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**A Study of clients' perceptions of a primary  
care cognitive behaviour therapy service.**

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In completing this dissertation there are many people I have to thank. Firstly my gratitude must go to the clients of the Primary Care CBT Service in Tameside and Glossop who agreed to be interviewed for the purpose of this study. You were so generous in the giving of your time and so enthusiastic in discussions with me. Without you this study could never have been realised.

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## 1.0

## ABSTRACT

Cognitive behaviour therapy (CBT) has recently undergone a massive explosion in popularity and is now considered to be amongst the most effective of psychological treatments. The efficacy of this treatment has been demonstrated in scientific evaluation utilising standardised pre and post-treatment measures, espoused to be scientifically valid. CBT is now considered the first-line treatment of choice for a number of psychological disorders, with increasing amounts of research being devoted to the development of more effective treatment models over a wider range of emotional and psychological difficulties. However there has not been a comparative increase in the quantity of qualitative research devoted to the process of therapy. This study attempts to find alternative methods of establishing what makes treatment outcomes successful rather than the heavy reliance upon traditionally 'scientifically validated' methods.

Whilst this growth in the popularity of CBT has occurred there has also been a greater emphasis on the role of the client within the National Health Service (NHS). As CBT is essentially a human interaction between therapist and client, a primary characteristic being the collaborative nature of treatment this study links the import of the client within mental health services to the clients' view of a primary care CBT service in an attempt to place the client at the centre of service development and utilise their experiences as a barometer of service efficacy.

In-depth interviews were conducted in a primary care setting with a number of clients that had completed treatment and been discharged from the CBT service. The interviews provided the data which reflected their views on the standard of service received and an insight into what made their treatment effective.

A thematic analysis of partial transcripts of the interviews was conducted which revealed the components of effective treatment, service considerations and possible amendments to service provision.

Data analysis revealed research outcomes favourable to the service provided and highlighted the pivotal role the relationship between therapist and client plays in the treatment process. The organisational implications of the findings are discussed and it is recommended that particular attention be given to the number of treatment sessions the service offers for each client. It is recommended that further research is conducted into the reasons clients discontinue treatment with the service.

## 1.0

## CHAPTER ONE

### SETTING THE SCENE

The author was partially responsible for the establishment and development of a Primary Care Cognitive Behaviour Therapy service in March 2000, commissioned by the local Primary Care Trust. The commissioners are in the process of reviewing the psychological services they purchase as they seek to establish a mental health service under of their own management structure. It is therefore apposite for a review of the CBT service to take place to establish if it is meeting the needs of the clients it was designed to and whether or not these needs could be better met by modifications to the service. Whilst the service now has a wealth of positivistic evidence, in terms of discharge psychometric measures, to illustrate it is providing effective treatment, there is a dearth of documentation detailing the clients' experiences and preferences for service provision. This echoes the lack of qualitative research into psychotherapy generally.

Aaron T Beck is generally considered the grandfather of cognitive therapy and described a theory of emotional disorder primarily based on depression in his 1976 book 'Cognitive Therapy and the Emotional Disorders'. Since this time cognitive behavioural therapy has undergone a massive explosion in popularity and is now considered to be the most validated psychotherapeutic approach and is the treatment of choice for a wide range of emotional disorders (Salkovskis, 1996; DOH, 2001a) being specifically cited as an effective treatment for depression and anxiety based disorders in the *NSF* (DoH, 1999a). Further It has been suggested that 'psychological Therapy should be routinely considered as a treatment option when assessing mental health problems' (DoH, 2001a p34). These factors of clinical efficacy and the requirement for clients to have access to a 'full range of services' (DOH, 1999a) coupled with a prevailing view of CBT being a cost-effective therapy has helped to propel this modality to prominence and establish it as a mainstream treatment.

However whilst acknowledging and applauding these major advancements and recognising the imperative of extending treatment boundaries I would also note an element of caution. As a cognitive behaviour therapist the almost seemingly endless supply of evidence highlighting the efficacy of CBT makes for alarming reading. It appears from some of the literature that almost any psychological difficulty can be treated with this modality. Whilst classical cognitive therapy (Beck, 1976; Beck et al, 1979) has been well developed and applied to emotional disorders such as depression and a wide range of anxiety-based disorders, other treatment models are still being developed, for instance work with psychosis remains relatively in its infancy, despite recent treatment advances with those experiencing chronic symptoms. This raises often unrealistic expectancy levels of the public and fellow professionals alike which in turn increases pressure on services and clinicians to meet these expectations.

Many of the studies cited in psychological literature are based upon carefully controlled, often 'cherry picked' clients who fit stringent criteria (Lott, 2002; Tarrier et al, 1999) and may not reflect the difficulties faced in clinical practice (Tarrier et al, 1999). This helps create a climate where services focus on treating as many clients as possible in as few sessions as practical (termed 'throughput') and rely on psychological 'outcome measures' (Kernick, 2001) to cite the efficacy of treatment. These expectations are often reflected in the commissioning process where constraints are placed upon clinicians with regard to the number of treatment sessions afforded to each client. Taken to its logical conclusion this could result in the ethical dilemma of clients either being discharged too early if their allocated number of sessions had been exhausted or being refused a service at point of assessment if their difficulties clearly warranted more long-term treatment. The government over recent years have made reference to placing the client at the centre of the National Health Service; in order to do that it is important to examine the clients' experiences of services that they encounter.

The issues outlined above have lead to the contemplation of a number of questions such as discovering how clients *themselves* view the service that is

offered, what *makes* the treatment modality of CBT efficacious from the clients' perspective? As a clinical practitioner I am aware of the evidence base for CBT – based within a positivist ontology. Equally I am aware of the various treatment models available for each psychological difficulty, but are these models the real change agent in treatment or are other factors responsible? How do services place the client at the centre of the service that they offer? It is my contention that only examining in depth a number of episodes of treatment that these questions may be answered.

## 2.0

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 Introduction

There is a plethora of literature concerning CBT with a burgeoning amount concerning the efficacy of this modality as a mainstream treatment. The literature concerning client involvement in care is similarly vast and provides the researcher with a challenge to effectively winnow down the themes. The main thrust of this proposal is focused upon the clients' perspective of a primary care CBT service; whilst the setting of the study is not the principal focus it is pertinent to give a brief historical outline of mental health care and its current standing in primary care as an preliminary to presenting a wider range of literature. As this study focuses upon psychotherapy a large proportion of the literature search is dedicated to the origins of CBT but commences with an exploration of client involvement in services. This review demonstrates that there is a dearth of qualitative research into psychotherapy as opposed to its quantitative counterpart, possibly due to the in-built bias towards the positivist paradigm as witnessed by the numerous randomised control trials (RCTs) completed; though this is not without contention.

