular circumstances and justifying why they felt that their need was greatest. Some drew on suicide risk as the central and appropriate criterion for making

resource allocation decisions. Focus group members described the additional pressures they felt under having to work fast, to act as advocates for their clients and make decisions about when to seek additional resources and in particular service policy required them to address issues of risk as a justification for the additional sessions.

Student participants generally described feeling put under pressure and being expected to return to functioning academically within the six session timeframe. This dilemma is described from a client perspective in the following extract when asked about their view of the six session policy. The six sessions are described in positive terms but then on reflection a limitation such as the pressure this places on the process of recovery is explored.

SP 2

‘And, in a way...say, in a way I think that was good because, you know, the fact that it was a shorter space of time that I was able to accomplish it but if it was longer I probably would have accomplished more maybe or kind of had more...I wouldn't have had to focus so hard on...you know, I wouldn't have had to have put so much energy into...into it, into kind of trying to make the changes.’

Elsewhere in the interview the participant describes herself as someone who copes even if it means putting herself under pressure. The description of the experience in counselling suggests that this compounded the pressure. This sense of pressure was shared by staff participants in the focus group.

FG3

‘It does put me on some sort of a, em...what would I say? Some sort of a rush. Rush is nearly too fast a word but there's something more. Oh I have to do something in these six sessions or there's some more agenda or something than there might be if I have a longer time with a client. So, the impact on me is something around being more agenda driven maybe than my training would be, or being more task orientated probably.’

This participant sees this pressure as changing the whole dynamic of the counselling relationship to one where goals have to be achieved, where counsellors have to demonstrate that they can cope. She is describing the tension which exists between competing discourses between a managerial discourse which stresses results and contrasting this with a professional discourse which would be familiar from counsellor training.

This is given further elaboration in the following extract from the focus group:

FG4

‘So I had some experience, good positive experiences, of short-term counselling work with people and I felt quite positive about what you can achieve short term. But I did have concerns about em...how to, in a way, how to em...limit or how

much...how to take slices of it or where to focus or how to eh...in a way, how to contain the work em...so that it was useful and digestible and em...to the...to the student in six sessions. So a bit sceptical, in summary, a bit sceptical. Aware that I needed to em...to work slightly differently. That I didn't...that things wasn't as leisurely as I would have been used to myself as a long-term counsellor. As a long-term eh...client in counselling as well, in psychotherapy.'

Short term counselling while described as attractive suggesting as a quick fix for the participant also contained a demand to make changes quickly which then had a negative stressful effect.

SP 1

'There's a little bit of pressure like to sort of get the important information out and not sort of like...and not sort of like waste time, for lack of a better term.'

SP 12

'I suppose six is very short but I suppose you would have to try and cover certain stuff or at least give them certain skills so they can get through afterwards. [Giggling] Like it's only six weeks. I think so, yeah. Yeah. They probably wouldn't get any chance to tell the counsellor anything. You just were told everything you have to do to make your life perfect again. [Giggling].'

Here the participant shifts perspective between her own view and views attributed to others. She refers to the counsellor's need to impart skills to service users. The development of self-management and coping skills geared towards the rapid return to function is an accepted role of student counselling services and reflects the productivity discourse which relates directly to the research question of how short contract counselling is discursively constructed and the effects and consequences of this.

4.2.6 Managerialism

Linked to the productivity discourse is that of the managerial discourse, which stresses rapid results, rapid student turnover and the ability to fulfil all service reporting requirements and operate under pressure. This is experienced directly by students as is reflected in the following extract which was responding to a general query about expectations held prior to attending counselling,

SP 13

'So...yeah like...and then I come here and suddenly kind of it's, well, one building and kind of a small group of counsellors trying to accommodate a lot of students and trying to do it a lot quicker as well, because, you know, they're in and out of college here every day. They've kind of like hectic lives so you'd want to kind of get them seen as quickly as possible.'

The discourse of the professional is significantly changed in a context where rapid results are required. Whereas longer was described as desirable, in this extract the main reason given for taking longer is that the counsellor is less experienced. The counsellor here is being socialised into a particular professional identity where there is implied equivalence between speed and professional competence. At the end of the extract this participant does allude clearly to awareness that there are possibilities other than the six session model, even though they are out of reach in the current setting.

When students access counselling they are asked to complete a form outlining their presenting issues. It could be suggested that, given the wide media and public attention to the issue of anxiety and stress, clients are 'encouraged' to fit into this category and to self-diagnose themselves as suffering from anxiety. A counsellor participant describes this process in the following quote:

FG7

'Yes and checking the medication and that you have the contact details right, em...you know, checking, bearing in mind what they...what they might have said at drop in as their primary issue, because I find that nearly every student will put down anxiety because they are feeling anxiety and for me that's a symptom it's not always the main issue they want to work with. So then you've got to see, you know, what...what really, what's going on for them, what's thewhat's the more substantive issue that they want to work with.'

There is an implied but undeveloped suggestion that pressure to function at high speed and the development of anxiety are linked. She expresses the view that the six session model can militate against the therapeutic task. She describes the competing pulls she feels between gathering info and concentrating on forming the relationship with client. She sees a tension between what is required by the service and what she herself sees as important. She suggests that there is an erosion of professional autonomy. There are two competing discourses that of the professional and that of the college. The professional discourse values relationship and time, the college values academic functioning and ability to produce results within a rapid time frame.

FG8

'I was a greenhorn. I didn't know, you know, I was just trying to...to figure my...trying to work my way through it and work out what was going on gradually, I was a better judge em...from reading the notes in the first initial meeting with the client, what was going on, what might be needed. I got a better sense of...I think, really, em...I'm not sure if somebody mentioned this before but it really got me focused on what was needed now, [laughing], and if I had more than six sessions, where I might go.'

Here the discourse stressed the need to be able to act quickly as a demonstration of professional competence. Counsellors described a perceived erosion of their expert

knowledge, a sense that how they worked had to be visible and to ensure that they complied with role requirements. Some of the mechanisms described earlier in this section such as the need to complete various forms contribute to a sense that they were under surveillance which is closely linked to the concepts of disciplinary power, governmentality and the panopticon discussed in chapter three.

4.2.7 Surveillance and risk

For a managerial discourse to be successfully established there needs to be mechanisms in place to ensure compliance and visibility of outcomes. These operate not only at the level of fulfilling explicit reporting requirements but also at the less visible level of what is considered necessary by professionals themselves in order to feel they are acting in an acceptable and professionally competent manner. In the short contract counselling environment part of this involves the ability to work at speed and under pressure. This also means being willing and able to comply with whatever are considered the dominant markers of acceptable professional practice. In the current context this is evidence based practice (Tanenbaum 2005). Particular examples are given which refer to the relationship of counselling research and practice. Evidence of acceptable practice in this setting links to the ability to have effective systems of risk management. In a risk-averse culture, with a strong tendency towards litigation, with the potential for blame to be attached to agencies when things go wrong, and where there are stringent protocols for the identification and management of high risk students, a potentially explosive anxiety provoking context is created (Lupton 2006). Responding to risk has become a high priority in higher education counselling services (Reeves 2015).

In the following quotes from the focus group the counsellor is describing himself and the group as powerless in a system which makes decisions and generally expects total compliance but which allows a little leeway in particular circumstances. The rules are taken for granted. Although there is scepticism, there is also acceptance that small modifications such as the granting of additional sessions are the only possible changes. Some study participants expressed considerable scepticism in a context where brief manualised models of therapy have gained a certain legitimacy by virtue of their claims to offer visible results, for example a certain duration of treatment leading to an evidence based outcome. The process involved in gathering this evidence is itself a source of pressure as described by a counsellor in the focus group.

FG9

‘So I sometimes find that first session exhausting and then you’ve got to go back and fill in all your notes and that does feel rushed for me at times. That’s when I feel that I am, you know...you know, “damn the six session policy” and I’m trying to do two person’s jobs at the same time, I’m trying to gather information and com...you know compile a kind of sheet of information and also ask about medication and ask about, you know, family history, eh...ask about previous experiences of counselling and if

that isn't to be a box ticking exercise to do that at a em....to pace that well and em... not to rush the client and then also to try and start to engage. So what's the bit they'd like to work with now? This might be different than what they had even said at drop in.'

Therapeutic modalities have their own languages. Increasingly these have infiltrated participant's speech as they have become part of popular culture. One of the most influential of these is CBT. As a manualised approach it fits easily into the dominant medical paradigm and has utilised the scientific discourse to make claims for the efficacy of its approach and was seen as essentially a short term approach (House and Loewenthal 2008; Shedler 2015).

Another participant draws on this and suggests that there is little actual connection between psychotherapy research and practice:

FG 10

'I am just thinking of one evidence based thing from...I'm...I'm interested in eating issues em...' X' has done loads of research with, you know, CBT enhanced...Cognitive Behaviour Therapy's lowest levels to say that...and he would say that for somebody with just...just anorexia em...Nervosa or Bulimia, em...or binge eating, with no other core...[inaudible] morbidity, em...that...that...that twenty session is what is needed. That's the industry standard and if you want to go to evidence based, if that's all it's cracked up to be, which I don't think really it is particularly but em...then twenty sessions. But for somebody that has depression as well or severe anxiety or some other thing he wants forty sessions. I don't know how you go up to...go up to the bursar's office and say this is...this is the evidence, you know'

Sometimes short contract counselling is discursively constructed in the setting via a manualised approach to therapy as advocated by CBT which operates on a principle that one size fits all however this is challenged by this finding. Additionally funding models can take precedence over research findings in the allocation of resources which supports the discursive construction of a short term model.

The identification and management of risk has become the most important criterion in decisions about resource allocation. As Lupton points out, expert discourses position people as being 'at risk'. This then effects individuals' view of their bodies and their selves (Lupton 2006).

In the first extract the student adopts a position of incredulity that not enough was being done to respond to the need of students for counselling. A clear statement which draws on the discourse of risk is made but is followed by uncertainty.

SP8

'I suppose I...I thought two things,. Em...so that, my first impression was that this is really good (counselling service) and yes as I said you know, why is it so limited. You know I just couldn't understand that because I know we have big issues in Ireland with suicide and young people and all that so I thought hmm but I mean....'

SP10

'I can understand that there is a limit to resources so therefore the university figures out who needs it most and therefore, you know, it can't just go on forever or, you know, when people are seen it would be people who are at higher risk who would be seen first I would imagine, you know, if the rate...I'm sure there is a rating system of some sort. I know that document I filled out at the beginning.'

Here the risk agenda is tacitly accepted. Risk discourse has become so dominant that it is not possible to challenge its far reaching effects, or to even challenge its dominant place in the public perception (Lupton 1992). What is being drawn on is a discourse of risk which suggests that it is something which is quantifiable (by using rating systems for example) and the implication is that it is something the counselling service should be able to mitigate against by having processes in place to manage it.

SP1

'...there was kind of the initial risk factor, so you can't just say "Go back...go away and come back in two weeks and we'll get you the person you were with two years ago" because that's sort of dangerous.....Because you don't know how that person will react when they go out the door. So like, when they go in at the time they definitely kind of need to be seen or need to be sort of like, assessed.'

The concept of danger is being invoked. It is implied that danger is not only about individual safety, but also about the consequences for counselling services and for other clients who are consigned to waiting lists.

SP11

'My second counsellor, she told me the people who get the second sessions of six em...counselling, they are the people mostly who are at the risk of suicide'

This participant had earlier argued against limitations on the number of sessions offered, but by the end the interview said that these limitations were 'proportionate'. Her change of position may have been influenced by the counsellor's explanation that additional sessions are mostly given to people at risk of suicide. Placed against such an extreme, it is difficult for a non-suicidal student to request additional sessions. The risk discourse becomes a regulatory measure (Lupton 2006). To ignore such a discourse can evoke responses such as guilt. This links to a broader discussion about how subjects manage themselves and learn what is expected of them and what is deemed to be appropriate behaviour. In this way the

delivery of short contract counselling is constructed in the space between the counsellor and the client.

4.3 Disciplinary Power.

Foucault (1977) described the development of disciplinary power as a development which followed on from physical power exerted over bodies by a monarch. It describes a particular type of power which is exercised by governments and which the subject then exercises over their own person. This included rules of conduct and appropriate behaviour. What follows from this conceptualisation is a series of disciplinary practices promulgated by various sciences (such as psychology, psychiatry and psychotherapy) which were developed and to regulate populations and individuals and construct the person with recourse to particular knowledge. He termed this bio power (Foucault 1979). The following extracts give examples of how this operated in the study site. This is not seen as a simple imposition of power. While individual behaviour is constrained by available discourses and certain rules of conduct and forms of self-regulation, resistance also occurs. Individuals position themselves in particular ways. Drawing on Foucault's later work Hanna (2014) uses the concept of the production of the ethical subject as a way of understanding some of this positioning. The following subsections consider two topics which are the positioning of the student and client and the production of the ethical subject which are aspects of the operation of disciplinary power. The discourses themselves are all inter related, impinge on each other in various ways and are often in a state of flux and change.

4.3.1 Positioning of student and counsellor

In the following extracts a question is asked by the researcher about whether or not the student could say something to the counsellor about things if they were unhappy about something, either in relation to working with a particular counsellor or any other matter relevant to their experience of counselling.

SP 2

'Well I say probably not; definitely not. I'd be more inclined to like worry about their well-being or their kind of, you know...you know, how they feel out of it. Like, say imagine if I went in and said like "I don't get on with this person. I want someone new". Just like I think I wouldn't get over how they'd feel about it because, you know, they could go home thinking 'Oh this person...' you know, '...didn't like me. They didn't like my methods so...'

This was linked to a sense of dependency and a fear if the therapist cannot be relied on to deliver the necessary expertise, then the therapy will be jeopardised or curtailed. The dependency is one dynamic but in the context of an ongoing relationship the emotional and social bond also leads to a sense of care for the counsellor and a desire not to cause upset or conflict as shown in the next extracts from the same interview which was in response to a question about whether they felt they could challenge the counsellor if they felt they needed to.

SP6

'It was more being offensive. I didn't want to be of...I'd say, at the time. I can't really remember at the time'

In the following quote later in the interview that position is reiterated but in stronger terms.

'Yeah, yeah, I would have been kind of 'That'd be kind of insulting if I say that actually, I want to go with someone else.' [Giggling]

Yeah, I felt kind of guilty, you know, because I was...I'm not sure, I don't know did I waste his time or did he have someone else that could have used...used the service, you know?'

There is a sense that the client is privileged in being able to access the service which has been discursively constructed in an manner that conveys this privilege, therefore they should willingly obey the counsellor. If not, then the result is an individual sense of guilt. The client is positioned as supplicant. It demonstrates how a person internalised the 'discipline' of counselling and what is expected of them. Foucault's concept of governmentality is helpful here (Irving 2002; Keenan 2001; Gutting 2005). Counselling is can be understood as one of the discursive practices which determines a knowledge about the person and is utilised by the state in the control of its citizens. One response is to view the therapist as equally bound by context and restricted in what they can do or offer. The student and the counsellor are defined by the knowledge produced by the discipline and as such particular ways of being and operating are taken for granted by them. Foucault's thought emphasises that for power to exist resistance must be possible. In a counselling context resistance might not be so visible and apparent compliance may not be the whole story. The following response is to a question about whether the six session policy had affected their experience of counselling:

SP2

'It...it held back on some things that were kind of a bit...I suppose I just delved what was on the surface, you know, what...what I felt I really needed to sort through. Whereas there's...there was a few kind of deeper things and I didn't really tap into them because I...I knew it was only short term and I thought there's no point bringing this up now and leaving.'

A dilemma is described of feeling that a complaint could be made but this seems impossible and that the awareness of scarcity leads to silent compliance which can also function as a form of resistance to the counselling process itself.

SP3

'I guess I'm grateful that there's anything at all. So that I'm...wouldn't be as...yeah, I wouldn't be as much to voice complaints about it.

I think you do have the right but don't feel like you do. It might be a free service, but it's still a service, therefore the clients...'

This tension is encapsulated in the phrase, 'It might be a free service, but it's still a service'. The sense of deprivation means that so little is available that any complaint might mean the removal of that little. The implication is that service users should be grateful for whatever they get and not question it. This is an example of the tension between the discourse of consumer rights and being positioned as a supplicant reliant on 'charity'. There is a tension between discourses about needs, rights and regulations which have to be negotiated by clients. These tensions can impact on the therapeutic encounter in different ways and have the potential to create resistance which may not always take visible forms. To further explore the operation of disciplinary power the findings suggested that a number of discourses related to the disciplinary function of student counselling were operating.

4.3.2 The production of the ethical subject

Study participants described ethical issues and dilemmas which they have to negotiate, drawing on the sometimes competing discourses of their own personal needs, rights, rules, social bonds and obligations to others, in their responses to short contract counselling. Choice of position is constrained by the available social and cultural discourses (Baly 2010). It is important not to assume that subjects assume coherent positions, rather they shift their stance to deal with the various dilemmas and contradictions they experience (Billig 1991; Benwell and Stokoe 2006; Reeves 2015). The extract demonstrates just how multi layered are the speech acts which express the dilemmas experienced by a student dealing with a situation where needs are unlikely to be met or if they are met this could be at the expense of someone else. The extract comes in response to a question about alternative ways the issue of scarce resources could be approached, if the participant were in a position to influence such decisions.

SP8

'Okay, I wasn't...I...I didn't go in everyday or even at the beginning thinking you know there is a lot of people waiting for this blah blah blah. I didn't, but at the end I was aware that...I'm not saying that somebody said to me, which they probably did, "Well there is a long waiting list and you know this is how it is" eh...I would have that awareness myself as well from once I knew there was waiting lists I would be aware, you know, that everybody, you know? Well I see what you're say...I know what you're saying, I don't agree with the limitations and I don't agree that a client should worry that if this person, this client, needs more that they are taking it away from somebody else. I don't agree with that and I don't think that's a good policy at all. The point is that is how it was for me. There was a big waiting list. Eh...having a second set of six sessions was the limit as far as I understood it and so...and I can't...I don't want to say that I left feeling really frustrated...la...la...la I didn't. They were very good sessions and I felt the value of them but certainly I would have been aware that eh... there were a lot of people on the waiting list.'