In order to provide clarity and a background to the study the literature is presented in the following manner:

#### **Historical Perspective of mental health care**

#### **Primary Care**

#### **Client, Patient or user?**

#### **Client Involvement in Services**

#### **Cognitive Behaviour Therapy**

This framework appears to be the best to reflect the issues concerned and conforms to aims of the study.

## 2.2 Historical Perspective of Mental Health Care

A major shift in the provision of mental health care occurred in 1989 with the publication of *caring for people: Community Care in the Next Decade and Beyond* (DoH, 1989) which espoused the philosophy that locally based hospital and community health services could provide care and treatment for people with a mental illness. Community mental health teams then became the main vehicle for treating individuals with mental health difficulties (Onyett, 1997), with the focus of care being on severe and enduring mental illnesses, despite 90% of mental health care at that time being provided by primary care (Goldberg and Huxley, 1992). As patients migrated from large psychiatric hospitals there was a requirement for further policy guidance on how best to cater for this population and this was provided in the 'Care Programme Approach' (DoH, 1990a) which focussed on the practicalities of psychiatric care in the community. The CPA was thus introduced in April 1991 and whilst this legislation was gaining its place on the statute books, attention had already been given to the provision of health and social care in the *National Health Service and Community Care Act* (DoH, 1990b). This was largely based on the *Griffiths report* (1988) and established the application of market forces to the provision of health and social policy by initiating the purchaser/provider split (internal market) in a bid to introduce competition and thus improve efficiency predicated on a belief that private sector management practices would raise performance (Doherty and Horne, 2002).

The (New) Labour government swept to power in 1997 amid promises to improve services in the NHS. Thus one of the government's first policy papers to be published was *The New NHS: Modern, dependable* (DoH, 1997), declared as a ten-year plan which in typical language of the day promised to modernise the NHS to be 'fit for the twenty first century'. *The National Service Framework for Mental Health* (DoH, 1999a) (*NSF*) built upon this report setting seven standards; including effective treatment (evidence based) and involvement of clients in their treatment. Standards

two and three targeted primary care and access to services, helping to redress the balance from severe and enduring mental health difficulties and secondary care services. The paper also refers to characteristics needed for successful implementation, including an integrated service 'with an efficient balance of provision between primary and secondary care' (DoH, 1997 p89).

### **2.3 Primary Care**

As outlined, the National Service Framework (DoH, 1999a) aimed to reform the manner in which health and social care were provided and delivered. It transferred the emphasis, resources and delivery of care for those with common mental health disorders from the specialist secondary care services to primary care services. The Primary Care Trusts (PCTs) thus became the commissioning agents for mental health services; this shift facilitated the creation of the primary care CBT service on which this study is based.

This transfer of responsibility and change in emphasis was welcomed by Tomson and Shiers (2003), contending that primary care had always provided the majority of mental health care provision; asserting that 70% of a GP's workload have a 'significant psychological component' and 20-25% of consultations would be due entirely to mental health problems. This corresponds to Davidson and Meltzer-Brody's (1999) findings who suggest that 70% of those with depression initially seek help from their GP. Lester and Sorohan (2003) consider that primary care services treat 90% of people with mental health difficulties. It is therefore clear that primary care is playing an increasingly important and central role in the delivery of services for the treatment of mental health and psychological difficulties. Tomson and Shiers (2003) argue that the needs of clients should be the guide for policy implementation and contend that the challenge for primary care is to place the client and their family in the role of partners in the delivery of treatment as they are a large resource for improving mental health services and should also be recognised as experts (Coulter, 1999).

Some years prior to the establishment of primary care trusts Goldberg and Gournay (1997) had argued for the community psychiatric nurses' role not to be confined to those with severe mental disorders and for a CBT approach to be utilised. Now purchasers of services are increasingly demanding health care providers to be able to demonstrate that the treatments they provide work as they say they do (Todd and Bohart, 1999) and this may in part help explain the explosion in popularity of CBT, the most validated psychotherapeutic approach (Salkovskis, 1996).

## **2.4 Client, Patient or User?**

As a precursor to examining the issues as outlined, it is important to scrutinise the language employed throughout the essay; the term 'client' is primarily utilised rather than that of patient, user, consumer, customer or stakeholder – all of which are used in current literature, with no consistency in the use of terminology (Noble and Douglas, 2004). These labels have connotations for the therapeutic relationship, essential in the treatment process (McGuire et al, 2001). The term 'user' triggers the author's discomfort as does referring to collaborators in the care process as patients.

The expressed preference here is for client as this suggests a more assertive and active role – a role of actively seeking treatment in a collaborative relationship. Whereas the characterisation of the term patient is one of being a passive recipient of care which has existed in the National Health Service for many years (Neuberger, 1999). This picture of the patient simply 'lying back' and accepting the wisdom of the clinician does not appear to be a good fit with a psychological mode of treatment, nor the current views of the 'patient' taking an active part in their own health care and recovery (Neuberger, 1999). However it may be necessary to utilise differing terms for differing services, as Hodgkiss (2000) considers the term client suggests somebody who has a choice in receiving a service. This choice may be elusive for many within psychiatry.

I recognise the term client would be a misnomer for the individual detained under the mental health act and the sense of being a consumer an anathema. Equally, as Eastman (1999) argues often psychiatry performs a dual function in which the needs of the client has to be balanced with a wider responsibility to society. However as a cognitive behaviour therapist in primary care, all the clients whom I work with have a choice of treatments and whether or not to engage in therapy. The word 'user' conjures up negative connotations as one who exploits and hardly the most felicitous of terms for those clients who themselves may have been used and abused by others.

Since the change in government in 1997 there has been a shift of emphasis with an increased importance given to individual and community responsibility; with this responsibility comes an increasingly assertive public who are less deferential to health professionals (Wilmot, 2003). The internet has resulted in an increased awareness of health issues and treatment solutions and with this knowledge comes increased expectations and demands, increasingly expressed by the 'customers' of the health service (Ham and Alberti, 2002) who are increasingly aware of their rights (Campbell, 2000; Kennedy, 2003). I argue therefore that the term client, within the context of a psychological service, is more apt and marries with this increasingly assertive and insightful population.

## **2.5 Client Involvement in Services**

Whilst there has been a stated preference for the term 'client' it becomes impractical to maintain this stance whilst reviewing current literature as most papers utilise differing terms, the cited author's favoured term is therefore adopted.