In this extract there is a struggle to reconcile different issues, the impossibility of getting what is wanted and awareness of others' competing needs, the need to develop a response which the participants feels is justified and acceptable to herself based on an ethical position. The discourse of the student as consumer who should get their needs met is drawn upon, as is the discourse of scarcity and the impact on others of getting one's own needs met. At the end a statement is made about how useful the service had been despite not being able to obtain what was wanted from it. This extract illustrates some of the processes which contribute to the production of the governable and ethical subject.

A further ethical dilemma is the challenge of not only behaving and regulating oneself as an individual ethical subject according to a moral code, but to what extent can this be extended to a view of how others actually or ought to behave. This could be seen as representing competing discourses which are those of individual rights versus collective responsibilities. The following extract illustrates how difficult it can be to not only to sustain a stance of personal responsibility but to then extend this to a view or a judgement of how others should act

SP10

'...you know like if...if those were the first...if that was the first time you'd ever gone into a situation like this I do think that em...because people have a lot of uncertainty around it, like they...or they don't know...they presume that they don't know what's right for them...you know like sometimes, em...you do kind of have your own intuition about what you need...'

The implication is that the student knows what is best drawing on a recovery discourse, but does not wish to criticise others who may not share this position. It is suggested that others who are more uncertain may position themselves as patients dependant on the available professional and medical discourses. This allows for the adoption of an ethical position of tolerance and acceptance of others differences.

The foregoing discussion links very clearly with Foucault's concept of self-policing and governmentality (Foucault 1977; Foucault 1979). In this configuration of power the emphasis is placed on the manner in which subjects self-govern by internalising rules of conduct and try to behave in ways which are acceptable to them and are linked to ethical positions within a moral universe. The internalised rules are drawn on to avoid questioning the duration of the intervention.

4.4 The effects of short contract counselling in practice

One of the objectives of the study focuses on how the effects of short contract counselling operate in practice. In the short contract setting there is an externally imposed rule which applies to all clients of the service and which has particular consequences for the way counselling is delivered. The features which demonstrate how this short contract policy works in practice are the processes involved in obtaining additional sessions, dealing with

enforced endings and changes of therapist if additional episodes of counselling are sought. These are three areas of short contract counselling practice which are very different from contexts in which session limits are not applied. Events such as enforced endings and changes of therapist can occur in any counselling setting but in an environment where the short contract policy operates, they occur as an inevitable event if additional sessions beyond a standard number are needed.

4.4.1 Obtaining extra sessions

The following extracts highlight how much can be learnt from considering exceptions to a rule. Having the awareness that one's experience is not the norm can lead to a sense of being different and of being marginalised. It is a feature of Foucault's thought that by drawing attention to what happens when rules are broken, the usually hidden assumptions behind and the social constructions upon which rules are based become visible (Foucault 1985). Participants described a range of responses to the process of obtaining more sessions. It became clear that obtaining extra sessions was something they felt could not be taken for granted.

SP2

'I was told about the fifth session that I would be taken on for another six because like she thought like I needed it. And I thought I needed it too. But I imagine there probably was some sort of like particular...some kind of work that had to be done into doing that.'

SP12

'I really, really found them helpful and I just couldn't...I really needed to go, do you know? I just really needed like that person to talk to and em...I felt like the counsellor that I was with, she definitely made an effort to...to try and get me more sessions and she did so I found them very, very beneficial.'

In both cases the counsellors are being seen as facilitating the student's desire for further sessions. The counsellors are described not as autonomous professionals who can make decisions but rather as subjects also bound by rules and processes which are relatively invisible, which reflects the discourse of surveillance and decreased professional autonomy previously discussed.

The allocation of additional sessions can bring its own dilemmas.

SP13

'Like as well it feels a bit weird that they had to apply to like ask am I allowed to have more sessions because I'm like, you know, like bad enough that I need it or something kind of. Like then I felt like, you know, am I like...because she said...well she asked...it kind of was my choice like, she asked 'Do you feel like in a way that you want more' as well, and then I wasn't really sure like is that kind of taking too many sessions that I don't need like. 'Should I be here? Am I taking sessions from

somebody else?' and...I don't know, I was just kind of worried like, 'Maybe I should just do the six weeks and then that should be it like.' I don't know.'

Is the offer of more sessions to be taken as an expert indication of more serious underlying difficulties outside of the client awareness but known to the professional? The client questions whether they should accept this definition of their needs. If the extra sessions are accepted, there is the concern that this means that they are depriving someone else. The terms used 'should I just do the six weeks' implies that the client is in a sense taking the medicine, the DOSE effect research described in the literature review. The extract ends on a note of deep ambivalence elaborated later in the interview.

SP13

'Yeah. Em...hmmm...whether I had to question it? I suppose, in a way, yeah. Em...it felt maybe a bit like that I wasn't...that I wasn't...like that the norm was six weeks and I felt a bit like oh maybe I'm not the norm or maybe I'm worse than other people or maybe I'm like, you know, more like mentally ill I guess.'

Given this uncertainty the reassurance given by her counsellor in the same interview was helpful:

'The actual like counsellor herself was em...really, I think, nice about it em...and she seemed quite like reassuring that em...I...I did need to keep going and I still had a like right to keep going'

There is also a hint of another discourse in this extract, that of the consumer of services, which is alluded to when the right to attend is spoken of.

The clients difficulties with obtaining additional sessions have been described but for the counsellors the process also had its challenges:

FG12

'I suppose, dealing with authority of, you know, sending an email to the head of counselling, asking for more sessions for a client and my own communication skills around that I think. That was a learning curve for me, to be more confident, and I think that came across. The more confident I became the more confident my notes were and, you know, it wasn't a problem ever getting extra sessions. And I remember bringing it to supervision and, you know, my supervisor saying "You've got to fight for your client", you know, "If you really think your client needs more sessions don't give up."'

This emphasises the personal dimension of dealing with authority. Being able to speak with a sufficiently authoritative voice and being able to advocate effectively is an important skill. The client discourse suggests that expertise is attributed to the professional yet there is also awareness that the professional is acting in a rule bound manner and had limited autonomy.

This was elaborated on by the professionals. There was a sense of responsibility. The external organisational context impacts on clinical judgement. This links in turn into issues of professional identity and reflects a wider managerial discourse as to what constitutes therapeutic effectiveness. Part of this concept of effectiveness is to use all resources to capacity and not to be seen to be wasting time.

FG12

'I'm aware of the limitations when you're offering a service to all of the students that are in this college. You know, em...and I think that for students that will come in, and I will be offering...we will be offering six sessions and maybe they would do it in three, that they would sort of say like "I think I'm...I've got what I've come for." So it isn't that I would have wasted time with the next three, do you know what I mean? You know, in the sense of not having a clear focus on what we were going to do for the following three sessions.'

This participant focuses on students' needs and the student as an active agent who makes choices. She is wary of the possibility of being seen as time waster if there is no clear direction or outcome to the counselling. The purpose of therapy has in this context become a goal driven activity relying personal productivity on the part of the counsellor. This links with the Foucauldian concept of bio power in which the subject as an ethical project learns self-government and applies rules to the self. This can be expressed as clear compliance but could also be a site of resistance or a sign of the recalcitrant subject (Savransky 2014).

4.4.2 Dealing with endings

Endings are generally viewed as significant events in psychotherapy practice (Barkham et al. 1996a). The ending can be seen as a barometer for how the therapy has progressed. Writings about this topic frequently assume a private practice setting where endings often happen when the client is ready or decides to leave (Mann 1991; Murdin 2000). This is rarely the case in the study site where endings are frequently pre-determined, irrespective of client wishes or readiness.

In this following extract the participant speaks in the third person initially and then shifts to using 'you'. This while more direct, does not refer directly to her experience.

SP12

'Em...I suppose if they're in...if they're in a bad situation and they really feel like they need more I definitely think it could make things...it could make things kind of worse because you...you could develop like...you know, you do start to look for support at the counselling sessions, especially if you don't have anybody else to get support from, and if that's just pulled then that's not...it's not really fair on, you know, on the student really. I think it could make things a little bit tougher because suddenly you're...'

The alternative open ended therapy model has its own dynamic. That can also be experienced in a myriad of ways. The following extract is in response to a question about how the student learnt about the six session model.

SP4

‘Em...I think when there was...actually I think that when there was no structure to say look we'll see where we are in this amount of weeks, or we will have this amount of sessions and then we'll see or whatever, that you kind of did feel like you didn't know where you were going or that you were kind of, just came in a bit unprepared and it was like you didn't have this framework to work around. And then I think it was maybe one of the first em...guys I ever saw was em...the one where it was, you know, no...no like set amount and I think I just wasn't ready for that either so that kind of colours that a bit, you know?’

This description places the focus clearly on the client discourse and implies a challenge to the professional discourse in which more is better. There is a suggestion that the counsellor was not doing what the client expected by not producing a structure and by apparently not recognising that counselling is something which needs preparation and work from the perspective of this participant.

4.4.3 Changing therapist when returning for further sessions

The phenomena of clients returning for further counselling is familiar to counsellors working in settings where session limits are applied. It not written about in the literature other than when intermittent therapy is advocated as an approach in its own right (Drisko 2005). It could be seen as a counter discourse in which subjects are resisting the short contract model and return on a reoccurring basis seeking what they need. In this setting where feasible, students are offered the option of remaining on the waiting list in order to see their original counsellor. Alternatively they can see a different counsellor with a shorter wait time.

The rationale for offering choice is the perceived importance of the relationship with the therapist. This is generally accepted in psychotherapy approaches and is part of the expert knowledge base associated with psychotherapy (Fonagy 2001; Bowlby 2005). A variety of views were expressed, which suggest that for clients the relationship with the counsellors is not the only issue. This suggests that the professional discourse drawn on by the counsellors is not always compatible with what the student wants. In the following extract the most important thing is to be offered support in a crisis whoever it comes from.

SP1

‘Yeah I was...like I did think about that at the time like, 'I have to kind of...I'm going to have to start at the start with a new person and, you know, it's going to be slow taking off and I'm not going to see any kind of like improvement for a while.' But like, at the time, I was like...I was in bad enough shape that I kind of didn't care. I thought’

In another extract from the findings the fit between counsellor and student was paramount, to the extent that the participant said they would do what they could to change counsellors. There is an ambiguity in that the implication is that immediate support would be sought but if this was not immediately satisfactory then a change would be sought.

SP 6

'I know now if I was ever to go back again that like if I didn't develop that connection first or quickly, you know, I'd know it probably won't happen, you know? So I'd try and find a way to switch, you know, if I could.'

In another extract primacy is given to the importance of becoming socialised into the role of being a counselling client who understands what is expected and how to behave and react in that role (Georgaca 2011). This is seen as more important than the relationship with the particular counsellor.

SP4

'...and that (changing to a new counsellor) does take away a lot of time, and it can be kind of disheartening as well if you are only seeing them... if you're seeing them... once a week and you take the first two sessions to warm up,

I think I just came from it so like, at this stage so open, em...I was just able to warm up quicker, or to get to the point quicker, (laughs) you know?'

The counsellor is described as fulfilling a certain role or function, almost irrespective of the specific individual occupying the role itself. This contrasts with the view of another participant who stresses the personal nature of the relationship, contrasting it with a model of being processed and handed on like a number or a set of case notes.

SP12

'So it wouldn't feel very nice if they just passed on a set of files to somebody else and said 'There you go. Digest that'.

I don't...I wouldn't find that comfortable anyways. I think you get to know your counsellor and...I...I didn't even want to go to somebody else, even if they had offered me somebody else.'

A powerful metaphor 'digest that' is used. This metaphor implies that the student could be seen as possibly indigestible food which can be taken in, mixed up and processed in some way, possibly even spat out by the institution, in this case exemplified by the processes of the counselling service. The student is speaking from a position of helplessness. All power is attributed to the institution. The aspect of a dynamic interaction between two individuals involved in a therapeutic relationship has disappeared. This participant while aware of and critical of this possibility of bureaucratic processing makes clear that this is something she could not accept and is describing how she would actively resist (Savransky 2014).

The next participant expresses a dilemma, describing her desire not to subscribe to the professional discourse which stresses that a client needs to connect with a therapist for the therapy to be effective. She wants to do something different, yet when she thinks about it she is not sure that she could tolerate having to continually repeat her story, if she attended different therapists. What remains lurking is the sense that she might displease the counsellor if she had not changed in the way the counsellor wished. In order to avoid this anticipated disapproval she would choose not to return. This illustrates the dynamics of power and resistance and how the apparently powerless client has to resort to a particular style of behaviour in order to have her needs met. The following response is given to a question about whether the student would prefer to see their original counsellor or be seen more quickly by a different counsellor

SP9

‘Em...well I used to always...I’ve often heard people saying that you need to have a counsellor that you’re...you connect with, or that suits you or whatever. So I didn’t know any different, so I kind of probably would have gone with something different just to see if...even though I don’t like em...having to explain it all the time (laughs). Like I don’t like having to. Like at least the counsellor, like if they already know what you...what’s wrong with you em...you don’t have to keep explaining it, so that...that’s another thing I hate going back to different ones, em...but em...yeah, I’m not sure, I probably would have...I don’t know if I would have gone back to the first one actually because I had this sort of thing that I was...I wasn’t em...I hadn’t changed, and she would see me just the same even years later so I kind of...disappointed her maybe or something.’

Working within this setting often means that counsellors are working outside the knowledge base they have accepted as true and which is a cornerstone of the psychotherapy profession. Examples of the literature which support this view has been discussed in the literature review, for example attachment theory (Fonagy 2001; Holmes 2009). Students on the other hand often seek immediate support in crisis situations and in which concerns about building or maintaining a previous therapeutic alliance are secondary.

In the focus group several counsellors raise the issue of why it is six sessions rather than any other number. One refers to the number of sessions as an ‘industry standard’:

FG13

‘Six sessions that’s become kind of popular and acceptable for...from...the...for the accountant particularly [laughing] more than for anybody else.’

This counsellor uses a financial metaphor and makes a comparison with the world of business. This theme is elaborated by others.

FG14

'I think I was a bit like, it's an industrial standard and I never thought about why it was six, eight, you know, 'cause I was thinking "maybe we should do eight or maybe we should do ten" but I don't know why...why would it be eight or why it would be ten and I never thought about it really other than it's like, yeah, the system thought of it and I went with it. Em...and I suppose the system allows us for extension which seems to be fair enough. Which seems to be I...I guess...I've probably done it three or four times that I've always been allowed extensions. Em...yeah.'

4.4.4 A counter discourse

The policy in this service was to have a different rule for the summer term when the majority of undergraduates are not on campus which means the service is under less pressure and a more flexible allocation of counselling sessions is allowed. This operates as a counter discourse to what happens the rest of the year. The justification for this is that the service is quieter during the summer and so can afford a more flexible approach. What this suggests is that although the short contract model operates most of the time, when there is an opportunity to operate in a different way this was done. This implies that when there is less demand on resources the counsellors extend the duration of counselling and that recovery and consumer discourses take dominance over the managerial discourse. However this also runs the risk of devaluing what is on offer for the rest of the year and challenges some of the rhetoric on which the decisions allocation of resources are made in term time.

The following participant had several different episodes of counselling. One of them occurred during the summer where, as evidence gained from an analysis of attendance figures from the study site showed, a lower number of students attend and additional sessions are made available in a flexible manner. Both experiences are compared. Her comments refer to her experience during the summer.

SP 11

'Like the first one, it was...it was good and it was like different because it was unlimited, first one. Em...so, I think it was also better for the counsellor because she didn't have this goal that she...she meets me six times and then I'm...I'm gone. So I think it's better for the counsellor as well, like to be able to work with someone for more time according to their needs, not...not to be limited with the time.'

She describes what she sees is a win-win situation in which both parties get what they want. An ethical position is taken in which the kinds of discomforts described by others when fearing that their needs were met at the expense of the invisible other, do not exist. Both client and counsellor get what they want and she did not see herself as being different, apart from the norm or marginalised.

SP10

‘...then said to me “Well you know if you are within the university you are entitled to come back and look for help again”. And then that just kind of threw me because I was thinking well...I was...I was getting mixed messages and I kind of said okay right, and part of me kind of felt do I want to go back into this as well, I'll be honest with you. Do you know what I mean?’

The participant is not openly resistant but is questioning what is on offer and suggesting there is something confusing and possibly untrustworthy occurring. This highlights a conflict on the part of the service which tried to ameliorate the effects of scarcity by allowing more than one episode of counselling. However, it may have inadvertently undermined its ability to provide an environment in which the therapeutic frame is clear and consistent.

4.5 Summary of Findings

The findings were discussed to reflect the research question on how short contract counselling is discursively constructed in an Irish Third Level college. The first area concerned discourses about student counselling, its relationship to academic functioning and the particular discourses drawn on by study participants. These were discourses identified concerned stigma, recovery, expert knowledge, productivity, managerialism, surveillance and risk. The second featured a consideration of the operation of disciplinary power and the production of the ethical subject. The third area concerned how the effects of the short contract model are discursively constructed and described how the short contract model operates in practice.

It is clear from the interviews that clients and counsellors draw on many discourses when describing their experience of short contract counselling. For the clients there was evidence of that a sense of stigma around seeking help for mental health issues still remained, even though participants were clearly aware of the current greater openness and increased public profile of these issues. This linked to a number of different positions which participants adopted ranging from dependence on experts to developing a more agentic position which related to an emergent discourse which allowed clients to position themselves differently. There was a clear oscillation about whether they viewed themselves as primarily ‘patients/clients’, who were receiving treatment from experts upon whom they depended or whether were they consumers with a sense of an entitlement to a service.

A professional discourse was drawn on by the focus group participants in a variety of ways ranging from the attribution of expertise to the counsellors by the students, to the sense of diminished professional autonomy experienced by the counsellors in this setting. Their work in student counselling was contrasted sharply with their own expectations about how they had anticipated they would be working as counsellors. Their training and their own experiences of receiving therapy were based on a private practice model in which duration of counselling is not predetermined.

The academic setting for counselling had a significant impact both on the decision to access counselling and the student experience. It was acknowledged that this setting did provide for easier access, but also raised the issue of whether the counselling was seen as an aid to academic performance or was it seen as of value in its own right.

The productivity discourse with its emphasis on optimal academic functioning and the rapid processing of clients positioned counselling as a scarce but desirable resource. This linked to a managerial discourse which produced a number of consequences and effects. This sense of pressure, the need for rapid interventions, the awareness of the waiting list and the need to demonstrate progress were experienced by all the participants. The counsellors adopted a number of different positions in relation to the managerial discourse, ranging from compliance and concerns about their own performance to outright scepticism and cynicism about the protocols they had to comply with. The effects of this managerial discourse such as the pressure to recover quickly and for counsellors to see students rapidly, were also felt by the students themselves. This was further linked to the production of anxiety as a common presenting issue for clients. A counsellor suggested that the use of certain forms and clinical instruments encouraged students to diagnose themselves with anxiety.

The findings related to the operation of disciplinary power and the production of the ethical subject drew on a number of aspects of Foucault's thought. Some of the findings demonstrated a conception of disciplinary power which emphasised the constraints imposed by available discourses. This was shown through the students expressed a desire to please their counsellors and their reluctance to say anything which the counsellor might not like. This extended to a reluctance to say anything negative about their counselling experience. The findings drew attention to how the students negotiated the dilemmas encountered between the need to self-regulate, to comply with rules, assert rights, deal with unmet needs and to balance all these competing factors in an ethical manner. There was a clear recognition of the needs of others and how to regulate oneself in the face of the need of the other. These dilemmas were particularly highlighted in relation to the discourses of risk and productivity. Focus group participants and students were acutely aware of the risk agenda. Counsellors were conflicted about how to balance this against their professional judgement around perceived early termination of therapy. Students were keenly aware of the risk agenda also and expressed fears that if they got more counselling than someone else, that student could be someone who might be at greater risk.

The chapter finished by considering how the effects of the short contract model are discursively constructed. These effects were those of obtaining further sessions, dealing with endings and changing therapists, all of which are features associated with the short contract model. For example the students who obtained extra sessions both appreciated these but wondered if this meant they were now a marginalised group, who were somehow more sick or mentally ill than other students seen by the counselling service. In relation to endings, the professional discourse stressed the need to work with these in a therapeutic

way, while in some cases the student described strategies for reducing dependence and withdrawing, in effect subverting the professional discourse. In relation to dealing with changes of therapist, the professional discourse advocates returning to a therapist with whom there is an existing relationship. For students this was not necessarily the priority. They emphasised the importance of getting seen quickly.

The following chapter will seek to contextualise these findings by considering broader changing social discourses which are relevant to this study. Before engaging with those considerations the literature review will be revisited in order to consider how this contributed to positioning the study and informing the approach taken to the findings.

Chapter 5 Discussion of findings

5.1 Introduction

The research question asks how short contract counselling is discursively constructed in an Irish Third Level college. This chapter will discuss and interpret the study findings in line with the study objectives. The findings drew attention to a range of discourses drawn on by the study participants when they spoke about the short contract model of counselling. The findings considered how disciplinary power and the production of the ethical subject operated in the study site. The findings also focused on how the specific effects of the short contract model were spoken about and operated in practice. This chapter begins by revisiting the research identified in the literature review and explores how this relates to the study findings. This is followed by a discussion of the neo-liberal context and the operation of disciplinary power, changing discourses about mental health and the development of short contract counselling. Some of the major changes in the higher education environment are addressed. The chapter moves on to a consideration of the discourse of ethics and the production of the ethical subject. It then discusses the limitations of the study.

5.1.1 Revisiting the literature review

There was no one clear body of literature which addressed the question of short contract counselling directly. This is significant given how widespread this practice is. It suggests that the trend may be taken for granted, which may have rendered it relatively invisible to researchers. The literature search was approached by considering a wide range of what could be termed relevant and adjacent literature. Seventy articles, books and newspaper articles were considered. Of the material specific to third level student counselling (Bell 1996; Hallett 2012; Mobley 2008; Pointon 2014; Taub and Thompson 2013), little of it addressed the short contract model directly.

A core part of Foucault's thought involves consideration of the historical and social circumstances which create the conditions of possibility for objects of discourse to emerge (Foucault 1971; Foucault 2002). With this in mind the literature search began by exploring and providing an overview of the theoretical basis and historical development of psychotherapy from its beginnings in psychoanalysis to the current time when psychotherapy and counselling have become taken for granted as part of contemporary life in the Western world, where publicly provided counselling is common but is frequently delivered in brief manualised forms. The role of managed and stepped care proved highly significant in these developments which have begun to be seen in student counselling. The historical development of student counselling itself was considered. It was particularly interesting to note that some of the reasons given for providing student counselling over a hundred years (Brailsford 2011; Kraft 2011) ago have remained consistent with present day understandings. The early justifications for setting up services were that they would contribute to academic progress, support retention and avoid wastage due to students' emotional issues interfering with their capacity to study.

In section 4.2.5 on the productivity discourse SP1 says the following:

‘It’s just the college mentality, you’re here to learn. Everything can supplement that, including the counselling,’

What is different is that these early studies do not mention the time counselling might take or the need to provide rapid responses refs and treatment, nor was the issue of risk management referred to. Concerns about high demand for services and resource constraints only emerge from the 1980s onwards. The pressure this exerts was summed up by one participant (See section 4.2.6 on managerialism):

SP13

‘Then I come here and its, well one building and kind of a small group of counsellors trying to accommodate a lot of students and trying to do it a lot quicker...They’ve kind of got hectic lives so you’d want to get them seen as quickly as possible.’

These features make the emergence of short contract counselling possible but do not suggest that it was inevitable. From any set of circumstances different outcomes and possibilities can develop.

It became clear by considering the psychotherapy research literature (Timulak 2008; Timulak 2007; Richards and Tangney 2008; Richards and Timulak 2012; Richards and Timulak 2013; Richards et al. 2013) from a social constructionist perspective that a dominant mode of enquiry in psychotherapy research is based on a quantitative methodology which uses a positivistic approach grounded in assumptions of measurability and standardisation. This frames what gets researched and what is considered to be evidence. To formulate this from a discursive perspective means considering how discursively objects are constructed in multiple ways and to consider how these discursively constructed objects relate to each other and what functions they serve (Hanna 2014). An example from the findings concerns the dilemmas and different discourses which are drawn on when additional sessions were agreed which was highlighted in the findings relating to the production of the ethical subject (Section 4.3.2).

To quote from SP8:

‘Well there is a long waiting list and you know this is how it is...I had that awareness...I don’t agree with the limitations and I don’t agree that a client should worry that if this person, this client needs more that they are taking it away from someone else.’

One issue the literature review sought to explore was whether research had provided any rationale for the practice of short contract counselling, as it might then become a discursive object which was drawn on by the study participants. Previous research (Baldwin et al. 2009), using a quantitative methodology, posed this as how much therapy could be deemed to be helpful in generating therapeutic change. According to these studies (the DOSE effect)

there was a finding that the amounts of therapy being offered in publicly funded settings was not adequate to effect therapeutic change (Wolgast et al. 2004; Miller 1996). The question of why a specific number of sessions rather than any other, was discussed by the focus group participants who expressed scepticism and suggested that the number of sessions was more likely to be a function of available resources, a position also adopted by Fonagy (2010). Focus participants were unaware of any literature which supported the six session model yet they were complicit in its operation and said that they felt they did not have a choice in this.

Clinical literature was explored with the aim of identifying therapeutic factors which might be helpful in understanding client responses to short contract counselling. One approach, the common factors approach, in its positioning of the client as the agent of change linked well with the recovery discourse drawn on by clients (Hubble et al. 1999). Attachment theory was helpful in considering some of the ways clients spoke about their therapists especially in the context of changing therapists (Bowlby 2005; Bettmann and Jaspersen 2010).

To quote from SP6 (section 4.4.3):

‘I know if I was ever to go back again that like if I didn’t develop that connection first or quickly. I know it probably wouldn’t happen’.

Or from SP12 in the same section:

I think you get to know your counsellor and...I didn’t even want to go to someone else, even if they had offered me someone else.’

This study considered both the individual subject and the context which is a vital part of a discursive approach. It was the range and complexity of the issues which this exploration revealed which led the research to adopt the methodology of discourse analysis which emphasises the situated nature of knowledge, the importance of context, an understanding of mental health issues, counselling and education as being socially constructed and subject to the operation of power. Important contextual issues for this study the current neo liberal context, operation of disciplinary power, changing discourses related to mental health and the changing college context, which will now be discussed.

5.2 The Neoliberal context and the operation of disciplinary power

The neo liberal context which will be described helps to situate some of the discourses which participants drew on in particular those of recovery and personal responsibility, productivity and managerialism. An extensive literature has explored the increasing penetration of what has been described as the neoliberal agenda into areas which classical liberalism saw as separate from government. These include education, health and the caring professions. Shore terms this the audit culture.

To quote:

‘contexts in which the techniques and values of accountancy have become a central organising principle in the governance and managing of human conduct and the new kinds of relationships, habits and practices this is creating’ (Shore 2008, p. 279).

Layton (2014) describes this neoliberal development as a partnership between government and market, whereby market values, derived from the world of finance, with their emphasis on competition, individualism and privatisation, are now to be found in welfare and education (Layton 2014). Associated with these changes is the development of different types of subjectivity which both reflect and influence these neoliberal developments (Türken et al. 2016; Petersen and O’Flynn 2007; Esposito and Perez 2014). This context fits very well with Foucault’s description of disciplinary power, bio power and governmentality discussed in chapter three. Neoliberal subjects are conceptualised as autonomous, self-directing, competing, rational decision making individuals who are expected to understand the rules of conduct and how they are to perform in this neo liberal context. This conceptualisation aligns well with the recovery discourse which was drawn on by participants.

To quote from SP4 (section 4.2.2)

‘You can get as many counselling sessions as you want...you have to make yourself better...I’ve always seen the counselling service as a kind of facilitator for you.’

One study explored the media presentation discourses associated with self-improvement which the authors describe as a technology of neoliberal subjectification (Türken et al. 2016). Through an examination of media presentations on the topic of self-improvement, they point to four discourses, those of rationality, autonomy and responsibility, entrepreneurship, positivity and self-confidence. They suggest that these discourses promote a strong competitive culture, in which if individual subjects fail to succeed it is their personal responsibility. The discourse of personal responsibility was frequently described by client participants. These discourses are detached from structural constraints and are isolated from contextual and historical conditions. Only one participant referred to the lack of financial support to study as a major contributor to her difficulties, even though for others it appeared to also be an issue but was not linked to their mental health. In order to succeed the individual is required to make psychological changes, develop skills and endlessly self-improve to accommodate whatever demands are placed on them.

Layton (2014) draws attention to the function of heavily proceduralised and protocol driven encounters in the field of mental health having become a means of distancing ourselves from others’ suffering so that the pursuit of individual wants replaces any sense of community or care for others. SP13 describes in section 4.2.5 how she feels that this kind of proceduralism has entered the counselling itself:

‘It kind of felt less personal...more like a clinical kind of....or something. It felt like a prescription of like you go six times and then that is it.....as opposed to you build up a kind of trust.’

In the focus group discussion there was reference to the six session model as an industry standard which was accepted without question (FG14 section 4.4.3). Other commentators point to the withering away of the concept of social responsibility in favour of a more instrumental view of emotional life as focus on acquiring a discrete set of skills to give a competitive edge (Rustin 2015; Jeleniewski Seidler 2012).

Corporate practices such as an emphasis on surveillance, risk management, bureaucratic control, quality assurance, benchmarking, targets, consumption and the development of market oriented structures are now commonplace in the public sector and specifically in publicly provided psychotherapy (Rizq 2012b; Plastow 2010a; Plastow 2010b; Plastow 2010c; House 2012; Rustin 2015).

These changes summarised as the development of the audit culture, have not solely been due to the decrease in available resources relative to rising demand, but are also linked to the increasing dominance of the neoliberal paradigm since the 1980s. These are considered below with reference to the discourses of productivity and managerialism, and risk.

5.2.1 Productivity and managerialism

Public bureaucracies have become subject to the disciplines of the market place. The paradigm has moved from an ethos of public service to increasing internal competition and outsourcing of previously government provided services. Funding is increasingly dependent on performance against indicators and targets. This context has a direct bearing on the experience of the study participants, both directly in terms of the resources users are able to access and in the way these services are managed and delivered. Chevannes (2002) suggests that managerialism has led to the situation where assessment of need is now transformed into an exercise of gatekeeping and assessing criteria for eligibility to services rather than being concerned with a more holistic concept of need.

Participants in the focus group drew on a professional discourse when they expressed their belief that at times they were very much working ‘on the surface’ in terms of the client’s issues and not necessarily in the most clinically appropriate manner. They also expressed the view that, in this educational setting, the prime consideration was restoring the ability to function optimally from an academic perspective, rather than the treatment of mental health difficulties. Being able to function well academically is linked to the capacity to be resilient and to bounce back quickly from difficulties. This is described by SP12 (section 4.2.5):

‘I suppose six (sessions) is very short but I suppose you would have to try and cover certain stuff or at least give them certain skills so they can get through afterwards.’

Resilience is seen as the capacity to overcome or bounce back from adversity, to be productive. This was frequently referred by many of the participants and was stressed by the counsellors in the focus group when they spoke about the pressure and expectation attributed to the setting, that their clients ought be able to bounce back after six sessions. To a degree emotional vulnerability is seen as a resource to draw on in learning resilience. This requires a positive attitude, an ability to self-manage and regulate oneself (Krueger 2008). Participants frequently described the expectation that they should be able to manage themselves, to get over whatever difficulties faced them, and to return to functioning as rapidly as possible. This is described by SP1 (section 4.2.5):

‘There’s a little bit of pressure like to sort of get the important information out and not sort of like...and not sort of like waste time, for lack of a better term.’

Critics of this approach point to the construction of adversity as an individual matter and leave out the possibility that adversity could result from circumstances which require social rather than individual change (Aranda et al. 2012; Aubrecht 2012).

Layton (2009) describes the development of a neoliberal subjectivity, which involves the repudiation of vulnerability, a decline in the capacity for empathy and a refusal to experience ourselves as responsible or implicated in the suffering of others. The findings from this study do not unambiguously reflect this neo liberal subjectivity rather an more nuanced position is taken in that many student participants expressed a concern that as student counselling is a scarce resources anything they received would be at the expense of another.

To quote from SP6 (section 4.3.1):

‘I felt kind of guilty...I don’t know did I waste his time or did he have someone else that could have used....used the service you know.’

However there was an attribution by some of the student participants, of a decline in empathy and refusal to consider the sufferings of others, to the college authorities. To quote from SP1 (section 4.2.5):

‘There’s a lot of cutbacks and we wondered like would they have to get rid of some services and only do some services because it is what the college wants them to do, rather than it being like what’s in the best interests of the students.’

There is a widespread expectation in student counselling that performance and activity levels are to be reported on as described previously in the examples of services developing their own performance monitoring systems (Broglia 2015). This can exert pressure to exclude clients who are deemed to be at risk or who are not recovering quickly enough, as they are categorised as unsuitable for treatment within a short contract model and should be referred elsewhere. If many stay longer than the allotted time the result will be longer

waiting times. Shorter waiting times rather than clinical judgements of what students may need are privileged by service providers and funders.

In this study participants referred to the process of obtaining extra sessions which described as part of description of how the short contract policy works in practice. They were aware that they were outside the 'norm' and that perhaps they were more 'mentally ill' or had failed by not being able to finish within six sessions. To quote from SP13 (section 4.4.1):

'The norm was six weeks and I felt a bit like oh maybe I'm not the norm or maybe I'm worse than other people or maybe I'm like, you know, more mentally ill I guess.'

One other student participant explained how she deciding to leave before her six sessions were complete as she had already realised that six sessions would not be adequate.

Student participants were clearly aware that counsellors had to seek permission to go beyond a standard number of sessions. In some cases clients described their therapists as being relatively powerless and caught up in a system beyond their control. However notions of professionalism are also subject to change. The traditional notion of the professional, dependent on expert knowledge and possessing relative autonomy has been eroded (Olsson 2014; Ziegler and Jensen 2015). In this study focus groups participants described feeling under pressure to work at speed in a goal driven manner, to be accountable and be subject to rules and regulation to a much greater extent than they might have anticipated from their earlier training as counsellors. They were very aware of the need for accountability. They described the need to be seen as efficient by achieving quantifiable outcomes for clients and by not demanding too many extra sessions for their clients.

Counsellors in the focus group described the challenges they experienced due to the service requirement that standardised information had to be gathered very quickly. Both therapists and clients identified forms and questionnaires as a source of pressure, and the need to achieve certain outcomes within defined time frames.

To quote from FG5 (Section 4.2.7):

'So sometimes I find that first session exhausting and then you have to go back and fill in all your notes.....I'm trying to do two person's jobs at the same time... I'm trying to compile a sheet of information...and if that isn't to be a box ticking exercise....not to rush the client and then also to start to engage.'

Hoggett (2010) suggests that public services have increasingly taken on the form of a perverse social defence. By this he means that relationships between service users and professionals takes on an 'as if' quality, and are mediated through a web of proceduralism. Face to face encounters are highly regulated. Rizq uses a psychoanalytic approach to elaborate on these regulatory processes. She draws attention to their role within mental health services, describing them as a social defence which protects staff against the effects

of the psychological fragility and distress they are expected to deal with. An important example of this is the imposition of the standardised six session rule.

To quote from SP4 (section 4.2.5):

‘It would be quite hard to pick out which ones are the most deserving.....the choosing part is not a job I’d fancy.....I can understand how they use the six sessions because that’s a cut-off point that’s arbitrarily decided before they start, you know?’

One participant in the focus group claimed (FG13, section 4.4.3):

‘Six sessions that’s become kind of popular and acceptable for...from...for the accountant particularly.’

The processes Rizq points to are the proliferation of bureaucratic and surveillance systems aimed at continually monitoring and evaluating staff and clinical activity (Rizq 2012a, p. 319; Rizq 2012b). The discourse of surveillance is closely linked to that of risk. Activity is measured according to different criteria, meeting targets is one key element but so also is the management of risk.