Client involvement is not a particularly new phenomenon but has been given a greater focus in recent years, with the number of structured user groups considerably increasing during the past thirty years (Crawford, 2001).

Campbell (1996 p 218) cites a confluence of international user groups in 1985 (Brighton, United Kingdom) to be a seminal point in the recent emergence of user influence. Rose et al (2004) argue that much of client involvement in the United Kingdom, whilst not directly driven by, is linked to the closure of the large psychiatric institutions. However the role of the client in mental health appears to be a global issue, with legislation aimed at cementing the influence of service users in several countries (Crawford et al, 2003). The World Health Organisation also highlights the need to involve clients in the development and delivery of health care (Crawford et al, 2003; Noble and Douglas, 2004). It seems therefore that involvement of the mental health client is now an accepted aspect of policy development (Bush, 2004), considered a tenet of current mental health care (Hansen et al, 2004) and an important driver of improvements in mental health services Hellar et al (1996).

The notion of the client being at the centre of care has been referred to as consumerism in the health service (Almond, 2001; Fox, 2003) and was strongly promoted in the 1980s (Coulter, 1999). The terminology and model of client involvement is influenced by the political and social climate of the time (Bush, 2004). Thus the introduction of market forces forced a consumerist approach (Rose et al, 2004) in the strategic planning of health and social care, the intention being to bring about greater choice; basing consumerism in a philosophy that individual users of public services could be empowered through the market (Barnes and Shardlow, 1997). Consumerism implies that clients of public services can exercise choice through the health care system, indicating a free market, or at least a mixed market economy. This may exist in Britain today with the combination of national health services and private health care alongside a growing voluntary/charitable sector, but it is questionable how much choice the National Health Service client actually has – this choice is affected by the finite resources of the NHS (Hewitt-Taylor, 2003); Melville (1979) considers that this paucity of choice in the ‘largely monopolised’ health service compounds difficulties in the consumer debate which remains problematic as there is an assumption of power redistribution (Almond, 2001; Fox, 2003).

The concept of consumerism is further elaborated upon by Rose et al (2004) who offer a 'ladder of participation' relating to different levels of client involvement and consider the most basic level as individual consumerism where for example the client is involved in the writing of their care plan. However Crawford (2001) contends the discussion of user involvement at this level is largely redundant and considers it time to focus on how difficulties in service-user participation can be negated. Likewise Campbell (2001) asserts that there is no longer a debate around the legitimacy of service users to be involved and prefers to view user involvement as an 'important element on a broad spectrum of service user action rather than to claim its the spectrum itself' (2001 p87).

Partnership has now replaced consumerism (Coulter, 1999) and the notion of individual responsibility as opposed to state responsibility forms a central plank in much of recent legislation, though the references to client involvement in the United Kingdom run throughout legislation dating back to the *Griffith's Report* (DoH, 1989) which recommended that consumers of health care should be involved in the development and evaluation of services and the *Care Programme Approach* (CPA) (DoH, 1990a) which stated that the an individualised care plan must be devised 'involving the patient and his carers'. It was however *The Patient's Charter* (DoH, 1991) that firmly recognised the client as having a stake in services and articulated their 'rights' within the health service.

*The New NHS: Modern, dependable* (DoH, 1997) also established the link between 'consumer' rights and responsibilities, termed the 'third way', an approach 'based upon partnership, driven by performance' (DoH, 1997 p10). *The National Service Framework for Mental Health* (DoH, 1999a) clearly delineated the importance of client involvement in their own care. The document specifically states a certain number of guiding principles;

- Greater service user involvement in multidisciplinary care planning (p 64)

- Performance of psychiatric services to be assessed by the experience of service users and carers, including those from black and ethnic minority ethnic communities (p 68)
- The successful delivery of mental health services by partnership including service users, patients and carers (p 89)
- Organisations are required to audit services including service user and carer involvement (p91)  
*NSF (DoH, 1999a)*

The theme of patient influence in and reform of the NHS was further outlined at the turn of the century (DoH, 2000) and the growing sense of the importance of the patient in their own care further reflected in *The Expert Patient: A New Approach to Chronic Disease Management for the 21<sup>st</sup> Century* (DoH, 2001b) in which the challenge of chronic disease management is addressed. Here the client is seen as a valuable resource capable of self-managing illness based upon a lifetime of experience and understanding, thus proficient enough to advise clinicians. The anticipation therefore is that clients of services should be viewed as equal partners in their care (White 2002; Sullivan, 2003) with a central role in decision making. Hossack and Wall (2005) concur with this perspective and contend that we now have a growing population of service users who understand and manage themselves well in the mental health system and further argue that these individuals, with training, can become 'paraprofessionals' working alongside the clinician.

Notwithstanding the advancements that have occurred with client-involvement in the NHS there appears to be continued resistance from professional groups to full and active involvement of clients at all levels. Crawford (2001) recognises this difficulty and compares the uncertainty of professionals pertaining to service user involvement in service developments to neighbourhood doubts regarding mental health patients living in their midst. This has resulted in patient-involvement being patchy with service users involved at the most basic of levels, such as a job interview panellist (Hossack and Wall, 2005) or consultation only (Lamont, 1999) and there remains a paucity of involvement in the planning and evaluation of services

(Rose et al, 2004). Rose et al (2004) assert that client involvement changes services, evidencing this by citing studies based largely on consumerism in America. However this appears to be a circular argument; does client involvement change services or do services need to change to facilitate client involvement? Without a cultural shift it remains unlikely that clients will be accepted at all levels in services.

There still appears to be a paternalistic sense that the clinician knows best (Bertram and Stickley 2005), which is clearly incongruent with the notion of the expert patient. But perhaps it is also due to the hierarchy that exists in mental health; as Rose et al (2004) intriguingly offer, the nurses as the main body of contact with the patient are perceived to employ a lower status than other professionals involved in the care process, such as psychiatrists and psychologists; with only clients perceived as being of lower status, thus by implication the nursing profession have a vested interest in maintaining the status quo. Cole and Oxtoby (2002) offer an example of this anxiety from nursing staff fearing an undermining of their profession in expressing disquiet at the extent of user involvement. This has been termed 'parochial self-interest' (Garside, 1998) where resistance to change is a consequence of individuals expecting to lose out.

In order for effective user involvement to take place this notion of paternalism, inherent in the NHS (Coulter, 1999) needs to change and hierarchies broken down. In addition to this as Bertram and Stickley (2005) highlight there also needs to be a cultural shift in statutory mental health services' attitudes towards clients as it is only when the service users are viewed positively – without the stigma prevalent in the wider society – can they be identified as able and competent rather than passive recipients of care.

## 2.6 Cognitive Behaviour Therapy

In order to explore psychotherapy it is necessary to explore the positivistic paradigm in which it has embedded itself, within the wider context of mental health and psychiatry. The notion that the disciplines of psychiatry and psychology are based within a social construct is also briefly explored as this questions the appropriateness of the paradigm.

Psychiatric distress has been viewed in differing ways throughout history, in medieval times 'madness' was viewed as supernatural in origin (Jones, 1996) and the mad as being possessed by demons due to lack of spiritual faith (Bush, 2004); as souls that needed care. However as the churches power diminished in the early seventeenth century the mad were seen as barely human, dangerous and in need of control and this coincided with a growth in social control and the founding of vagrancy acts (1601 English poor law act) in an attempt to exert control over these outcasts (Jones, 1996). The term 'mental disease' was coined early in the nineteenth century, which substituted the more pejorative terms such as madness and lunacy (Kendall, 1996).

A growth in the number of asylums occurred as each county was required, as dictated by government policy (Jones, 1996), to establish institutions; this policy retained a sense of control over those deemed as 'unfit' and 'unproductive' members of society (Lader, 1973; Jones, 1996; Foucault, 1967). This is mirrored by the writings of Szasz (1971, 1972, 1979) who views psychiatric intervention as an 'inquisition' driven more by a desire for social control rather than indication of underlying pathology; the 'evidence' gathered, it is asserted, is solely centred in the information obtained from what he terms, 'the inquisition'. This process has, he argues, in-built strategies to deal with the patient that refuses the label of being ill – that they lack insight.

Nonetheless this period marked a shift to a perception that ‘the mad’ were capable of being cured. Thus the medical view of mental illness emerged and saw the rise of psychiatry as an academic discipline (Bush, 2004), imitating general medicine which had grasped the scientific methodologies (Hart 1985, Richman 1987). Attempting to ascertain the ‘correct solutions to the human condition’ (Richman, 1897) psychiatry was thus quick to follow in recognising the importance of the new ‘scientific activities’ (Chalmers, 1980) and established itself as a profession (Bush, 2004). Therefore the identification of ‘the mad’ based upon psychiatric ‘scientific evidence’ became the norm (Szasz, 1971). Psychiatry and psychology have therefore based themselves in the positivistic traditions and relied on perceived ‘facts’ (Lader, 1973). However these facts are only facts within the framework that the psychiatric and psychological disciplines have constructed (Foucault 1967, Szasz, 1971, 1972; Gove, 1982; Freud-Loewenstein, 2004) and reality can only be viewed within this theoretical construct. These issues are also strongly expressed by Gove (1982);

**“...the subject matter in which psychiatry claims to deal – the various mental illnesses – is suspect and indeed improper, since these illnesses have no status other than that of convenient social fiction” (p199).**

This sense of construct can be identified in modern psychiatry in that there are, to illustrate, differences in diagnostic criteria for disorders between the Diagnostic and Statistical Manual (DSM-IV) (American Psychiatric Association, 1994) and the International Classification of Diseases of Mental and Behavioural Disorders (ICD-10) (World Health Organisation, 1992), the diagnostic manuals for the United States of America (and widely used in the UK) and Europe respectively. Kendell (1996 p25) argues that ‘the concept of illness or disorder involves a value judgement’ and depends on the ‘deliberately defined terms’ utilised for each disorder, implying differing clinicians can assess the same individual and arrive at divergent diagnoses, something with which most clinicians may relate to.

Freud-Loewenstein (2004) contends that this construct is also class ridden, with more poor people with mental health difficulties incarcerated in prisons where their more wealthy counterparts are admitted to hospitals. The construct also changes, for example homosexuality was a classified sexual disorder as recently as 1973 (DSM II) (American Psychiatric Association) before societal views became more tolerant and forced a change. Equally it was not until 1980 that post traumatic stress disorder (PTSD) first appeared in the DSM III manual (American Psychiatric Association, 1987), after being variously described as shell shock and combat neurosis in the first world war (Tomb, 1994) or battle exhaustion, and more pejoratively, lacking moral fibre (LMF) in the Second World War (Holden, 1998). These examples demonstrate that 'disorders' are not necessarily a matter of science but can also be viewed as socially constructed incorporating contemporary social values and norms and as such are subject to discussion and change.

The term cognitive behaviour therapy was first used in the scientific literature in the mid 1970's (Clark and Fairburn, 1997) and can be viewed as a synthesis of differing frameworks (Gordon, 2000). Cognitive behaviour therapy is considered to be a 'science practitioner model' in that it is founded in empirical ideals (Hawton et al, 1989) and much of the treatment places the individual in the role of 'scientist', testing out hypothesis and predictions and gathering information, such as behavioural experiments conducted in and between treatment sessions. Original theories were based largely on animal experimentation (Gordon, 2000); Smith (1987) highlighted the emphasis of these experiments as being the careful manipulation of variables with outcome evaluations based on concrete, observable and measurable results. As the theories were tested, developed and researched further they became increasingly applied to human activity, with the growth of behaviourism and other competing psychological models such as psychoanalytical therapy (Gross, 1995).

The evaluation of cognitive behaviour therapy is likewise based within the positivistic tradition with results invariably cited in terms of positivistic measures in the form of psychometric scales such as Beck's Depression

Inventory (BDI) (Beck et al 1961), and Beck's anxiety inventory (Beck et al, 1988) all psychometrics are presented as having reliability and validity. These positivistic techniques have remained the criterion for judgement of psychological treatment success despite criticisms of the approach from other scientists (Smith, 1987) and cognitive behaviour therapy has almost exclusively been researched using this positivistic approach (Maione and Chenail, 1999) to validate its efficacy, for example;

**“...emphasis is placed on expressing concepts in operational terms and on the empirical validation of treatment, using both group and single-case experimental designs in research settings and in everyday clinical practice. In order to ensure the replicability of findings, specification of treatment in operational terms, and the evaluation of treatment with a variety of reliable and objective measures are also emphasised” (Hawton et al, 1996 p11-12).**

This may largely due to achieve scientific credibility and to strive for the 'gold standard' of randomised control trials (RCTs) and emphasise its scientific acumen. It also allows the modality to be compared to pharmacological interventions thus illustrating its cost effectiveness, as Bohart et al (1998) surmise there is a need to demonstrate that the treatment is the efficient cause of the alleviation of the disorder. This, convention argues, can only be done utilising the quantitative methodology of RCT's, considered to be the 'gold standard'. However Grossman and Mackenzie (2005) challenge this orthodoxy by initially arguing that there are also less direct influences effecting choice of study, such as opinions of funding bodies and publication policies of journals that favour the scientific methodology. Grossman and Mackenzie (2005) assert that many RCT's are in fact flawed due to inadequate sample size resulting in a negation of the benefits of randomisation, which they argue is reputedly the design factor that introduces the scientific factor into research.