5.2.2 Risk

The risk discourse was identified as a prime criterion used to allocate additional counselling sessions. The risk policy from the study site, which was produced by the counselling team, is included as appendix I. The concept of risk comes from actuarial insurance (Shore 2008). Risk assessment is based on the discourse of the expert. The power of this discourse lies in its claim to be objective and empirically derived. The assumption is that risk is knowable and predictable (Pollack 2010). The risk discourse (in relation to suicide and self-harm) was frequently spoken about as the core criterion on which resource allocation is based by both sets of participants. One effect of this was that it was difficult for students to avail of extra sessions unless they were deemed to be ‘at risk’

To quote from SP 11 (section 4.2.7)

‘My second counsellor she told me the people who get the second sessions of em...counselling, they are the people who are at the risk of suicide.’

Several participants made reference to this issue in the interviews. This designation on one hand discouraged students not ‘at risk’ from asking for more, while on the other hand possibly producing the behaviours the processes were set up to mitigate, as the main gateway to obtaining extra counselling sessions.

In public organisations working with potentially vulnerable clients there is a perception that risk can be managed but also that if it is not, then the organisation is at fault. The counselling risk management discourse focuses on those who are unwilling or unable to manage themselves, who are deemed incapable of exercising self-government. The manner in which risk is dealt with is heavily based on protocols and completion of risk assessment tools which seek to assess risk. The practice in the study site of using outcome measures to

determine risk and evaluate outcome is particularly relevant. These seek to demonstrate therapeutic effectiveness and clinical change in an environment where sessions limits apply. They are presented as a neutral and relatively unobtrusive means of demonstrating clinically significant change (Kelly et al. 2012).

This use of these tools as measures is by no means an uncontested practice (Kelly et al. 2012). The selection of a particular set of outcome measures over others has particular consequences and effects. It impacts on what is done and silences other possible outcomes and strategies. Depending on their orientation and training therapists may see them as a constraint which interferes with the therapy process or as a means of demonstrating the effectiveness of their particular approach. In this particular study focus group participants indicated that the use of these measures promoted a culture of self-diagnosis particularly of anxiety. To quote FG 7(section 4.2.6)

‘Checking (on the forms completed by the student) what they might have said at drop in as their primary issue, because I find that nearly every student will put down anxiety because they are feeling anxiety and for me that is a symptom. It is not always the main issue they want to work with.’

These outcome measures can have many meanings for the client. They can be experienced as containing, distracting, interfering or helpful. Kelly et al. (2012) use a discourse analysis framework to explore these shifting and ambivalent meanings by carrying out interviews with clients who had filled in a particular widely used outcome measure.

Students deemed to be at risk are managed by a medical practitioner and may attend student counselling. In the study site clients are assessed for risk when they first attend. The severity is graded according to a mixture of use of an outcome measure and clinical judgement. The grade of risk will then determine how quickly the student is seen. This means at times of high demand for services such as before the exams, students who are not deemed to be at risk may not get seen for a considerable time. The service keeps a list of clients at risk which is monitored on a weekly basis and certain protocols are activated if the client has lost contact or has failed to attend an appointment. This context links with Foucault’s concept of governmentality and the panopticon which represents in physical terms the concept of constant surveillance of the student. One mechanism which functions as a technique of bio power is the medical gaze which is used to measure against a norm, in this case the existence of risk behaviours (Foucault 2003; Foucault 1979).

Verhaeghe discusses the social and cultural construction of mental health symptomology. He points to a change from the nineteenth century during which psychoanalysis was developing, when some of the main sources of mental distress were attributed to repression and sexual morality. Nowadays where there is greater focus on issues such as risk, self-harm and acting out (Verhaeghe 2008; Verhaeghe 2007). This leaves open the question of the interaction between a protocol driven risk adverse context and increasing

presentations of identified risk behaviours in mental health settings and the possibility that the very procedures which are designed to manage such behaviours instead are evoking them. This leads to a consideration of the changing nature of mental health discourses including the different conceptualisations of mental health and responses to this.

5.2.3 Changing mental health discourses

Mental health is a site of competing discourses which are in a state of flux and change. Some examples of changing discourses were considered in chapter two, section 2.3 of the literature review which gave an overview of the theoretical basis and historical development of both psychotherapy and student counselling. There have been changes in what is described as mental healthcare moving from care at home or in the immediate community, to the development of institutions such as the workhouse and the asylum and now to the closure of institutions and the emphasis on care in the community (Foucault 1988). In Western societies mental health difficulties have traditionally been surrounded by secrecy, shame and stigma. This was visible in the study, where some participants had feared being thought of as crazy if they sought counselling or were surprised when they were treated with consideration and respect.

Within the last twenty to thirty years there has been a considerable change in attitudes. One indicator of changing discourses was the publication of *Vision for Change*, an Irish government policy document, which argued for recovery based services and that more mental health provision should be community based and that the older larger institutions should be closed (Expert Group on Mental Health Policy 2006). A more recent example of this changed viewpoint is the anti-stigma campaigns funded by See Change, an Irish government funded body (seechange.ie 2014) and the Student led 'Please Talk' campaign (Please Talk 2015). This has not always translated into practical changes in treatment and facilities available to people with mental health issues.

What has endured since the institutionalisation of mental health is the position of power ascribed to the doctor by Foucault and others (Foucault 2003; Foucault et al. 2008; Harper 1995). This is reflected in the role of medicine in positioning mental health as essentially a medical matter which relies on clinical diagnosis and medical expertise (Harper 1995). This positioning of dominance is supported in this study by the practice of medical referral of all students who are deemed to be at risk, in which case clinical responsibility is ultimately held by the doctor. The relationship between a medical discourse and stigma is complex. Jenkins (2014) suggests that a biomedical explanation of mental illness increases stigma as it encourages a perception of dangerous and unpredictable behaviour and a genetic or neurochemical inability to exert control, by people who have mental illness. It was clear that the language of medicine and symptoms had infiltrated the participants' speech. They spoke about having diagnoses, and frequently referred to having anxiety. In her study of the emergence of social anxiety disorder, Hickinbottom-Brawn (2013) uses the method of historical ontology to explore the conditions under which certain phenomena such as social

anxiety disorder thrive. She points to a link with conceptualisations of the self as a commodity which have developed within the enterprise culture associated with neoliberalism. As part of the conditions for emergence of social anxiety disorder she points to the pressure to conform to a neoliberal ideal in which the self as a marketable commodity is placed under intense monitoring and self-surveillance. The remedy for any problems is improved self-management skills. It could also be suggested that participants are actively encouraged to medicalise their distress in this manner by the common practice of being invited to tick boxes with a choice of symptoms on an intake form, as was the practice in the study site. Services are organised in such a way that clients must adopt medicalised language to express their distress in order access services. This indicates the disciplinary function of medicine, psychiatry and psychology in constructing the person and their experiences.

Ecclestone has traced the increasing attention being paid to the role of emotion in all facets of life and its influence on public policy development (Ecclestone 2007; Ecclestone 2004; Ecclestone and Hayes 2009a). She argues that we are being encouraged to focus on emotional vulnerability and the need for interventions to be in place to avoid any kind of emotional challenge or suffering. She links this to the focus on the individual at the expense of social and community interventions and actions. Bondi (2005) describes this as the cultivation of vulnerability which she sees as linked to the pervasive nature of psychotherapeutic discourses in contemporary society. Suffering is to be avoided at all costs and cannot be tolerated. It is possible that this increasing focus on emotion and mental health is a contributory factor in the rising demand for psychological services and concern about their scarcity. Media attention is frequently given to the question of long waiting lists and inadequate facilities (Havergal 2015; Campbell 2016; Kingkade 2016; Coughlan 2015; Gardiner 2015).

The research question asks how short contract student counselling is discursively constructed. The student participants in this study described a number of competing discourses which reflect broader discourses about mental health. The discourse described in section 4.2.1 about stigma, pointed to the desperation and urgency students described when they decided to seek counselling. The findings related to the competing discourses of patient and consumer referred to in section 4.3.3. describe different positions.

To quote SP2 (section 4.3.1) who describes a position of dependency on professional expertise:

‘I guess you go into them and you...you...they’re kind of the expert in the situation so you kind of...you don’t necessarily...well you kind of hope that they’d like, know what to do

This is contrasted with the position of being a service consumer with a sense of entitlement which is alluded to by SP3 in the same section:

‘I think you do have the right but don’t feel like you do. It might be a free service, but it is still a service.’ .

This consumer/rights based discourse links with the recovery movement in which the focus is on customer choice rather than automatic compliance with the treatment delivered by the expert. The client or patient becomes the consumer of mental health services. Esposito and Perez (2014) see this development of patients being seen as consumers as consistent with the rise of neoliberal society which emphasises consumption as something which is empowering and mental health becomes part of this market place. However discourses about consumption also reflect the power of the doctor in this case or the marketing manager in other forms of consumption. However there remains a difference between the purchase of commodities in which consumers are protected by laws which do not apply in the case of availing of a free service. This highlights the connections and differences between consumer rights and human rights often described in the form of charters. This study has found that participants often oscillated, adopting both positions at different times. The rights discourse and how it is expressed in a mental health context is one strand of a wider discourse of neoliberalism which has a profound influence on many areas of life in contemporary society.

5.2.4 Changing college context

This discussion of the changing college context links to the literature review in chapter two section 2.4, which provided an overview of the development of student counselling in universities and research on student mental health and student counselling in section 2.4. The numbers of young people attending third level education has increased substantially, to the extent that third level education has become part of mass education provision (Mair 2015; Berg et al. 2016). The widening participation agenda requires and funds colleges to increase access to students from disadvantaged backgrounds and to students with disabilities including mental health difficulties. Education at third level is seen as an absolute prerequisite to obtaining professional employment as described in the recent higher education strategy paper for Ireland (Higher Education Strategy Group 2011).

The research for this study was undertaken in Ireland but reflects broader trends. It is widely accepted there that demand has risen while the current climate is one of financial upheaval and spending cuts. These social changes alongside the changing discourses around help seeking have led to an explosion of demand for services such as student counselling (Coughlan 2015; Seldon 2015; Bell et al. 2015).

Study participants emphasised the pressures of the academic setting. These pressures and in particular the impact in terms of the mental health are also felt by academic staff (Berg et al. 2016). The pressure experienced by academics to perform is passed onto the students

who are required to perform for the academics. Services are put in place to keep up productivity and the functioning of the university. This is an example of the operation of bio power. However not only are the participants being regulated, if this regulation proves difficult participants are encouraged to see their difficulties as examples of individual failure which links to a pathologising discourse. Educational institutions provide what Hickinbottom-Brawn (2013) describes as 'surfaces of emergence' through which the socially constructed category of social anxiety disorder becomes widespread. They describe and critique a highly psychologised 'triple E' student, who is required to express opinions, demonstrate a capacity for enterprising self-management and promotion and who feels entitled to demand rights. Participants felt they ought to possess resilience and be able to return to functioning academically as soon as possible. The cost of this pursuit of success can be a high degree of anxious self-surveillance. This generated a level of distress which was seen as part justification for demanding immediate and urgent support.

This is particularly relevant for study participants. The clients want to be seen quickly and for the amount of time they feel they need. This came through in the findings in the descriptions of not being willing to wait to see their original counsellor if they returned for further sessions, because they wanted to be seen as quickly as possible. This is however not on offer. Therapists have a dilemma in terms of whether they prioritise the needs of existing clients over those who are on a waiting list. For example in numerical terms the longer existing clients stay in therapy, the longer those on the waiting list will have to wait.

This brings into focus a key issue about the role and purpose of student counselling. There are competing discourses, the discourse of the professional would give priority to providing mental health treatments even if this requires longer term support or the discourse of productivity which sees student counselling mainly be seen as a short term academic support. This links to the discourse of productivity which will be explored later in the chapter. Many student counselling services have accepted provision of the academic support agenda, as evidenced by the adoption of outcome measures which stress the relationship of counselling to academic progress (Wallace 2012). This clearly illustrates the Foucauldian emphasis on the role of disciplinary of bio power. Universities need to produce functioning students (a proposition with which many students themselves agree). Disciplines such as psychotherapy operate as a manifestation of disciplinary/bio power (Devisch and Vanheule 2015).

This discussion also highlights the issue of the respective roles and responsibilities of services such as student counselling against other government funded mental health providers. The latter maybe responsible for providing mental healthcare and dealing with the most complex cases, yet often do not have the resources to do this. The client may prefer to attend student counselling, but that service may try to refer them back to other adult services that either will not or cannot respond adequately to them.

A group such as the student participants, for whom six sessions was not sufficient, are most likely to be in this position. They can end up been referred back and forth between different services; this was the experience of several client participants. Another important contextual consideration is how available discourses relating to mental health were linked to how clients responded to student counselling in general and then the short contract model in particular.

5.2.5 Dilemmas and responses from the university sector

Colleges are under pressure to recruit more students in order to increase their share of government funding. Students are under greater pressure due to the financial climate and in some cases their existing mental health difficulties. This can mean that they have support needs which the recruiting institution may be unable or unwilling to meet. These topics arose frequently for student participants. For example a number of the participants spoke about pre-existing contact with mental health services based on earlier difficulties prior to college entry.

The funder (in this case the college) discourse has shifted from valuing the provision of support (as exemplified by limitations on the provision of what is deemed an expensive service such as counselling) to an emphasis on student development (as delivered through what are seen as less expensive interventions such as psycho education workshops, groups, online programmes etc.) which is seen as the legitimate task of an educational institution. As these changes continue certain groups are more likely to be marginalised, such as those who do not fit into the six session model of counselling. Student counselling services have less of a distinctive identity than in the past. Counselling has become seen as a support activity which creates dependencies which are deemed to be bad. Instead students are to be self-managing and resilient (Aubrecht 2012). Many universities now employ Mental Health Advisors who are tasked with promoting the development of coping and functioning skills and managing possible mental health crises on campus, all achieved at a lower unit cost than employing counsellors. Broglia (2015) highlights another related trend in her report based on the 2013/14 annual survey of British Association of Counselling and Psychotherapy (BACP) university and colleges counselling provision. This is the increased use of unpaid staff usually as interns on unpaid placements.

Participants from both groups, counsellors and clients, referred to the importance of speedy service access. This is also a priority for college managers. From a psychoanalytic perspective, a number of authors have provided a critique of these developments which represents a counter and oppositional discourse. The emphasis on speed and urgency is seen by them as demonstrating the role of student counselling as a social defence against institutional anxiety in that immediate access is provided to services which manage troubled and troubling students (Hoggett 2005; Hoggett 2010; Heyno 1999).

Counselling services have responded in a number of ways, usually implementing measures such as short contract counselling, drop in sessions, workshops emphasising psychological

education, online programmes and other interventions. Session limits and frequency vary according to local institution policy.

These trends and their implications are mirrored in the findings of this study. Participants spoke about their awareness that they were somehow different because they had received additional counselling, which was not something that could be taken for granted. Therapists frequently referred to the pressure they felt under to complete working with clients within six sessions, or to justify the need for their recommendation for additional sessions. Clients spoke about attending different services both college based and external, sometimes on a revolving door basis. A number of therapists who participated in the study were unpaid interns.

5.3 The discourse of ethics and the production of the ethical subject

Hanna's (2014) work on the production of the ethical subject which has been discussed in the findings chapter has proved a very helpful means of understanding some of the dilemmas expressed by participants, when they recognised that they were effectively competing with others to obtain counselling. References to ethical dilemmas were expressed by client participants in several different ways. They discussed issues such as their concerns about the possibility that additional sessions given to them would be at the expense of someone else who could be deemed to have more urgent needs or be at risk. They were reluctant to attribute blame or criticism to those who for example might be more dependent on the medical discourse than they considered themselves to be. The practice of counselling is explicitly governed by adherence to professional codes of practice. However these are guidelines rather than rules and can be a source of dilemmas especially if they are at odds with other discourses such as the need to have a rapid throughput of clients. Counsellors referred to matters such as the need to work more quickly than they felt was in the best interests of the clients' mental health or ending with clients before they felt the client was ready. They drew on discourses of managerialism productivity and risk, but also a professional discourse which is framed in terms of ethical codes of practice. The question of whether the drivers for change in psychotherapy practice are primarily clinical, managerial, or financial remains open (Coren 2001). Decisions tend to be justified by reference to pragmatic considerations alone. Ethical dilemmas involved are rarely made explicit nor are the moral and value based positions which are also implicated. However recourse to ethics is one of the dominant discourses within psychotherapy, and practitioners frequently regard ethical codes as the final arbitrators in making difficult decisions. The discourse of professional ethics merits consideration, in particular how this interacts or competes with other discourses to create the current situation.

A starting question is what makes a psychotherapy practice or policy an ethical issue. Ethics is a branch of moral philosophy which examines human values and questions of how people should live and act (Stokes 2002). To identify the ethical dimensions of an issue consideration needs to be given to what principles are involved and to identify the

underlying philosophical positions which are informing action. Those who favour limiting sessions tend to be influenced (consciously or not) by the Utilitarian philosophy of John Stuart Mill and Jeremy Bentham (Stokes 2002). This position emphasises the need to do whatever brings the greatest happiness or benefit to the greatest number.

In the context of service provision this aim could be interpreted to mean the need to distribute the available resource to reach the maximum number. There are a number of problems with this approach. It is not always easy to calculate utility which requires individual value judgements, nor to rank consequences or deal with unintended consequences. For example rationing number of sessions and offering the same ration to everyone is justified on the basis that the greatest number of those seeking it will all be given some resource. At the same time this may create worse outcomes for those who have more severe problems (Hallett 2012). This is a core issue for this study. The focus group participants made frequent reference to the question of how to ensure that the greatest number of students were able to access counselling, to the anxieties caused by having a waiting list, and to the countervailing need to continue to see those deemed to be at greater risk, and the apparent impossibilities of reconciling both of these considerations.

A clear alternative ethical position, used to support the argument for basing resource decisions on individual need, is deontology. This position focuses on motivation. It is based on the Kantian Categorical Imperative that man must always be treated as an end in himself. This is seen as the basis of human rights and the belief that persons should be given what they need (Callender 1998). Links could be drawn between this individually based position and the discourse of the entitled consumer previously discussed. However there can be the tension between individual rights and the possible needs of a group when both are not in alignment and there is a shortage of resources, which does then not allow for the satisfying of all individual needs. Student participants, while also apparently influenced by the utilitarian viewpoint, in so far as they spoke about the need for everyone to be seen who sought help, tended to place the greatest emphasis on their own individual needs. However this highlighted how difficult it can be to negotiate these dilemmas. The study traced some of these complexities using the concept of the production of the ethical subject which was discussed in chapter four, section 4.3.2.