CBT is a time-limited treatment (Beck, 1976, 1995) and in a climate of finite resources this suits commissioners as it encourages throughput of clients, reduces waiting lists and theoretically prevents systems from silting up. This focus on throughput and outcome measures is pronounced in psychological

services, which Kernick (2001) refers to as an 'outcome jamboree' and in many respects the psychology profession in its crusade to demonstrate clinical effectiveness has created a rod for its own back in that commissioners cite published work that claims to demonstrate ever more effective (and thus fewer sessions) treatment models. However many of these studies are based upon 'cherry picked clients' (Lott, 2002), or less value laden, 'carefully recruited population groups' (TARRIER et al, 1998) with questionable inclusion criteria where co-morbidity often effectively disqualifies patients from trials. This raises unrealistic expectations from both fellow mental health professionals and clients alike, though forms a central premise in the commissioning process.

It can be observed that the literature search raised little information other than quantitative papers, as Grossman and Mackenzie (2005) assert the health literature over the last ten years reveal an almost exclusive use of RCTs. My efforts differed little, however whilst my literature review uncovered relatively little qualitative research into perceptions of CBT or psychotherapy generally a growing number of papers highlighted the need for qualitative research. Geanellos (2004) offers a cogent analysis of research into mental health nursing asserting that the drive towards evidence based practice, founded in scientific methodology, is misplaced as the activity of mental health nursing is mediated via relationships and as such requires a qualitative methodology to explicate the complexities involved. Psychotherapy is no different to this. Kozart (1996) argues for progressing qualitative inquiry into psychotherapy research and inclines towards ethnography, forwarding the proposition that the study of the participants' conversation provides access to their perceptions of a given situation at a given time.

Weedon (1987) also argues for the ethnographic methodology;

**“ Language is the place where actual and possible forms of social organisation and their likely social and political consequences are defined and contested. Yet it is also the place where our sense of ourselves, our subjectivity, is constructed” (Weedon, 1987 p21)**

The therapeutic relationship in therapy has been studied utilising qualitative methodologies (Crabtree and Miller, 1992; Maione and Chenail, 1999).

**“By far the most qualitative inquiries in psychotherapy have examined and found support for the importance of the therapeutic relationship” (Maione and Chenail, 1999 p63).**

In a wide ranging review Maione and Chenail (1999, p60-72) noted four main categories where qualitative methodologies can aid further study; Client factors, the therapeutic relationship, techniques and models in therapy and multi-factor studies. There are studies that detail the process of therapy and in this respect Rennie (1990, 1992, 1995) has added greatly to the qualitative debate in investigating the client’s perceptions and experiences of therapy, for example;

**“Storytelling by clients leads to increased self-understanding, feeling and contact with inner disturbance” (Rennie, 1992 p228).**

Bischoff and McBride (1996) identified the characteristics of a good therapeutic relationship, including therapist empathy and perceived helpfulness of various techniques whereas Howe (1996) cited engagement in the therapeutic process and being understood as prerequisites in the therapeutic process. There have been a number of studies addressing the therapeutic relationship, including the client’s perception of the therapeutic alliance (Bachelor, 1995), misunderstandings in treatment (Rhodes et al, 1994) and collaboration in the therapeutic process (Bischoff et al, 1996). Related to this theme, and pertinent to the stance of this dissertation, in particular interviewing as a method, are studies that focus on how therapist help clients with the story telling process (Miller and Silverman, 1995; Stancombe and White, 1997). The general focus of these studies is how the content and form of the therapist’s questions encouraged clients to reveal their stories.

## **2.7 Conclusion**

The literature review has presented issues and themes pertinent to the study. The review commenced with a brief outline of mental health issues within primary care and a justification for the utilisation of the term client over that of patient or user. The current position of client involvement in mental health services was explored and it was suggested that despite advances throughout the past decade this still remains a contentious issue for many clinicians who may see it as undermining their clinical authority. The current standing of CBT and its alliance with the positivistic paradigm as it strives for scientific recognition was discussed in the context of the history of psychological distress and mental illness. The literature review concluded with citing a small number of qualitative studies into psychotherapy rather than the cognitive behavioural therapy modality which has almost exclusively been reviewed using quantitative methodologies.

It is contended that to understand what is effective in CBT and gain an insight into how to improve services clients need to be asked directly. The study now focuses on the research methods which might achieve these aims.

## **3.0**

# **CHAPTER THREE**

## **METHODOLOGY**

(The Plan)

### **3.1 Introduction**

This chapter details the process by which the methodology was chosen and developed for the study. It describes in part, a personal journey in which my thinking and ideological stance has been shaped by experience and observations throughout my career in the national health service. To provide a context to the declared ontological and epistemological positions the scientific paradigm is briefly explored as is cognitive behaviour therapy's alliance to the traditional paradigm before settling on the paradigm with which I identify most closely. The sampling procedure undertaken is also outlined as is the chosen method of data collection.

### **3.2 Objective of the research study**

The function of this research is to explore the clients' perception of a primary care cognitive behaviour therapy service and identify the key ingredients of change in the treatment process. It is hoped that by doing so possible improvements to the service can be identified and operational changes made. In considering this general intention the following aims can be specified:

#### **Aims**

- To explore clients' perceptions of the CBT service**
- To Identify possible improvements to service delivery**
- To explore the factors which contributed to a successful or otherwise treatment outcome**

**These aims have the objective of placing the client at the centre of the CBT service.**

It is important to delineate the underpinning philosophical viewpoint of the study as the underlying belief system of the researcher affects the framing of the research question and largely defines the choice of methodology (Krauss, 2005). However it is also appropriate to highlight that research need not be driven by purely ideological considerations, as Silverman (1993) suggests the choice of method is best made on the basis of the purposes and circumstances of research rather than the researcher be enslaved to an ideological or methodological design – it depends on what you are trying to do.

### **3.3 Philosophical approach**

The notion that individuals have a set of beliefs, or a belief structure, which determines their emotional reactions and guides behaviour is a central premise in cognitive therapy. In cognitive terms the framework for making sense of the world is termed the schema (Beck, *et al* 1979; Beck and Freeman, 1990); these schemas (attitudes and assumptions) are developed from previous experiences. The construct that guides the inquirer in the research process is termed a paradigm. Guba (1990) identifies a number of paradigms, each based in assumptions regarding the nature of truth (ontology), the relationship between the inquirer and the inquired (epistemology), and the way in which the inquiry is conducted (methodology).