5.3.1 Ethical challenges of working in the public sector

For psychotherapists in the public sector ethical decision making reflects different considerations emanating from different sources, which are not always congruent. Ethical responsibilities towards clients, informed by the ethical codes of professional associations, may not always sit easily with the needs of employers and funders of services. These issues were clearly highlighted in the focus group. Dilemmas about the value and limitations of the six session model were informed by ethical concerns based on a professional discourse. Concerns were expressed about the need to work in a more short term and surface manner

than they felt the client needed juxtaposed against what the client wanted and the need for them to be academically well functioning.

In higher education the university is interested in a rapid throughput of students who are all helped to remain in college and be academically successful whatever the consequences for individual mental health (Rana 2000). Yet the university also has a duty of care and wishes to avoid reputational risk from student suicide or other high risk behaviours. It could be argued that a more successful strategy to mitigate risk is to give everyone a brief screening and then concentrate the resources on those most at risk only drawing primarily on a risk discourse. This then could be at odds with the goal of providing less support but to the greatest number of those who are struggling academically. This strategy could be acceptable to funders who want to promote retention and academic success but might not be in the best interests of the students mental health.

To quote from SP1 (section 4.2.5)

‘Well it’s (counselling) a means to an end in the academic sense rather than something to make you feel better about yourself and better about life.’

Trying to reconcile the tensions between academic and mental health needs have prompted many institutions to develop policies in relation to Fitness to Study. The aims of these policies are to provide procedures which are deemed to be supportive but will also allow the college to exclude students who are seen not to be coping but to do so in a manner which will avoid legal challenge. Even if there is an agreed ethically sound aim, two opposing strategies based on differing assumptions can be proposed to achieve this aim. It could be argued that the best preventative measure is to avoid waiting lists, see everyone quickly, and move them on. The opposing argument is that it is more effective to identify high risk presentations and concentrate all resources onto them.

This discussion highlights a number of competing discourses which are present in psychotherapy practice in general and are made more visible in context where there are scarce resources. Bondi (2005) draws attention to how psychotherapy practice both contributes to and resists neoliberal forms of governance.

To quote:

‘...conveys autonomy on practitioners who are deemed to have internalised and to embody the knowledge and conduct required for professional practice. In doing so it recruits practitioners into modes of action that express autonomous, decision making agency at the same time as submitting to disciplinary measures (Bondi 2005, p. 501).’

She uses the concept of empowerment to explore how therapists in voluntary sector services use the concept both to describe their role as one of promoting choice and freedom for both themselves and their clients while also recognising the regulatory role of the psych-

disciplines in shaping self-understandings and encouraging individuals to self-govern as described in Foucault's description of bio power (Hickinbottom-Brawn 2013).

5.4 Limitations of this Study

This study focused on how a group of students and counsellors, using and working in a student counselling service, spoke about and understood their experiences of a short contract model of counselling delivery. Their responses are specific and may not be applicable to the wider group of students who used this or similar services. The study was limited to one centre. The sample size while consistent with a qualitative methodology was relatively small consisting of one focus group and thirteen individual interviews. The group was an exceptional one in that they were not the 'norm' for clients of the student counselling service. Although this can be justified from a Foucauldian discourse analytic approach, it is open to criticism that its broader relevance is limited. The study was deliberately concerned with subjects who could be described as marginal, in the sense that they did not fit the norm. The aim was rather to consider what meanings these marginal subjects ascribed to their situation, and how these meanings shifted and changed and became discursive constructions in a particular historical and cultural context

For the majority of students who attended this service, the short contract model could be assumed to be working well in that they attended the service, undertook counselling and left. However this begs a number of questions. It is very tempting to interpret participants' views and behaviour on the basis of an external action such as whether they choose to attend counselling. There is really no way of knowing what influences behaviour without the kind of in depth conversations based on qualitative approaches (in this case discourse analysis) which could explore how the behaviour in question is spoken about and understood. Even allowing for the apparently homogenous nature of service provision the purpose of qualitative research is not to make claims about prevalence or to suggest that the research represents typical responses which could be generalised to a large group. When discourses are shifting and changing there is a potential for groups such as the study participants to become further marginalised. Studies such as this one can help to highlight these effects and to provide an alternative perspective to accepted assumptions about the apparent inevitability of the developments previously outlined.

The study was unable to explore the question of the possible extent to which the short contract counselling model may influence all attendees, whether they attended for six sessions or fewer. In making this comment it is important to distinguish between a standardised short contract counselling model of counselling which this study has featured from the psychotherapy literature which describes brief interventions which tend to be of longer duration and are delivered to treat specific conditions or symptoms. When an expectation is set that the norm is six sessions and anything else is a deviation from that norm, this may have an effect on for example, a decision whether or not to attend in the first place.

In this study participants were counsellors and student clients of the service. However these are not the only groups who are affected by this policy. Other groups, for example university managers who allocate funding to services have much to contribute to this topic. For instance, there is a role here, with discourse analysis in mind, to include material from decision makers (those who may have set up the service and those, outside of its immediate management, may have had a role in influencing it, extending it or limiting it). Equally other services and referrers such as student health, support services and academic staff who refer students to counselling could contribute their particular perspective. Also the general student body including those who have not sought counselling may well have views which need to be heard. A different study using a different methodology could have been used. However discourse analysis appeared to be the most pertinent approach to answer the question and did result in a set of robust findings. It might also be worth replicating this study in another environment to see if similar findings emerge.

The researcher's dual role as researcher and service manager (which is also discussed in more detail in chapter one in the section on personal position and in chapter three in the context of the overall study design) may have influenced the study design and questions asked of the participants due to her own familiarity with the topic of the study, despite the measures taken to counter this which have been described in chapter three about methodology which provides a description of the study design. To some degree this possible tension is inevitable. It is not possible to be completely neutral. All researchers have their own concerns and motivations for undertaking specific pieces of research. The most important aspect is not to deny previous knowledge or interest in a given topic but to explore it and be as open as possible and as aware as possible about how this might affect a particular study. It could be argued that these are acceptable general principles but that the situation is different if the researcher has a specific role in the organisation in which the research is being carried out. For example it might have been particularly difficult to interview those to whom the researcher has a reporting role or for others where the researcher has a very public profile and is clearly identified with a particular viewpoint. The measures described of excluding clients with whom the researcher had previously had contact proved helpful. Most of the client participants did not appear to be aware of the researchers dual role. There were two exceptions. In both cases the dual role was acknowledged and did not appear to create a difficulty. While the researcher's personal position in relation to the topic has been described, this only became fully clear to her during the course of the research. For the counsellor participants the researchers dual role was clear and openly acknowledged. They would have been aware that her position was one of struggling with the dilemmas this policy created for her. It was to try and seek a balance between transparency and to give enough distance for participants to express themselves freely that the researcher did not facilitate the focus group but did remain in the room.

5.5 Summary

This chapter which discussed the study findings began by revising the literature review. In keeping with a Foucauldian approach particular attention was given to providing a theoretical and historical overview of the development of psychotherapy and student counselling which creates the conditions of possibility for the emergence of the short contract counselling model. The chapter then went on to contextualise the findings with reference to broader social discourses. The first of these was the increasing penetration of the neo liberal agenda and the operation of disciplinary power into the fields of health, education and student counselling. This was related to the discourses identified in chapter four and drawn on by the study participants. Reference was made to the discourses of stigma, recovery, productivity managerialism, and the management of risk. The changing discourses concerning mental health featured the role of the medicalising discourse and the oscillation for student participants as to the degree to which they viewed themselves as patients or consumer of services. The changing college context and the dilemmas this creates in terms of pressure on services was described. This led to the question of whether the primary purpose of student counselling is academic support rather than mental health treatment which links to the discourse of productivity. The chapter continued by considering the discourse of ethics and the production of the ethical subject, in particular how this relates to dealing with a context of scarce resources. The limitations of the study and was discussed. The topic of the researchers dual role as both researcher and service manager and the potential role conflict inherent in these two identities was considered. In chapter six this thesis will consider the implications of the study for a number of fields such as service improvement and counsellor training. Bearing in mind the limitations of this study consideration will be given to areas of further research which could elaborate on some of the issues identified and focus attention on the short contract model of counselling which is now to be found in many different settings in which counselling is offered.

Chapter 6 Conclusions and Implications

The aim of this research was to explore the discursive construction of student counselling in general and short contract counselling in particular in an Irish third level college. Short contract counselling refers to the practice of offering a small standard number of sessions to the client. Semi-structured interviews were held with a group of student participants who all received more than the standard six sessions on offer. A focus group was also held with counselling staff participants. This chapter summarises the main conclusions of the study. It comments on possible implications of this study particularly in relation to theory, policy and practice and suggests areas for future research. It contains a personal reflection on the researcher's motivation for undertaking the study the study.

In chapter four the author presented the findings which were discussed in detail in chapter five and which are briefly summarised as follows. Within a college discourse counselling is normalised and is seen as something desirable which the college should provide. Increased recruitment of students has increased the demand for services and highlighted the challenge of meeting this demand. This links to the defining of the role of student counselling as an academic support which draws on specialist mental health expertise for the purpose of optimising academic functioning and promoting retention. Participants frequently drew on more than one discourse or changed their positions during the interviews. This reflected the broad and varied range of discourses through which individual participants constructed their understanding of and response to short contract counselling. All participants, students and counsellors, spoke of the sense of pressure which they felt in order to perform in the university. For the students there was a need to prove that they could quickly return to functioning as successful students and healthy productive members of society. This was what they generally wanted but also what was required of them by the setting. For counsellors the pressure was generated by the need to be productive and to work quickly, being constantly aware of the waiting list and the six session framework. The operation of disciplinary power in this setting was explored. The participants' responses highlighted the dispersed nature of power which did not necessarily reflect a subject's formal role or position.

6.1 Key Conclusions

Discourses are always operative and have a constitutive importance. An object, in this case short contract counselling, is constructed as it is spoken about. The routes by which this happens are complex and the effects and consequences are multiple. The study explored how a range of factors created conditions of possibility for the emergence of short contract counselling. It has emerged as one particular response to what has been constructed as a shortage of counselling resources needed to respond to a high level of demand. A development which contributes to this is the increased prominence given to the role of emotional difficulties and the need to regulate these in social policy in general. This is a significant feature which has contributed to the increased demand for counselling services,

followed by public concerns about such shortages and to which short contract counselling is constructed as one response.

This study explored how participants both students and counsellors positioned themselves in relation to this particular construction of 'reality'. It explored the range of discourses that were drawn upon and which were influenced by broader social discourses in relation to the role of higher education, mental health and neoliberalism. These interconnected and competing discourses particularly in relation to scarcity and risk, created dilemmas to which one 'solution' was the imposition of a rule which legitimised the rationing of resources. This is not the only or inevitable 'solution', but was one made possible by the context and circumstances within which it developed. Discourse analysis provides a means of considering the unexpected ways that different discourses, apparently competing with each other, can be drawn on and spoken about by the same person at the same time. For example many client participants oscillated between speaking about themselves as patients or consumers. Therapists varied between speaking of themselves as professionals with a specialised and powerful knowledge base and being on 'the production line', working with whatever 'the system' decides.

The discourse of scarcity was frequently drawn on and the question of rationing became something all the participants were aware of and had to respond to. The complexities involved in scarcity and rationing were seen by some participants as drivers for the construction of short contract counselling, as an imposed rule which would allowed everyone involved to avoid the complexities of making decisions based on competing individual needs. Student counselling services found themselves in a difficult position when numbers expanded and demand increased, but resources did not. Many service managers dealt with this by imposing limits which then linked to definition of the role of student counselling being to support academic functioning only (Mair 2015) which by definition is more possible to achieve in a short term time frame.

The most visible discourse associated with scarcity was risk. The discourse of risk has become a very powerful justification for limiting session numbers and has a disciplinary effect on both counsellors and students (potential and actual clients of the service). Expert discourses were highly influential in identifying those at risk. The existence of this categorisation had far reaching effects. Many of those not so designated felt they could not easily ask for more counselling should they need it, as their needs would be seen as less urgent than others who were at risk. This was mentioned by a number of participants. It adds weight to the description of student counselling as a disciplinary site through which power and knowledge are constructed. It is a site for the production of resilient citizens, for identifying those who are unable to manage their own risk and ensuring that others restrain their demands in order not to further jeopardise what might otherwise then be available for those at risk. Another scenario is one where the risk discourse functions to ensure that those at risk are moved out of the student counselling service by external referral and

priority is given to ensuring the rapid return to functioning of those who are not deemed to be at risk.

This study found that student participants tended to draw on discourses such as stigma, recovery, patient or consumer. These conflicting discourses influence and were influenced by the medicalised discourse of stigma relating to mental illness and the consumer discourse in which counselling is viewed as a commodity.

The patient discourse also tended to draw on the discourse of stigma, relative powerlessness and social marginalisation. This reflected too the medical discourse in which the patient was dependent on expert knowledge and was relatively compliant. The consumer discourse linked to a position of entitlement in which the client was the expert in their own mental health and talking was spoken about as therapeutic and something they should be able to access. The discourse of the consumer assumed right and entitlements to services. The traditional professional discourse positioned the professional as the possessor of particular knowledge and expertise which bestowed the authority to speak. It assumed the existence of client groups such as students who are willing to accept and defer to the judgement of the professional expert. Associated with this position was an acceptance that the professional was relatively autonomous and that regulation should be light touch and to come from the professional bodies themselves. This sense of professional power and autonomy was being eroded for counsellors in a college environment. Focus group participants described themselves as under pressure to deliver rapidly, to be accountable and to comply with a managerial discourse strongly associated with a neoliberal agenda in which the economics of the market place have penetrated the field of student counselling provision.

The discourses that operate in the delivery of short contract counselling are part of a wider tranche of developments. In psychotherapy there is an increasing emphasis on brief therapy, to the extent that what was considered brief in the past has become the new norm (Barkham et al. 1996a). There has been a growth in manualised therapies such as CBT (Cognitive Behavioural Therapy) and DIT (Dynamic Interpersonal Therapy) (House and Loewenthal 2008; Lemma et al. 2010; Proctor 2008), alongside the development of the very influential stepped care model delivered through IAPT (Improving Access to Psychotherapy) in the UK (Proctor 2015; Rizq 2012a; Rizq 2011). The stepped care model features hierarchically arranged interventions to which access is restricted, usually on the basis of a score determined using a questionnaire or similar clinical instrument which includes risk assessment. Elements of this approach can now be seen in student counselling in general and may develop so they become part of a new 'norm'.

Drawing on Foucault's conceptions of the nature of disciplinary power and governmentality, the study drew attention to the role of psychotherapy and counselling as promoting various constructions of reality in which subjects effectively self-govern by adopting certain ethical and moral positions which makes them responsible for any difficulties they may experience.

This is discussed in chapter four as the production of the ethical subject (4.3.2) The counsellors had the formal power but students at times resisted this, typically by not saying what they felt, and in one case leaving before the six sessions were completed. Some client participants demonstrated care for counsellors by not requesting additional sessions or by not fully disclosing their concerns to avoid pressuring staff to offer additional sessions. They were sensitive to the possibility that their demand for further sessions could be seen as a criticism of their counsellor.

The study was conducted in a third level student counselling service contextualising the service around academic demands. Student counselling reflects the pressure experienced by the broader student and staff body. Factors such as the structure of the term, the exam cycle, the need to compete and succeed, and the increasing diversity of the student body are mirrored in the concerns students bring and the speed with which they feel the need to return to successful academic functioning. This means that counselling is attended often in a series of short bursts, with further episodes in which clients work with different counsellors. Students are aware from the start that they are availing of a scarce resource, a point which was spoken about by all the participants. These features illustrate differences between accessing and attending counselling in this setting compared to others where externally imposed pressures are less evident.

Focus group participants said that their trainings as counsellors had not prepared them for the challenges of working in publicly funded environments where they are more likely to have to work within a short contract model. It was stated that even those approaches which would claim to work within a time limited framework, for example CBT, still operated with a longer number of sessions than is usually found in the short contract model.

6.2 Implications of the study

Studies based on discourse analysis tend to consider implications rather than make recommendations based on findings. The focus is on exploring how existing discourses operate, attempting to deconstruct them and thereby open up possibilities for new knowledge and new understandings to emerge. Discourses identified should be seen as recognisable, relevant, coherent and trustworthy by potential readers. Yet the nature of the approach could be said to make it difficult to formulate specific recommendations as in the manner typical of most research studies. There has however been a discussion within critical discourse analysis (CDA) about the status of action as something which is compatible with a CDA perspective which is based on a social realist ontology (Wodak and Meyer 2009; Willig 1999; Willig 2012).

The focus on context means that attention is drawn to large scale macro social features, and can be particularly difficult to reduce to a series of finite implications. This challenge is especially difficult in an environment where the demand for mental health services is so high, so that to suggest anything other than the continued rationing of an already scarce resource could be seen as perverse. Factors driving this demand include responses to social

phenomena which are more likely to be influenced by social changes outside the direct sphere of mental health. One illustration is the pressured environment in third level colleges which generates anxiety for academics (and students) which are then treated as mental health conditions arising from individual vulnerabilities (Berg et al. 2016). However despite these provisos the study goes on to consider implications in three areas these are theory, policy and practice and research.

6.2.1 Theory

Discourse analysis is a very wide ranging interdisciplinary approach which does not have prescribed research techniques to be followed. As meaning is not fixed, everything is open to continuous interpretation (Morgan 2010). A range of methodologies all claiming to feature discourse analysis have been adopted to fit specific research questions (Taylor 2001; Wodak 2008).

Discourse analysis has been criticised as lacking an action orientation and being ambivalent about the significance given to the individual subject as an actor rather than being more acted upon by the operation of discourses, other than making the claim that language itself is a discursive accomplishment. Related to this is the further criticism about the inability of discourse analytic studies to capture participants' experiences and meanings. Kendall and Wickham suggest that Foucault's methods can be used to see culture as a set of practices aimed at producing certain kinds of person, not a collection of phenomena which hold meaning (Kendall and Wickham 1999). This is challenged by Willig (1999) who points to the consciousness raising aspects for participants who are encouraged to view their experiences from different perspectives. It was very clear from the responses of the study participants that they appreciated the opportunity to speak about their experiences and to be critical.

A common approach in discourse analysis is to use official documents or media representations to illuminate particular discourses in contrast to this study which relied on interviews and the transcripts which came from those. This was a very pertinent issue for this study which was based on interviews rather than analysing policy documents as a main data source. Savransky writes about the limitations of reliance on official texts as a primary data source in discourse analysis, and relating this to psychotherapy says:

'It is rare to find any discussion regarding the potential sources – material, affective and discursive – that contribute to transforming therapeutic relationships into complex, risky processes of negotiation, creation and change which may often trigger a whole set of undesired and non-conscious effects' (Savransky 2014, p. 104).

Savransky argues for the need to rethink the question of the formation of subjectivity. He uses the term "recalcitrant subjects" to describe how subjectification may be resisted. The question is not to enquire what is the subject is, but rather to enquire how subjects become and how they are produced. He goes on to suggest that the concept of resistance, given great significance in discourse analysis, should not be reduced to a description of a subject caught between competitive regimes of subjectification but should be seen as a dynamic and

active process. The participants in this study could certainly fit the description of recalcitrant in the sense that they resisted the six session model and sought what they needed, drawing on a variety of discourses to describe this.

While Foucauldian discourse analysis approach has proved very valuable and has provided new insights into the role and effects of short contract counselling, it does provide some challenges perhaps especially for researchers who are also psychotherapists.

For the overall coherence and credibility of this study it was important and necessary to maintain the discourse analytic stance selected for the study. A different, and perhaps more nuanced, account could be produced by using psychoanalytic concepts. This would allow for a wide range of subject positions, sometimes adopted, sometimes attributed, or sometimes perhaps the result of past developmental histories or the actions of others, to be explored. These positions can be precarious. The challenge is whether a discursive account can capture this adequately (Mills 1997).

Discourse analysis has been used to explore different subject positions adopted by individuals in a therapeutic context and have been used to track indications of therapeutic change (Madill and Barkham 1997; Georgaca 2013; Georgaca and Avdi 2011). Other researchers have sought to develop what they term psycho discursive accounts, which seek to situate the discourses adopted by subjects in the context of their individual histories (Hodges 2002; Gough 2009). The focus in both approaches has been to understand changes in how individual subjects spoke about and described themselves.

A particular challenge is to develop a multifaceted and evocative account which could address a group response to a particular phenomenon such as the topic of this study and which could provide a lens sensitive enough to consider both the discursive construction of accounts and what might be the processes whereby individuals draw on particular discourses rather than other alternative ones. There is an ethical dimension to be considered in that when a participant agrees to be interviewed for research purposes this is different from going into treatment where more challenge and interpretation of motives are to be expected but which would be part of writing a psycho discursive account.

Jørgenson argues for a multi-perspective research framework which can embrace diversity while stressing the need for compatibility of different philosophical premises (Jørgensen and Phillips 2002). Discourse analysis has considerable flexibility as an approach which is both a strength and a challenge in that it can be difficult to ensure that research is actually adhering to a discursive approach (Antaki et al. 2003). From theoretical considerations the next part of the chapter will consider implications for policy and practice.

6.2.2 Policy and practice

The focus of this study is student counselling. This has its own particular features but is also part of a broader network of mental health services for young people offered by different

providers. Much has changed. For example when Maloney et al. (2007) reported on implications for counselling services of the increased attendance at college of 'non-traditional students the issue was relatively new. Improving service accessibility for those groups has now become a significant issue in student counselling, with much provision now been taken up by these groups. Many mental health services external to colleges have developed independently, each with different sources of funding, organisational structures and professional cultures. The main strands are the publicly provided services which include secondary care, community and voluntary organisations and the education sector. It has been largely the gaps in the state sector which have provided the impetus for the development of the other two.

In practice this means that some students, including some of the study participants, are bounced back and forth between different services with no clear referral pathways. Instead of co-operation with the aim of providing the best outcome for the student, each service tries to enforce boundaries which make clients the responsibility of someone else. Secondary care services are typically run on an exclusively medical model, with little regard for educationally or community based services. This does not clearly address the needs of those seeking mental health support or treatment, and urgent development of a collaborative approach is vital. It suggests that an approach based on mutual respect for different skills and specialist experience would lead to a better experience for clients. This might mean, for example, better availability of psychiatric consultancy to agencies in the education, community and voluntary services delivering therapy. This could avoid unnecessary hospitalisation and could also provide a referral pathway for clients who cannot be contained by services such as student counselling. What is also needed is a diversity of primary services; in which providers do not all operate on a short contract model.

The normalising agenda adopted by anti-stigma campaign groups such as See Change seechange.ie (2014) represents a particular discourse. However these campaign groups tend to focus on mental health conditions, such as anxiety and depression, with which the broader population can more easily identify. They tend to have less impact where longstanding mental illness is involved and where stigma continues. Some study participants fell into this latter group. Student participants certainly complained of anxiety and depression, which could not be adequately addressed by the provision of resilience training and the development of better coping skills. In some cases their difficulties were much more severe, but were being responded to in a service environment mainly geared to short term interventions more appropriate for those with less severe difficulties. This links to an almost pervasive denial of the nature and severity of the suffering endured. Ultimately what is needed is a reconceptualization of mental health and illness, an acceptance that an overemphasis on the positive psychology assumptions about resilience and coping can serve to deny the severity of the suffering of those who continue to endure mental illness. Anti-stigma campaigns need to address this reality.

The recommendation which follows is that the funding base of student counselling and mental health provision, needs to be re-examined especially in the light of the current reality that third level college campuses are now accessed by a significant percentage of the population and therefore an appropriate site in which primary mental health care could be available. This should be jointly funded by the education and health authorities. If extensive mental health services are developed on college campuses this does not match the current primary care service plan for Ireland which the Department of Health is committed to. This plan should be reviewed to take account of the numbers of young people in college and the need to provide services which can be accessed promptly in a manner which is acceptable to students as student counselling clearly is given the level of demand for college based services. The overall budget for mental health needs to be reviewed to accommodate this expansion and to avoid further pressure being exerted on already inadequate mental health budget. Within that model the medical discourse would be part of the offering but would not determine the complete nature of the services or the interventions made available, which would be responsive to client need and desire.

Resourcing is likely be a continuing source of difficulty for the foreseeable future. The influence of the stepped care model appears to be growing and extending into the field of student counselling (Proctor 2015). An implication for student counselling is that it can become primarily a mechanism through which risk is identified and managed which changes the whole nature of the counselling process. Those who exhibit too much risk may be excluded. The only acceptable levels of risk is that which can be mitigated within the time frame of the short contract. There are alternatives to be considered. Rather than the counsellor (or the institution) being the sole gatekeeper for accessing mental health support, more importance could be given to enabling the client to make genuine choices about what kind of help would be most beneficial within a pluralistic model which includes one to one counselling, groups, workshops and psychoeducation. Rather than be told what they can have, clients would be invited to make meaningful choices in collaboration with their counsellors. Research shows that a better outcome is more likely when the help on offer is aligned with the client's expectations and wishes (Greenberg et al. 2006). This suggests that the process of assessment could become a conversation rather than a rating of clients on tick box scales. This was spoken about by the focus group participants who gave the example that the presenting problem may not be the one for which a box has been ticked, and that this only becomes fully apparent during the course of a clinical assessment. The focus group participant danger that the risk agenda was replacing clinical assessment as the focus of the initial meeting between client and counsellor.

The Cardiff model, described by Mair, has elements of this approach (Mair 2015). The client is offered an initial longer consultation of one and a half hours in which they are encouraged to resource themselves by accessing various materials available through the service. The emphasis here is on the development of resilience which was previously discussed in chapter five and was seen as part of the penetration of a neo liberal agenda into mental

health (Aubrecht 2012). A follow-up is offered four weeks later. Only at that point is short term counselling made available and only if the resources accessed prior to the follow up have proved insufficient. However the choice remains in the hands of the professional not the client as discussed in chapter five as a part of the operation of disciplinary power.

Disciplinary power is also present at the level of the individual therapeutic encounter. Telling the student client they only have six sessions immediately puts a limit on what can be said, it inhibits a free flowing approach to the discursive style of some forms of psychotherapy. It directs the therapist to be directive in their approach and to 'watch the clock'. It supports a system that preferences one style of therapy and promotes the one size fits all approach. While there is ample evidence to support that brief interventions work there is also a significant body of research that argues for a therapy of longer or indefinite duration. The short contract model has implications for how the therapeutic alliance may develop, some of which were explored in chapter four sections 4.4.1, 4.4.2 and 4.4.3 concerning obtaining extra sessions, endings and changing therapist.

The question of the attribution of blame and responsibility is a significant issue in therapy (Avdi and Georgaca 2007). In their review of how discourse analysis has been used to research therapy, they focus on the role of the therapist in promoting certain ways of dealing with the question of blame and see this as an interactional accomplishment in which the therapists plays a leading role. This case is different as the attribution of blame to an outside party could be seen as something which both parties collude in to avoid disruption within the therapeutic encounter. In chapter four in which the findings were discussed student participants talked about the college not caring about the students mental health and making cutbacks. In describing the process of obtaining additional sessions, several student participants distinguished between their counsellors wish to provide additional sessions but being subject to external restrictions. The focus group participants referred to external forces such as 'the accountant' and the existence of 'industry standards' in terms of numbers of sessions as external forces which created constraints which then influenced what they could or could not do as counsellors.

The underlying assumption seems to be that clients will always opt for face to face counselling, and that this will overwhelm the available capacity of the service. There is some evidence to support this. A report titled 'Help-Seeking at Third Level', described a strong student preference for a face to face encounter with a mental health professional rather than being offered an online programme (Karwig et al. 2015). What has not been explored is how long the majority of clients would choose or would need to remain in therapy, allowing for this preference. This number of sessions offered in the short contract model is not explicitly based on research findings but rather on professional and resource discussions among service managers. The average figure is in any case misleading, as the reality is that attendance tends to be in the shape of a bell shaped curve. That is, relatively small numbers drop out very quickly and small numbers stay on for much longer. This has been described

as the utilisation paradox, where most service capacity is used by a relatively small number with generally more complex and continuing difficulties (Barkham et al. 1996b). It is quite plausible to suggest that this pattern would persist irrespective of session limits. Removing explicit session limits could however lead to more choice and empowerment for the client. Therapists are likely to feel more comfortable and happier about working in a manner which affords greater respect to clinical judgement and decision making.

However the counter argument is that there is a bottomless pit of demand, that this would mean opening the floodgates so that services would be overwhelmed. Another way of thinking about this is that there are now very different groups of students accessing counselling, for example as mature students, access students, international students and students with disabilities. For many of these students it is possible that a short intervention chosen by themselves would be sufficient and appropriate. However for some who need longer support, they are being shoehorned into a standardised service delivery model which does not work for them. This situation is exacerbated by the extreme paucity of other available mental health services in Ireland.

6.2.3 Therapist training

Many therapy training organisations do not tend to consider issues such as the setting and context within therapy is delivered. This is interesting in that there is from a number of counsellor training organisations active encouragement for their trainees to seek placements in the education, public and voluntary sectors where provision is built around a model of limited sessions, without integrating the clinical implications working in these sectors compared to a private practice model where clients can opt in or out, mostly but not exclusively depending on their ability to pay. Private therapy is inescapably restricted and could be described as elitist. Many private therapists are concerned about this and some offer fees on a sliding scale. However the whole climate is difficult and many therapists are unable to build a financially resilient practice from which they can make a living. The reality for many therapists in private practice is that, although they are trained in providing long term therapy, much of their work is more short term than they anticipate. A typical working pattern is likely to include a range of activities some of which are likely to be offered in a funded environment.

Training organisations could offer a broader clinical education which values different ways of working both long and short term and which can consider the impact of the setting on the therapeutic work itself. For example current models of therapy training are not sufficiently sensitised to differences between education, community and primary care settings. There is little research about the extent to which each setting can provide an intervention which is deemed by clients to be sufficient rather than becoming part of a revolving door experience of serial short term encounters, as was the case for the client study participants. Perhaps this is inevitable, but a possible step in changing this culture might be to increase the emphasis on trying to actually meet client needs. This would

require the development of pluralist models, grounded in identifiable conceptual frameworks and allowing for the development of specialisms, not linked to symptoms alone, but also attuned to different contexts, in this case an educational one.

6.3 Future research

Paying careful attention to the development and context of short contract counselling has highlighted the profound nature of the changes to publicly provided counselling and psychotherapy which have been occurring. These are far more widespread than the study site. To obtain a fuller picture further studies and appropriate methodologies need to be developed. Studies could consider other environments such as services provided by the HSE and the voluntary sector. A quantitative study on the national availability of services and the duration of therapy both offered and attended would be of great relevance to the issues identified in this study. Future studies using different methodological frameworks should privilege the voices of those most directly affected, the clients and the therapists who most directly feel the effects of these changing practices. In order to achieve this consideration, could be given to other additional approaches such as those based on narrative and psychoanalytic understandings of individual experiences.

It is not known how the existence of the short contract model might have influenced those who choose not to attend, or whether the short contract model influenced their decision. The question of ending counselling was a very important topic for the study participants as was the question of changing therapists and returning to counselling on a serial basis. A further aspect is the “revolving door” of repeated episodes. It could be that such short serial therapy is satisfactory and fulfils particular needs for some but not for all. Alternatively, it could be that the brevity of the contract means that a return is more likely to be needed. Other important topics for research are the dilemmas experienced by the counsellors, whose training may have led to different expectations about how they would be practicing rather than the reality of working in these short contract environments. There are a number of other stakeholders who were referred to in the section about the limitations of the study, such as funders of services internal and external to the university, the medical profession, the voluntary sector, service users groups to name but a few, whose views of the short contract model should be the focus of further research. Referrals are made between services who all need to communicate better with each other in the best interests of their users. As the operation of this short contract policy has become a regime of truth, it has in some ways become taken for granted, is not questioned and therefore possible alternatives ways of delivering services are not considered.

The material on which this study is based comes from client interviews and from the counsellor focus group. This means that it was not possible to trace the interactions between counsellor and client which could lead directly to the adoption of the discourses and subject positions described and then how these might link to responses to the short

contract counselling model. Exploring this would require access to counselling session transcripts which were not part of this study.

For the overall coherence and credibility of this study it was important and necessary to maintain the discourse analytic stance selected for the study. A different, and perhaps more nuanced, account could be produced by using psychoanalytic concepts. This would allow for a wide range of subject positions, sometimes adopted, sometimes attributed, or sometimes perhaps the result of past developmental histories or the actions of others to be explored. These positions can be precarious so the challenge is whether a discursive account can capture this adequately (Mills 1997).

Discourse analysis has been used to explore different subject positions adopted by individuals in a therapeutic context (Madill and Barkham 1997; Georgaca 2013; Georgaca and Avdi 2011). Other researchers have sought to develop what they term psycho discursive accounts, which seek to situate the discourses adopted by subjects in the context of their individual histories (Hodges 2002; Gough 2009). The focus in both approaches was to understand changes in how individual subjects spoke about and described themselves.

A particular challenge would be to develop a multifaceted and evocative account which could address a group response to a particular phenomenon such as the topic of this study, which could provide a lens sensitive enough to consider both the discursive construction of accounts and what might be the processes whereby individuals draw on particular discourses rather than other alternative ones. There is an ethical dimension to be considered in that when a participant agrees to be interviewed for research purposes this is different from going into treatment where more challenge and interpretation of motives are to be expected than a research participant might feel they have signed up to. Jørgenson argues for a multi-perspective research framework which can embrace diversity while stressing the need for compatibility of different philosophical premises (Jørgensen and Phillips 2002). The challenge is considerable!

6.4 Personal reflections

My motivation in undertaking this study was a direct response to a career spent working in the public sector in various capacities. My desire in most of these roles was a wish to be of help to others. That motivation in hindsight sprung directly from the experience of coming from a family which had many challenges including serious mental illness. In that context my family was not exactly helped by the services which then existed. As my career progressed my roles became more management oriented which was certainly not due to any conscious planning. I became increasingly involved with dilemmas associated with resource allocation and running services ill resourced in terms of the needs they were expected to address. In one role I was given the task of cutting the very services I had built up over the previous ten years. I decided that I had had enough and retrained as a psychoanalytic psychotherapist and group analyst. Little did I realise that in another ten years or so later I would be back in a similar position, but this time managing a service which provided counselling for students.

The key purpose of the doctorate in psychotherapy is to provide candidates with the knowledge and ability to work as senior psychotherapists and researchers. I find this personally stimulating and fascinating in equal measure, but it does provide considerable challenges. As a practitioner I am aware that research is rarely drawn on to influence psychotherapy practice in the public sector. This creates a dilemma for me that while I value research the availability or not of resources tends to be a key driver of decision making. If however research findings are not considered this can lead to simplistic thinking and can ignore the reality that even within circumstances of straitened resources all kinds of decision are made without the rationale for them necessarily being clear. This led me into considering the importance of socially constructed discourses as constitutive factors.

I have always been very practical and have got great satisfaction from developing services and bringing projects to fruition. This is quite different from the core role of the researcher, although the ability to manage big projects is an increasingly essential part of the researcher job description these days. In undertaking this research I was invited or rather required to stand back, to think, to consider but not to intervene directly. The programme provided an in-depth introduction to postmodern conceptions of knowledge production which emphasise a social constructionist ontology and epistemology. My challenge was to consider the apparent relativism this implied. I am quite comfortable with accepting concepts such as the discursive construction of phenomena, but found it difficult to let go of the grand narrative and my wish to identify causal relationships. Instead I have come to accept that meanings shift, that power is dispersed and that there are no simple drivers of change.

While Foucauldian discourse analysis approach has proved very valuable and has provided new insights into the role and effects of short contract counselling, it does provide some challenges perhaps especially for researchers who are also psychotherapists. Being in that position, I found it very challenging to pay attention to the role of discourse and the processes of subject creation without also considering issues of individual motivation and the apparent attachment subjects appeared to have to certain positions and discourses. My own psychoanalytic psychotherapy training makes it difficult for me not to interpret participant's material using psychoanalytic concepts.