The traditional paradigm, positivism is based in a realist ontology, meaning there exists a reality driven by natural unalterable laws, which must be studied objectively, without interference – free from bias allowing claims of research free from contamination and aiding generalisability. This positivist view of the world is aimed at finding the truth, by laws of cause and effect – a linear causality – and has at its basis empiricism – relating to experimentation and observation. Much of quantitative research attempts to isolate these

causal (predictive) relationships and universal laws that are believed to underpin social reality (truth); these laws are deemed by definition to be context-free (Murphy et al, 1998).

However it seems too simplistic to view the world like this; humankind does not survive in a laboratory where every variable can be conveniently controlled to achieve a desired or predicted effect; Silverman (1985) contends that social variables are intrinsically more difficult to isolate and test than those in natural sciences. Mishler (1979) termed this approach 'context stripping' which Guba and Lincoln (1994) expanded upon stating that to focus on selected sub-sets may alter findings; they also argue this reduces the generalisability of the studies as they can only be replicated under similarly 'contextually stripped situations'. Smith (1984) defines truth as 'socially and historically conditioned agreement' with which Guba and Lincoln (1994) concur asserting further that what is generally taken as fact is often theory-laden. Smith (1987) maintains that many philosophers and historians of science have found the assumptions of positivism 'highly questionable' and despite the longevity of the positivistic paradigm (Douglas, 1985) and its undoubted achievements (Lincoln and Guba, 1985) much of it is now considered to have been undermined (Guba, 1990).

The view that it may not always be possible to ascertain the 'truth' led to the formation of a new paradigm termed postpositivism, in essence a modified version of positivism (Guba, 1990). The ontological perspective of postpositivism becomes one of critical realism, characterised by a recognition that whilst there may be a reality it can only be approximated by the constraints of human knowledge and intellectualism of that time. Thus 'the truth' can never be truly established; this shift recognises the possibility that an assertion at any particular time can be annulled upon further investigation, thus beliefs are not absolute and unchallengeable. The view that the inquirer can be completely removed from the scientific process and remain an 'outsider' has also been challenged as it is now perceived that the background knowledge held by an investigator can influence what is

observed (Philips, 1990), though objectivity remains an regulatory ideal (Guba, 1990) in this paradigm.

Qualitative researchers however, tend to connect with the social world differently (Waitzkin, 1990) and as social variables are intrinsically more difficult to isolate and test than those in the natural sciences this complexity of the social world should be placed at the centre of the research (Silverman, 1985) with the researcher seeking to study the phenomena of interest within the wider context in which they occur (Murphy et al, 1998).

As established in the literature search cognitive behaviour therapy promotes itself as a scientific model, founded within a positivistic paradigm. However psychological and psychiatric disorders are also human constructs and as such often reflect the social, cultural and political mood of the time (Gove, 1982; Szasz, 1971). Thus these 'facts' are only facts within the framework that the psychiatric and psychological disciplines have constructed and reality can only be viewed within this theoretical context.

My professional observations, experiences and discussions have propelled me towards what is known as the constructivist paradigm (Guba and Lincoln 1989; Guba, 1990). Cognitive therapy is based upon a premise that it is not events themselves that determine individuals' emotional response, but their interpretation of that event. This therefore suggests that individuals can experience the same event and due to their idiosyncratic interpretation react differently emotionally. Their interpretation is their reality. People impose order on the world in an effort to construct meaning and this meaning lies in cognitions and not in elements external to them (Lythcott and Duschl, 1990). Through our cognitions information is screened, translated, altered and rejected based upon the knowledge previously held (early experiences) (Beck, 1976). This marries with the constructivist stance which proposes that reality exists only in the form of multiple mental constructs which are socially and experientially based. A perspective that Crotty (1998) shares;

**“It is clear that different people may construct meaning in different ways, even in relation to the same phenomenon”**  
(Crotty, 1998 p9)

Constructivists reject the notion of an objective reality or truth which can be arrived at utilising positivistic research methods, as Guba and Lincoln (1989) assert;

**‘It is dubious that the constructivist paradigm requires a term like ‘truth’, which has a final or ultimate ring to it’** (Guba and Lincoln, 1989 p86)

Similarly May (1997) contends;

**‘Social science is not the same as natural science and human actions, unlike the observed effects of molecules when heated are meaningful and involve a process of interpretation of events...’** (May, 1997 p17)

These multiple realities can be contradictory and co-exist side-by-side, any of which could be overthrown should a new insight emerge (Guba and Lincoln, 1989). The constructivist paradigm occupies an ontological perspective known as relativism (Guba, 1990), which dictates the only feasible position of inquiry becomes one of subjectivity, utilising a methodological approach that attempts to identify as many of the constructions that exist and form a consensus if possible.

The constructivist also challenges the notion of objectivity in the research process, as it is debatable whether research can ever be value-free, as long as the potential biases are made explicit throughout the research process and discussed openly (Lincoln and Guba, 1985) with the researcher addressing their role in the process then this allusion to objectivity can be minimised. As this study is centred upon the service in which I work and helped establish it is important that I am fully cognisant of any preconceptions that I may have regarding the service that the department offers and attempt to view this from a differing perspective than I had previously done, a process Hammersley (1992) refers to as ‘making the familiar strange’.

### 3.4 Methodological approach

My philosophical orientation as outlined not only aids to frame the research issues but also determines the methodological approach employed and directs the methods utilised which might realise the stated research aims. Gordon (2000) offers a compelling justification for using qualitative methodology in psychotherapy, arguing;

**“Focusing on the perspectives of the consumer will provide relevant data which will increase our understanding of psychotherapy and its effects” (Gordon, 2000 p11)**

Similarly Todd and Bohart (1999) reinforce a qualitative approach;

**‘Psychotherapy is not like a medication that can be simply administered to a large group of subjects and its effects measured and compared to a placebo control group’ (Todd and Bohart, 1999).**

The methods employed must be congruent with the stated aims and espoused philosophical stance. It would for example be inappropriate to rely entirely upon standardised questionnaires, as these reflect the researchers’ own concerns (May, 2001; Bowling, 2002; Bryman, 2004). As this study is primarily concerned with how the CBT service is perceived by its clients and as psychotherapy is in essence a human interaction it appeared apposite to conduct in-depth interviews. This is also germane to the constructivist stance as Guba (1990) asserts;

**“If realities exist only in respondents’ minds, subjective interaction seems to be the only way to access them” (p28).**

Kvale (1996 p1) simply asks;

**“If you want to know how people understand their world and their life, why not talk to them?”**

### 3.5 Interviews

There are a number of ways in which to conduct interviews, the function of which determines the style of interview as they can be utilised for quantitative or qualitative research depending on the perspective of the researcher (Bowling, 2002). A number of terms have been used to describe interviews in qualitative research, Rapley (2004) suggests that the purpose of the interview is to produce 'elaborate and detailed answers' by a process of asking questions and prefers to call the process 'qualitative interviewing' as a broad phrase, a term Rubin and Rubin (1995) explain as 'a way of finding out what others feel and think of their worlds'. Many researchers differentiate types of interviews by categorising them according to whether or not the interviewer enters the dialogue with a pre-set agenda or schedule and whilst many authors use differing terms, ranging from semi-structured interview and focused interview (May, 2001) to open ended interview (Creswell, 1998) there is generally considered to be three types of interviews in research; structured interviewing, semi-structured interviewing and unstructured interviewing (Bryman, 2004). This study, due to its philosophical stance concerns itself with the unstructured interview, though it is appropriate to briefly outline the reasons for rejecting alternative approaches.

The structured interview is more concerned with quantitative research (Bowling, 2002; May, 2001) and is often used in surveys in an attempt to measure facts, attitudes, knowledge and behaviour in a way that ensures the results are replicable – that if they were repeated at another time the results would be comparable (Bowling, 2002). The questionnaire is the tool of the structured interview (May, 2001; Parahoo, 1997) with the structure frequently consisting of standardised closed questions where the respondents' answers are circled, ticked or combined with more open-ended questions with room for short answers to be written verbatim (Bryman, 2004). The structured interview requires the interviewer to ask the questions exactly as they are formulated in the questionnaire, with neither the wording or sequence of the

questions altered from interview to interview in order to ensure replication and thus comparability.

The semi-structured interview provides the researcher with a list of questions or specific topics to be covered (Bryman, 2004). There is however flexibility and the interviewee does not have to choose from a selection of answers nor does the interviewer have to adhere to the interview guide as they can respond to issues raised (Bowling, 2002). Generally though all questions will be asked using similar wording (Bryman, 2004) and the meaning of the questions remain the same (Parahoo, 1997). Neither of these approaches would generate the in-depth discussion that this study seeks.

Conversely the 'unstructured interview', so termed to reflect the lack of rigidity in how the researcher conducts the interview (Murphy et al, 1998), normally face to face (Bowling, 2000; Rapley, 2004), has much less structure. The interviewer does not follow a strict format, but has an 'aide mmoire' such as a brief set of prompts (Bryman, 2004), allowing exploration of more complex issues and uncovering meanings that people give to their experiences (Bowling, 2002). Thus the questions asked can differ from individual to individual; Rapley (2004) emphasises this by stating you don't have to ask the same question in the same way in each interaction as the principal aim is to work with the interviewee and gather 'contrasting and complementary talk' on the same theme or issue. This reflects philosophy of qualitative research; 'to find out what others think and know' (Rubin and Rubin, 1995).

In the qualitative interview the researcher deliberately introduces a number of questions and asks the interviewee to explore them in depth. There are three main types of questions utilised; the main question to guide conversation, such as 'Can you tell me about your experiences?' probing questions to gather further information (Can you give me an example of that?) and follow-up questions in order to expand on themes raised in the interview (Rubin and Rubin, 1995 p145), Charmaz (2002) adds 'ending questions.'

Amongst the disadvantages of the qualitative interviews include the time-consuming and difficult nature of collecting and analysing the data (Bowling, 2002; Bryman, 2004). In addition to this Bowling (2002) asserts that there is a greater opportunity for interviewer bias to intervene in the process and argues for the researcher to be neutral in the interview process; to avoid leading questions and biased questions, a concern with which Sapsford and Abbott (1992) find some accord suggesting that interviewers adopt a 'neutrally sympathetic' manner. However Watson and Weinberg (1982) contend that it is actually impossible to remain neutral within an interview situation as interviews are always active. This activity involves the interviewer controlling the talk utilising silences and para-linguistics (such as okay, uh huh's etc) and associated non-verbal communication. It is also the interviewer that chooses which questions to follow-up and expand upon. Rapley (2004) argues that the interview data cannot be 'tainted' as long as it is viewed in context – as an interview for a particular reason. It is therefore not about finding a 'truth' from one interviewee, but how 'specific (and sometimes contradictory) truths are produced, sustained and negotiated' (Rapley, 2004).

### **3.6 Target Population and Sampling**

The target population are clients who have completed a treatment contract with the service – whether this has been deemed successful or not (via standardised psychometric questionnaires) within the past two years – and who have been treated by clinicians other than myself. I thought it important for issues of honesty in feedback that clients I had worked with were not approached as they *may* feel indebted and give a more positive gloss on their experiences. Clients that had completed a course of treatment (rather than dropped out of treatment) within the past two years were considered more appropriate as these clients have perhaps formulated a more considered (and fresher) opinion of the treatment received and as such it is postulated that they may be better candidates to interview. Additionally it

was also assumed that these clients would be more likely to respond positively to the request to be interviewed.

As Creswell (1998) states;

**“One needs to find an individual to study, an individual who is accessible, willing to provide information, and distinctive for her or his accomplishments and ordinariness or who sheds light on a specific phenomenon or issue being explored”. (Creswell, 1998 p111)**

At the route of sampling is whether or not there is a desire to generalise the findings of a study to a wider population group (May, 2001; Robson, 2002 and Bryman, 2004). It is generally thought that in quantitative research the samples are larger with probability samples used the most, whilst qualitative research uses smaller non-probability samples (Bryman, 2004). Ritchie et al (2003) assert that probability sampling is generally considered the most rigorous approach for quantitative research but inappropriate for the qualitative inquiry. In the probability sample elements from the population are chosen at random, with a known probability of selection – the aim being to achieve a statistically representative sample (Ritchie et al, 2003; Bryman, 2004). However in non-probability samples participants are deliberately selected as they reflect particular features within a sampled population – this sample is not intended to be statistically representative (Ritchie et al, 2003; Bryman, 2004).