Having worked in hierarchical organisations for much of my working life, I was certainly aware of a top down understanding of power relations, roles and rules, yet I was equally aware that in practice it can be very different. Conventional management theory even alludes to this with ideas such as the importance of 'influencers', 'stakeholders' and 'champions' who take over from formal managers as drivers of change. This encouraged me to look beyond the individual subject to the processes of subjectification and the discourses which influence this and to relate these to specific contexts. This led to an understanding of power as dispersed but also that for power to exist resistance must also be possible which aligned well with a Foucauldian perspective.

I am keenly aware how easy it is in roles with management responsibilities to fail to pay attention to the consequences of decisions made and how these are spoken about and understood both by staff and clients. There is a kind of distancing. The further away from the consequences of decisions the makers of them are, the easier it is to make decisions which have far reaching effects for the clients of a service. I wanted to understand some of these dynamics but also to produce research which has clinical relevance and allows the voices of those who have less apparent power in the formal sense to be heard and valued. From that perspective this research has achieved that and has reminded me, and hopefully others, of just how variable these accounts can be.

6.5 Concluding comment

This study has arisen from my curiosity about how short contract counselling has become an accepted means of delivering counselling in many publicly funded services. Within a short time, it has become so taken for granted that it has the status of a 'truth' which is rarely questioned and is not supported by research findings. It is changing the nature of provided counselling in fundamental ways. In student counselling the need to be productive and successful is privileged above all else. The demand for counselling has increased. It could be argued that this cultivates a sense of vulnerability in which counselling is seen as the answer to all life's difficulties. Additionally and within this study many people struggle with chronic and ongoing difficulties which are also expected to be catered for in this 'one size fits all' model as the specialised mental health services they may need are not easily accessed.

The assumption of standardisation and measurability is embedded in an approach in which the diversity of human need is rendered invisible. The neoliberal context of managerialism, surveillance and risk management is firmly embedded in student counselling provision, which is likely to grow in significance as the numbers of students attending college continues to increase. However it is important not to be prescriptive as to what future developments are possible. From a Foucauldian perspective change is contingent and not necessarily predictable. It is hoped that studies such as this one can provide a lens to consider what is happening currently and how new possibilities and alternative perspectives can be identified in the future.

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Appendix A Participant information sheet for counsellors

Research Title: Exploring the Limits of Short Contract Counselling in a Student Counselling Service: Going Beyond the Six session Model.

You are being invited to take part in a research study. Before you decide it is important to understand why the research is being done and what it will involve for you should you decide to take part. If you agree to take part you will be asked to give your written consent by signing this form. If there is anything you are not clear about, I will be happy to explain it to you. If you would like to take part you will need to return this form a week after you receive it. You should only consent to take part in this study once you feel that you understand what has been asked of you.

This study is being undertaken as part of a doctorate in psychotherapy at DCU. Ethical approval has been granted by NUIG and DCU.

The purpose of the research

The Student Counselling Service like many other similar services has a policy of offering six sessions of counselling. However patterns of attendance at counselling are much more varied.

The counselling service will use this research to help it to review the current policy. It is a very important aim of this research that the voice of the service provider as well as the service user is clearly heard so that the service can be as responsive as possible to the needs of those who seek help from it.

The focus group will last for up to an hour. For some participants this will be all that they are asked to do. In some cases it might be necessary to have a further follow up to clarify details or to ensure that the researcher's record of the group is accurate.

In order to gain a fuller picture the researcher will access clinical notes of your work in relation to occasions on which you sought additional sessions for clients as these notes and requests were written up at the time and so can provide a contemporaneous account.

The focus group will be held in a quiet and comfortable location. Participation is completely voluntary. You can withdraw at any time during the process. Neither your participation or withdrawal will have a negative effect on your current work or the offer of future work with the service.

Risks and Benefits

Participating in this study will enable you to have an influence on future policy which may lead to a direct benefit for service.

Should this study cause you any kind of distress, information will be provided on local sources of help

Anonymity and Confidentiality

Anonymity of participants and confidentiality of the interview material will be safeguarded through a number of measures including:

- The transcribed record of the focus group will be coded and stored so that individuals are not identifiable
- Recorded material will be transferred to a password protected computer for storage and retrieval.
- Signed consent forms will be kept in a locked filing cabinet and will not carry any identifying codes that could connect individuals to recorded data.
- The study material will be destroyed 5 years after the research is completed.

Study material is subject to legal limitations, which means that it could be subject to subpoena, a Freedom of Information claim or mandated reporting by a professional

If you want to discuss any of the issues in this leaflet or have cause for complaint please let me know by contacting me at bea.gavin@nuigalway.ie or by contacting the supervisors of this study (Dr Gerry Moore 01 700 5340 email gerry.moore@dcu.ie or Dr Raphaela Kane 01 700 8600 email raphaela.m.kane@duc.ie)

Appendix B Consent form - Counsellors

Have you read THE PARTICIPANT INFORMATION SHEET?

Yes ☐ No ☐

Did you understand all the information contained in it

Yes ☐ No ☐

Have you had an opportunity to ask questions about the study

Yes ☐ No ☐

Have you received satisfactory answers to any queries or questions you may have

Yes ☐ No ☐

Do you agree to have the focus group recorded

Yes ☐ No ☐

Are you willing for your counselling requests for further sessions for clients and clinical notes to be accessed for the purposes of this study?

Yes ☐ No ☐

Participants Signature:

I have read and understood the information in this sheet and the attached Participant Information Sheet. My questions have been adequately answered and I have a copy of the consent form. Therefore I consent to participate in this research project.

Participants Signature _____

Name in Block Capitals _____

Date _____

Appendix C Focus group schedule for counsellors

Settling in

Explain the purpose of the research

Check that the information sheet was clear and that the consent form has been signed

Ask again for permission to access any relevant service records and clinical notes

(Under the Freedom of Information Act the interviewee can also see these)

Remind the participant that the interview will be taped

Thank them for agreeing to take part

Confirm basic demographic information

Name

Length of time working at the counselling service

Flexible guide to the topics to be addressed during the interview including some sample questions. (one question per topic with follow up prompt if required. What follows are the general themes to be investigated rather than actual questions)

Six session policy

When and how were you made aware of the six session policy?

Tell me about what you can recall about your reaction to this?

Do you think the six session policy has affected the way you work as a counsellor?

Tell me about this?

Ending of Counselling

Tell me about what happens when you come to the end of six sessions with a client?

What sort of circumstances might lead you to seek additional sessions for a client?

How do you feel about the process of seeking additional sessions for clients?

Can you describe any occasions on which you felt you ended with clients earlier than you would have wished?

Has it been beneficial to clients when the additional sessions have been agreed?

Can you describe any occasions when it may not have made a significant difference?

Attitude to the six session policy

What thoughts do you have about the six session policy?

What do you think might be the reasons for its existence?

Do you think it works or should things be organised differently?

General wrap up and debrief on the experience of the focus group itself

Appendix D Student recruitment mail

Research into NUIG Student Counselling Service - six session policy.

Dear Participant

As a past user of the Student Counselling service at NUIG you are invited to take part in research which is being carried out with the agreement of the service, to explore students views on their current policy of offering six sessions of counselling. This research is being carried out under supervision as part of a higher degree I am undertaking at DCU.

For some students this is sufficient in that they finish their six sessions and end counselling. Other students attend for a longer number of sessions or return later for further sessions after the initial six. In order to really understand how this policy operates in practice and how it might affect students experience of counselling, a research project is being undertaken which will seek to look at this issue in depth. It will involve carrying out interviews with a group of students who have attended counselling in the past and have attended more than the standard six sessions.

An email invitation to is being sent to you as one of this group, to ask if you will agree to being interviewed for up to an hour about your experiences in counselling. Participation is voluntary. You decide what information you want to share. You may withdraw at any point. Everything you say in the interview is confidential and will not affect your ability to access counselling in the future should you wish to do so. The interview will take place on campus and will be timed to suit your convenience

If you are interested in taking part please reply to this email within the next week and let me have your contact details. I will then send you an information sheet, a consent form and will make contact to arrange the interview.

Best Wishes,

Bea

Bea Gavin

Appendix E Participant information sheet for students

Research Title: Exploring the Limits of Short Contract Counselling in a Student Counselling Service: Going beyond the six session model.

You are being invited to take part in a research study. The Student Counselling Service has a policy of offering six sessions of counselling. However patterns of attendance at counselling are much more varied than this. The counselling service will use this research to review the current policy. One of the aims of this research is that the voice of the service user is clearly heard so that the service can be as responsive as possible.

Before you decide it is important to understand why the research is being done and what it will involve. This participant information sheet will tell you about the purpose, benefits and risks of the study. If you agree to take part you will be asked to give your written consent by signing this form and returning it to me within a week of receiving it. If there is anything you are not clear about, I will be happy to explain it to you. You should only consent to take part in this study once you feel that you understand what has been asked of you.

This study is being undertaken as part of a programme in psychotherapy at DCU. leading to an award of a D.Psych.in Integrative Psychotherapy. Ethical approval for the study has been granted by NUIG and DCU.

The purpose of the research

This study will seek to interview students who attended for more than six sessions. The interview will last for up to an hour In some cases it might be necessary to have a further follow up interview to clarify details or to ensure that the researcher's record of the interview is accurate.

In order to gain a fuller picture the researcher will seek your permission to access your service records and clinical notes as these were written up at the time you attended and so can provide a contemporaneous account The only information looked at will be that which is relevant to the decision to offer you more than six sessions. You are can refuse this request and still take part in the study if you wish.

The interviews will be held in a quiet and comfortable location. Participation is completely voluntary. You can withdraw at any time during the interview process. Neither your participation nor withdrawal will have a negative effect on your rights including the right to seek further help from the counselling service in the future.

Risks and Benefits

Reflecting on your experience in counselling and since then with an interested other person, is generally experienced as therapeutic in its own right. Considering your current needs and wishes including the possibility that you might be interested in accessing further help from

the counselling service will be beneficial. Participating in this study will enable you to have an influence on future policy which may lead to a direct benefit for either yourself or for future users of the service.

There is however a small risk that the recalling of personal experiences can be distressing, should this occur you can withdraw from the study and be supported by the researcher to access further help from the counselling service. If you feel that the distress is manageable and you want to continue the interview the researcher will facilitate you to do so.

Anonymity and Confidentiality

Anonymity of participants and confidentiality of the interview material will be safeguarded through a number of measures including;

- Interview material will be coded and stored so that individuals are not identifiable
- Recorded material will be transferred to a password protected computer for storage and retrieval.
- Signed consent forms will be kept in a locked filing cabinet and will not carry any identifying codes that could connect individuals to recorded data.
- Any additional anonymous clinical information obtained from the counselling service will be destroyed once the study is written up.
- All your case notes and service records will continue to remain the property of the service and protected by the confidentiality policies and protocols of the service.

Study material is subject to legal limitations, which means that it could be subject to subpoena, a Freedom of Information claim or mandated reporting by a professional. This would be necessary if you were assessed as being at risk of harm to yourself or if you disclosed information that indicated that you presented a potential risk of harm or had inflicted actual harm on another person.

If you want to discuss any of the issues in this leaflet or have cause for complaint please let me know by contacting me at bea.gavin@nuigalway.ie or by contacting the supervisors of this study (Dr Gerry Moore 01 700 5340 email Gerry.moore@dcu.ie)

Appendix F Consent form – students

Have you read THE PARTICIPANT INFORMATION SHEET?

Yes ☐ No ☐

Did you understand all the information contained in it?

Yes ☐ No ☐

Have you had an opportunity to ask questions about the study?

Yes ☐ No ☐

Have you received satisfactory answers to any queries or questions you may have?

Yes ☐ No ☐

Do you agree to have your interviews recorded?

Yes ☐ No ☐

Are you willing for your counselling records and clinical notes to be accessed or the purposes of this study?

Yes ☐ No ☐

Participants Signature

I have read and understood the information in this sheet and the attached Participant Information Sheet. My questions have been adequately answered and I have a copy of the consent form. Therefore I consent to participate in this research project.

Participants Signature _____

Name in Block Capitals _____

Date _____

Appendix G Interview schedule for students

Settling in

Explain the purpose of the research

Check that the information sheet was clear and that the consent form has been signed

Ask again for permission to access any relevant service records and clinical notes

(Under the Freedom of Information Act the interviewee can also see these)

Remind the participant that the interview will be recorded

Thank them for agreeing to participate

Confirm basic demographic information

Name

Course

Student ID

When counselling was attended and for how long

Flexible guide to the topics to be addressed during the interview including some sample questions. (There will be one question per topic with follow up prompt if required. What follows are the range of possible themes to be investigated. They are not intended to be actual questions and may not necessarily be used)

Experience of counselling

Tell me about what made you seek counselling?

Tell me about any general expectations you might have had about counselling before you came?

Did you have any expectations about the number of sessions you might be offered?

Six session policy

Tell me about how you learnt about the six session policy?

Can you recall what you made of this at that time?

Could the six session policy have affected your experience of counselling? (Please describe how)

Ending of Counselling

Tell me about what happened when you came to the end of the six sessions?

How were additional sessions negotiated?

Tell me about how the counselling eventually ended and how you felt about this?

Current Functioning

How are you doing now compared to how you felt at the end of your counselling?

Did you or do you feel you could approach the counselling service again should you need to?

Is there anything which might prevent you doing this?

Attitude to the six session policy

What general thoughts do you have about the six session policy?

What do you think might be the reasons for its existence?

Do you think it is ok or could things be organised differently?

General wrap up and debrief on the experience of the interview itself

Appendix H Reminder

Subject

Reminder: Participants needed for Counselling Service Research

Dear,

I wrote to you recently asking you to take part in research about the NUIG Student Counselling Service policy of offering a standard six sessions of counselling. The idea behind the research is to see if that policy is meeting student's needs or not. I am contacting students who have had than this number of sessions to see how they feel about the policy and if it has had any impact on their experience of counselling.

I am carrying out this research under supervision as part of a higher degree at DCU.

Although I had a good response to my first email some more additional participants would really add to the quality of the study. Taking part will involve is agreeing to meet for a maximum of an hour in a quiet confidential office on campus.

Participation is voluntary and you may withdraw at any point. Everything you say in the interview is confidential and will not affect your ability to access counselling in the future.

If you are able to take part please reply to this email within the next 7days and let me have your contact details. I will then send you an information sheet, a consent form and will make contact to arrange the interview to suit your availability.

Thanking you in advance for your interest.

Best wishes,

Appendix I Service policies for risk and additional sessions

Risk Management Protocol (version 7)

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1 Risk Categories

- 1.1 There are two broad categories of risk: **safety risk** and **academic risk**. Safety risks need to be flagged on our client management system (CMS). Academic risk does not need to be flagged on the CMS system, but is self-recorded by client at induction and at end of therapy and this data is stored and is reported.

2 Levels, Designation, Recording, Monitoring and Revision of Client Safety Risk Levels

- 2.1 There are 3 levels of safety risk: **severe**, **moderate** and **mild**. Ideally in our CMS we would like 3 corresponding coloured flags, red, orange and green, labelled as severe, moderate and mild respectively. When implemented in our CMS, the current risk list Excel spreadsheet will be replaced by the capacity to call up lists of clients by safety risk category. This is possible with clients recorded in the CORE Net system and flagging of risk level may be possible using Microsoft Dynamic, but, until summer 2013, not all clients will be recorded in these systems, so therefore there will be a need, at least until then, to continue with the use of Excel spreadsheets (both general **At_Risk** and severe risk to share with SHU, **Severe_Risk_Share_SHU** – see 2.9 below).
- 2.2 ***When, at drop-in, or at a counselling session, a client is identified as at safety risk, then the identifying counsellor will complete a safety risk assessment form.*** Where the suicide risk is judged as **moderate** (as recorded in the therapy assessment form in CORE Net), then the severity code assigned to the student, and written on the counselling request form, should be accompanied by the letter **R** (e.g. 5R is severity 5 with a moderate suicide risk). Similarly, if the risk is **severe**, then the severity code assigned to the student should be accompanied by **R⁺** (e.g. 4R⁺ is severity 4 with a severe suicide risk). ***In allocating counselling appointments, admin will give priority to students with risk designation R⁺, then R*** (e.g. severity code 4R⁺ has priority over 5R, which has priority over severity code 6). ***If there is not an early appointment available for a student with an R or R⁺ designation, or if s/he is unable to take up an early appointment offer for any reason, then admin will inform the Head of Counselling of this situation.*** The identifying counsellor should make a copy of the safety risk assessment form: the original is for the student's file (returned to admin with other drop-in forms, if seen as drop-in, or placed in the paper file of an existing client) and the copy is given to admin. Admin will scan this and then place this paper copy in the at-risk file held by the Head of Counselling.
- 2.3 ***Where the risk is deemed to be severe, the counsellor will refer the student to the Student Health Unit by making an emergency appointment and sending the***

student directly to the Health Unit. Any communication by letter with the SHU in the case of severe risk must be accompanied by a phone call and an arrangement will be made for the student to be seen on the same day. **If it concerns an existing client there must also be phone contact with the SHU.** The exception to this is evening emergencies, where either a call is made to the SHU emergency number or the student will need to go to A & E.

- 2.4 ***In every case of referral to the Student Health Unit, severe risk or otherwise, the referring counsellor must give a referral letter to the student to give to the doctor when they meet them.*** The contents of this referral letter should have been agreed with the student. It needs to be made clear to the student that they will not get any particular priority but will be seen in the order determined by the SHU, unless it is an emergency case as outlined above.
- 2.5 In all instances of referral to the Student Health Unit, the referring counsellor must make a copy of the referral letter for the student's file (returned to admin with other drop-in forms, if seen as drop-in, or placed in the paper file of an existing client) and make sure that admin is aware of the referral. In cases of risk, the counsellor involved should make **two** copies of the referral letter to the Student Health Unit (to accompany the two copies of the safety risk assessment form): one copy for the student's file, and the other set for the at-risk file held by the Head of Counselling. Admin will scan the referral letter along with the safety risk assessment form and attach same to student records on the CORE Net system.
- 2.6 ***For every safety risk client there is a designated counsellor who is responsible for monitoring risk levels and revising and recording these as appropriate. In the case of severe risk, then that counsellor will also be responsible to ensure that she or he has weekly contact with a doctor in the Health Unit (or external doctor, in the less common case where that is appropriate).*** In the case of a client attending a core counsellor or an intern or trainee supervised by a core counsellor, then the core counsellor will be the designated counsellor by default. Sessional counsellors will normally act as designated counsellor for their clients, unless an alternative arrangement is agreed with the Head of Counselling.
- 2.7 ***Where a core counsellor is the designated counsellor, then she or he will update CORENet and Excel spreadsheets on a weekly basis. Sessional counsellors will be responsible to revise their at-risk clients' risk level, as appropriate, on a weekly basis, on CORENet and also to send an e-mail with the single word subject line RISK by Friday each week to specify revisions to risk levels or to confirm that no revision was necessary.*** These e-mails can be automatically sorted to a dedicated folder by rule on Outlook and ***admin will be responsible on Mondays to make revisions accordingly. All counsellors with a client at severe risk will e-mail the Head of Counselling each week with an update on the situation of their severely at-risk clients.***
- 2.8 ***In any instance where an at-risk student does not respond to contact from admin, admin will inform the designated counsellor; in this case, or where an at-risk student does not attend the Counselling Service for an appointment, the designated counsellor will contact the Student Health Unit (or other***

GP/psychiatrist) to ascertain the current status of the student. In cases where the severe risk to the student's life overrides the confidentiality of the counselling contract, and is therefore considered an essential element of the counsellor's duty of care, and where the student has not attended the appointment in the SHU, the counsellor will contact both the home GP of the student, if provided, and the parents, where applicable, by getting their contact details from Quercus (via admin who have access to this database).

- 2.9 *Every Tuesday morning the core counselling team will review risk lists as updated on Monday, following communication from sessional counsellors, on the monitor in the group room and further update them.* One spreadsheet is the **YY.MM.DD_Severe_Risk_Share_SHU** file (with the names of those current severe risk clients who are shared with the Health Unit). This spreadsheet will also contain, among other data, the name and contact details of the designated counsellor. The other spreadsheet is the **YY.MM.DD_At_Risk** file. Not all clients at severe risk of suicide are under the care of the SHU: some will be attending an external G.P. or psychiatrist, and will therefore be listed on the **YY.MM.DD_At_Risk** file, but not the **YY.MM.DD_Severe_Risk_Share_SHU**.
- 2.10 Each Tuesday, after the core team meeting, admin will save the fully updated versions of the spreadsheets under the new title corresponding to that day's date (see examples overleaf) and e-mail the file **YY.MM.DD_Severe_Risk_Share_SHU** to the medical director of the SHU. Thus, in time, we will have an At_Risk folder that will contain a list of spreadsheets, one corresponding to each week, so that each spreadsheet only those clients currently at risk, but also maintaining an historical record of risk designations (see overleaf). The same system will apply to the Severe_Risk_Share_SHU folder.

Guidelines in relation to offering additional sessions to the standard six sessions limit

Student Counselling Service can only offer time limited counselling. For the vast majority of students, this means six sessions only. This does not apply in the case of counselling trainees who are still completing their initial training.

In exceptional circumstances additional sessions may be offered. All such requests must be agreed with the Head of Counselling. In the case of the core team, these exceptions will be discussed at the fortnightly clinical meeting.

In addition to the initial six sessions a further six sessions can be offered if there are exceptional circumstances.

In general a student will not be offered more than two six session contracts.

If the student recontacts the service after completing their six sessions, they will need to attend the drop in and be assessed. At that point they will take their place on the waiting list.

In general, the service is not able to work with students who are deemed to have long term or severe emotional difficulties. This should be explored fully at the assessment stage. The aim of the six sessions would be to provide support and containment while longer term external referrals are taking place.

While acknowledging that sessional staff and trainees do not generally have much flexibility, in the case of clients of core team members it may be possible to offer brief supportive sessions with much longer intervals as part of the process of ending counselling. This would need to be discussed at the clinical meeting.

Decisions are made on a case by case basis but there are certain issues which need to be taken into consideration when a request is being made for additional sessions. The following list is not intended to be prescriptive, but should be seen as representing the kind of information which needs to be available in order to make the best decisions in an environment where demand will usually be in excess of resources available to meet it. We need to make the basis of our decisions as clinically sound and as equitable as possible.

Counsellors need to address the reasons as to why more than six sessions are required and provide evidence to support that case. This does not necessarily require a full case presentation but should be a short, focussed submission.

- Can it be demonstrated that the student has benefitted from the first six sessions and has the motivation and desire to continue counselling? (Did they attend regularly?)
- The student is at risk of suicide or self-harm (NB – is there a high severity CORE score after six sessions? Has an 'at risk' form been completed?)
- The student has experienced or is at risk of experiencing a mental health breakdown or crisis
- The student is at high risk of academic failure and there are retention issues (Needs of final year students may require additional consideration)
- There is a recent traumatic event, e.g. bereavement, assault, a significant loss, major illness
- Current misuse of drugs and/or alcohol
- In the case of a 'return' client, the student's circumstances will have deteriorated substantially since the ending of the last counselling contract
- What may be achieved by offering the additional sessions, given that long term on-going counselling will not be available? Are there any relevant referral pathways? Have these been discussed with the student?

Appendix J Data sample, counsellor focus group

1.	...and the amount of time it takes to build up a relationship sometimes with somebody. And I thought in six sessions I mightn't even remember...you know, there's a lot of stuff that you wouldn't have done in six sessions. And then I know, having been there a while now, some students are only able for six sessions and they only want six sessions. But it would be very good to have the option, freer option, to see them for longer. But it's just that thing of relationship with the client that takes a lot longer than six hours with all we're talking about, you know? So, my initial thing was, "God, that's really short. What would you get done in six sessions?" you know?	Realisation that some students may not want or be able to cope with anything other than short term. Sense of shock at this realisation. Doesn't fit with her expectations of how therapy should be conducted. Drawing on professional discourse? Awareness of constraint and wish for more freedom to exercise own judgement?. Need for time to develop the relationship
2.	Yeah.	
3.	INT: And do you think it's affected the way you do work?	
4.	SEVERAL RESPONDENTS: Yeah.	
5.	: I think so.	
6.	INT: Can you say a bit more about that?	
7.	: Em...well, just to maybe link back to the earlier question, when I was a student myself, many moons ago, with another institution, I had used the student counselling service and I had a sense of how even short or brief interventions can be really useful. And that'd be my experience. What,	Draws on range of experiences as both client and counsellor Measured view or accommodating out of necessity? Having to match approach to what is possible. Self

	<p>maybe what, twenty years ago or something. So when I came to work in this service I had also been working in private practice myself for about a year/a year and a half and had experience of working with some long-term clients if you got...one year long clients. But also in shorter term with students that were doing the foundation in Counselling Studies in the...in...in X, in the service there. So I had some experience, good positive experiences, of short-term counselling work with people and I felt quite positive about what you can achieve short term. But I did have concerns about em...how to, in a way, how to em...limit or how much...how to take slices of it or where to focus or how to eh...in a way, how to contain the work em...so that it was useful and digestible and em...to the...to the student in six sessions. So a bit sceptical, in summary, a bit sceptical. Aware that I needed to em...to work slightly differently. That I didn't...that things wasn't as leisurely as I would have been used to myself as a long-term counsellor. As a long-term eh...client in counselling as well, in psychotherapy. So I would have had a number of different experiences that I would have brought at that stage.</p>	<p>policing? Making the best of things? Sheer challenges of how to do work within short time and still give primacy to relationship with client. Degree of scepticism. Sense of pressure creeping in linking back to previous expressions of this.</p> <p>What is driving the pressure? Being imposed upon? Notice use of language. Powerful metaphors 'slices', 'digestible' Quite a few hesitations. Moving from a context where choice and leisure was present to one of speed and pressure and imposed tasks. Reflection of imposed managerial discourse?</p>
8.	<p>It's funny that you did say leisurely because I think some of the bit about the six sessions for me is it does put me on some sort of a, em...what would I say? Some sort of a rush. Rush is nearly too fast a word but there's something more. Oh I have to do something in these six sessions or there's some more agenda or something than there might be if I have a longer time with a client. So, the impact on me is something around being more agenda driven maybe than my training would be, or being more task orientated</p>	<p>Changing the whole dynamic of the counselling relationship to one of immense pressure where certain goals have to be achieved, where counsellors have to demonstrate that they can do this. What does this mean for the nature of counselling as an activity and the relative power/powerlessness of the counsellor?</p>

	probably, maybe. Yeah. I'm not sure if I'm wording it correctly but...	
9.	SEVERAL RESPONDENTS: Yeah.	
10.	it's almost like from leisurely to something that's not leisurely. Yeah.	
11.	I think...I think there's something very interesting about what you're saying about your...the difference between your training and the six session model...	Dilemma of being trained in one way and been expected to practice in another
12.	: Mmm.	Consensus building
13.	...because I mean, for most of us, we didn't get trained in brief therapy or...	
14.	SEVERAL RESPONDENTS: Mmm. Yeah.	
15.	Most models are kind of long-term and then the training I was on, we did three...three...three...three...three years of therapy whilst we were doing our training so I was used to three years with the same therapist. Em...but I did...I do think that being allowed to spend longer as em...a trainee was really beneficial because I mean, obviously I was a greenhorn. I didn't know, you know, I was just trying to...to figure my...trying to work my way through it and work out what was going on. Em...but I think that that gave me the scope to, kind of, gain a bit a leeway, just to notice the effect of the therapy on...that I was doing in my hypotheses on the client. And gradually then I could get a...I got a better sense of, you know, I was a better judge	<p>Underlying assumption that quicker is better and the main reason for taking longer is because the therapist is less experienced rather than it is a fundamental part of the whole therapy that the client has the time to explore. What are implications? Assumption of professional identity?</p> <p>Being socialised into a particular kind of professional identity. Equivalence suggested between being quick and being professionally competent</p>

	em...from reading the notes in the first initial meeting with the client, what was going on, what might be needed. I got a better sense of...I think, really, em...I'm not sure if somebody mentioned this before but it really got me focussed on what was needed now, [laughing], and if I had more than six sessions, where I might go.	
16.	SEVERAL RESPONDENTS: Mmm.	
17.	But really...so I think in some ways it's useful to really get you to focus on "I only have six..." I think you were saying that? "I only have six sessions so I really need to get some work done here." Get you to focus on what's...and to keep checking back with the client what's important to you or what's, you know, is this what's important about em...	Introducing the notion of client feedback but also the assumption that the client y knows what they want from the counselling experience and that they would be willing to say this.
18.	INT: I'm...that's an interesting point in that I'm wondering what sort of training background people come with. Eh...you know, that don't...might not fit in to, you know, this...this sort of six session kind of model, eh...way of working.	
19.	ULI: Well, for me, you know, I was just kind of, as he was saying, that em...I...I have a coaching background as well before I did my therapy training. I was training kind of as a Life Coach/Executive Coach, and they're kind of, it's...it is very short-term. And the interventions, you know, are short-term. And at the same time you learn as a coach as well to stay more on the surface. You know? Kind of to check in and to really keep it consciously on the surface. And that, I think, sometimes works very well, you know, in the...in the student setting, because sometimes it is the six	Useful quote. Distinction between surface and depth introduced. That awareness is itself a cause of frustration because as a trained counsellor there is greater awareness of what isn't being addressed. Limitations from a therapeutic perspective of only addressing the surface. Yet wanting to also not be too critical....another example of self-policing? Some

	<p>sessions, I notice, are fine. They don't want more. You were saying it there as well. But sometime I find it very difficult, you know, because I could feel it in the first session that it's...it's...it's more underlying, you know, and that we can work with the six sessions on the superficial level but I feel sometimes frustrated because I feel, you know, the work that would probably be more beneficial long-term would be on more deeper layers, and em...yeah. And that is sometimes not, you know, the reasons that I'm aware of that we can get more sessions is...is either drop out or...or, you know, risk of suicide and sometimes these two, that the student would not qualify for these two, you know?</p>	<p>acceptance of the inevitability of having to conform to what the setting requires. Unhappiness about the limited criteria upon which extra sessions are granted. Management of risk being the prime one, but also need to fit into the employers agenda re retention. Description of these as restrictive. Will other participants recognise introduction of risk discourse</p>
20.	SEVERAL RESPONDENTS: Yeah.	
21.	<p>And you can't get more sessions, you know, but you know...you know? It's not...you're not even near to where we could be but...that I find sometimes frustrating. Not all the time. Sometimes the six sessions, if they are, you know, kind of goal orientated and focussed well are fine, but sometimes they're not and that...yeah, I find it really brings some frustration [inaudible].</p>	<p>Elaboration of previous identified themes. Lot of use of qualification phrases. Asking for agreement from others, seeking consensus. Drifting off at the end waiting for others to take up the issues.</p>
22.	<p>INT: Eh...[inaudible]. So what are the reasons that people would ask for extra...an extra six sessions or what...what is...what is the policy if you think you need more time with somebody?</p>	
23.	<p>I think it's not...I haven't found it a problem. And I think for myself it would...was part of my own, I suppose, dealing with authority of, you know, sending an email to the head of counselling, asking for more sessions for a</p>	<p>Personal dimension. Issue of dealing with authority. Challenge of being able to speak with sufficiently authoritative voice and being able to advocate</p>

	<p>client and my own communication skills around that I think. That was a learning curve for me, to be more confident, and I think that came across. The more confident I became the more confident my notes were and, you know, it wasn't a problem ever getting extra sessions. And I remember bringing it to supervision and, you know, my supervisor saying "You've got to fight for your client", you know, "If you really think your client needs more sessions don't give up." And eh...so it was a learning curve for me I think as well and eh...coming from the client why they needed more sessions so it didn't always have to be something very serious, but they're commitment or it meant a lot to them, to the client as well. And just me being able to get that across.</p>	<p>effectively on behalf of client. How to be taken seriously as professional if one can't do this effectively. If counsellor is not able to argue then client will suffer. Sense of responsibility. Impact of external 'world' of organisational context on clinical judgement. What discourses are driving that? Therapy becomes risk assessment and management only. Reflection of wider maybe competing discourses as to what constitutes therapeutic effectiveness.</p>
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Appendix K Data sample, client interview

Interview 6

	Text	Commentary
98	INT: If you weren't happy with your counsellor, do you think you would talk to them about that?	
19 6	RESP: I...it was more being offensive. I didn't want to be of...I'd say, at the time. I can't really remember at the time.	Difficulty of criticising counsellor. Use of word offensive then followed by saying he can't remember. Will DA be sufficient to analyse this?
19 8	RESP: Yeah, yeah, I would have been kind of 'That'd be kind of insulting if I say that actually, I want to go with someone else.' [Giggling]	Need to be mindful of counsellor Link Foucault and governability. What can I say about giggling without drawing on interiority and imputing motivation?
39 0	RESP: Kind of...or recommending, you know? And I used to just laugh about it saying 'Yeah, that's only for crazy people' kind of thing. But now I'd go, you know eh...as much as possible. Well, not as much as possible but, you know, if there was ever anything that I needed to figure out I'd be straight down, you know? Because...	Change in own position re value of counselling? Discourse of stigma influenced his earlier position? Interesting shift from I'd go as much as possible and then immediate back track? Why ? Scarcity?
55 2	RESP: Yeah, I'd imagine that, for a counsellor, it'd be advantageous for them to understand my past, you know? It has no bearing on me like but like...	Interesting! Counsellor might need something from the client which client doesn't see the point of but goes along with. Deference to professional discourse?
57 6	RESP: I suppose...I don't know. I have a better understanding of it now because I study it so, you know, it's kind of unfair for other people to expect, you know, different. I...I can analyse my own behaviour, you know, and...before I even go in there, you know? I probably did...I don't think I did it in first year when I went the first time but the second time I could definitely analyse my own behaviour when I went in there. You know, I c could work out past experiences and...	Changed attitude between first and second attendance at counselling. Feels more empowered implication that he is a bit dismissive of the service. That he has outgrown it somehow. Discourse of client as expert/ Client as selective consumer of service. Has both accepted and moved on from discourse of the patient who has to go along with whatever the expert says.

Interview 8

	Text	Commentary
32	RESP 8: I think that is the best way to put it but because resolution wasn't coming in terms of my status in college or if you'd like em...and my...my future it was going to be something to do with about my future you know getting this. So in my case I...I believe I was somebody who could have done with ongoing counselling.	Feels that she has to justify why she sought counselling by reference to her future as well as implied difficulties in college. Clear hesitations. Tone sounds quite meek and deferential.
48	RESP 8: Yeah. So...so I got the feeling that it is something you get if you need it really. And I deemed that I did and I believe my counsellor would have also deemed it, you know? I didn't think it was just something you just get like that, you know?	Feels comfortable having been given the additional sessions. Contrast with other interviews? Stresses her awareness of scarcity and that both she and counsellor agreed about what she needed
60	RESP 8: Em...yes, I think it always is. I think it's always helpful to talk about limitations and...and the need as well you know, em....I suppose if I if...if...if there was a possibility I would have said "Can I please have more, even in six months or four months or..." eh...if this is possible. Em...in my case, I did go back...I did go back to having telephone counselling again, which I had had before. So I needed more counselling basically.	Scarcity not enough sessions actually available to meet her needs. Self-policing? Tone is that of supplicant. Nothing can be taken for granted
66	RESP 8: I think that can happen. Em...I think that my need was so great for counselling at that time that I really invested in it, right. However, if you are asking me would it have been more satisfactory?	Virtuous patient role? Really invested. Compliant ?
68	RESP 8: If I didn't know when it was going to end, if the ending was linked to my needs, oh absolutely, it would have been absolutely way better if I knew that I'll have this as long as I need it, the service you know to...to ground me or to you know?	Powerless. Reliant on the judgement of others. Uncertainty expressed. Not confident that her needs will be taken into account. The experts will decide.

	Text	Commentary
70	RESP 8: Em...so I think the answer to your question is kind of two-fold, one I needed the service so badly that yes I invested in it, yes I brought what I needed to, yes and it was very powerful or very positive and also that, however, that em...you know, it would have been infinitely more relaxed you know...I could have relaxed more.	Good quote. Suggesting that counselling becomes very different when there is a lack of containment or even clarity about how decisions are being made which will impact on her but yet she has no ability to influence them.