It was decided a sample of twelve clients would provide sufficient and manageable data, but I was equally cognisant that I would not obtain a 100% acceptance rate from clients willing to participate in the study. The literature on response rates in quantitative research was consulted, particularly postal questionnaires, as my first contact with clients was, by necessity, to be by letter. Figures range from 30–60% return rate being acceptable (Bryman, 2004) though Mangione (1995) considers anything below 50% to be unacceptable and only barely acceptable up to 60%. With this in mind I thought it better to have an initial working assumption of an acceptance rate of 50%.

Once this decision had been made clients were randomly chosen for inclusion in the study. Each client as a matter of course, to keep track of referrals, is allocated a number when admitted to the service; this offered a practical solution to client selection. The numbers allocated to clients that had been treated by another therapist within the last two years were noted and a secretary chose twenty-five at random. Letters were then sent out to the clients identified explaining the study and requesting their participation.

As this sample is readily available it could be considered a convenience sample, so termed because the sample is simply 'available to the researcher by virtue of its accessibility' (Bryman, 2004) but could also be considered a purposive sample as individuals with a certain characteristic – those who have completed treatment – have been deliberately targeted (Bowling, 2002 and Parahoo, 1997). I accept that there are limitations to the claims that can be made from data obtained through this non-probability sample; the data would only provide useful insights into this particular service, at this particular time and could not be generalised to other services.

### **3.7 Ethical Deliberations**

The process of applying to both the NHS Trust and local ethics committee forces the researcher to contemplate the ethical aspects of their study (correspondence appended).

Consideration was given to the wording of the letter sent to clients; this made explicit that involvement in the study was purely voluntary, that the taped interview would be no more than an hour in length, the preferred location of the interview and anonymity would be guaranteed. As McLeod (1998) recommends the letter also emphasised that the client could refuse participation in the study or withdraw their consent at any point without adverse consequences for future contact with the service. It was also explained that the research was an attempt to investigate the service as a whole and not individual therapists. All research materials were stored in a

locked cupboard and each tape only identified with an individual number. No research participant was referred to by full name on the tape.

I was also concerned that clients may come to the interview with unresolved issues from their period of treatment, which would sidetrack the purpose of the interview but would need to be dealt with effectively. I therefore ensured that a two-hour period was set aside for each interview allowing sufficient time to deal with unexpected issues. In addition to this I also made arrangements for another trained therapist to be on site should their assistance be needed.

### **3.8 Arrangements for Data Analysis**

**“Qualitative research is a research strategy that usually emphasises words rather than quantification in the collection and analysis of data.” (Bryman, 2004 p266)**

Quantitative data tends to lend itself to precise analysis with general consensus on the techniques for analysis. Qualitative analysis offers somewhat more of a challenge due to the nebulous nature of the data and its inherent need for interpretation, as such there are no universally accepted rules for the analysis of qualitative material (Robson, 2002). This emphasis on interpretation obviates the need to follow a strict formula (Robson, 2002) with no priori codes, though this in part explains the difficulty in which the qualitative paradigm has experienced in trying to establish itself as a creditable alternative to that of the quantitative paradigm, which has at its heart statistical analysis – considered conventionally to be the ‘bedrock of research’ (Silverman, 1993). The apparent emphasis on subjective interpretation of qualitative data in order to elicit underlying themes, meanings, concepts and characteristics (Silverman, 1993; Bryman, 2004) gives the quantitative inquirer scope to pejoratively dismiss qualitative research purely as impressionistic and lacking validity.

However from the literature it appears universally accepted that in qualitative research it is far from simple. Bryman (2004) contends that analysis becomes difficult due to the 'thicket' of data obtained, which Rubin and Rubin (1995) acknowledge can be an intimidating process. Whilst data analysis is generally considered to be the final stage of 'listening to hear the meaning of what is said' (Rubin and Rubin, 1995, p226), in the qualitative study it is regarded as an ongoing integral aspect of the research process, with data obtained informing the next step (Bryman and Burgess, 1994; Robinson, 2002; Bryman, 2004). Rubin and Rubin (1995) consider this particularly important in the interviewing process as the data that has been 'heard' directs which areas should be examined in greater detail.

Kvale (1996 p160) offers valuable guidance in describing a number of methods for the recording and transcribing of interviews including audiotape or videotape recording, note taking and remembering; all of which have advantages and disadvantages. Clearly if the researcher utilises notes or memory alone, there can be no verbatim transcript of the interview. Kvale (1996 p161) asserts that there is no correct way to transcribe as there is 'no true, objective transformation from the oral to the written mode' and maintains that the purpose of transcription determines the method and style of transcription. For example a verbatim transcript is necessary for linguistic analysis whereas a more literary style of transcript communicates the meanings of subject's stories. Kvale (1996) continues;

**"The amount and form of transcribing depends on such factors as the nature of the material and the purpose of the investigation, the time and money available....Transcribing from tape to text involves a series of technical and interpersonal issues for which, again, there are few standard rules, but rather a series of choices made." Kvale (1996, p 169)**

As this study centres upon the opinions of discharged clients of the service, which are to be presented thematically, it is not essential that every nuance is conveyed. I have consequently elected to undertake a partial transcription of the interviews. To some extent time constraints involved in an academic study also dictate this.

Again Kvale (1996) provides effective advice;

**“If they (transcripts) are to give some general impression of the subjects’ views, rephrasing and condensing of statements may be in order. Also if the analysis is to be in a form that categorises or condenses the general meaning of what is said, a certain amount of editing of the transcript may be desirable.”**  
(Kvale, 1996, p 170-171)

The data itself was to come directly from the interviews, each of which were audio-recorded to facilitate partial transcription in readiness for thematic analysis. May (2001) contends that simply listening to the tapes assists in the process of analysis as this helps familiarisation of the data. Kvale (1996) warns the researcher that there is no magical formula in the analysis process as it is singular to the theme of the questions and design of the study, though concurs that listening to and structuring the material into text helps to construct an overview, constituting the commencement of analysis.

As psychotherapy is a give-and-take, back and forth process between therapist and client the process that emerges is different for each therapist and client (Todd and Bohart, 1999). Similarly each interview conducted is a back-and-forth process between researcher and client with possibly many different themes emerging; this makes a thematic analysis particularly pertinent as it not only marries-up with the modality of CBT but also the constructivist paradigm. Many authors recommend the researcher ‘immerse themselves in the data’ (Hammersley and Atkinson, 1995), though Bryman (2004) cautions the researcher against getting so caught up in the richness of the data to the extent of it losing its significance to the wider social sciences. Clearly there is a balance to be struck between making sense of the data that is presented in the ‘local interaction’ and having so much data that it becomes unwieldy and unnameable to analysis.

### **3.9 Conclusion**

I have endeavoured to outline the process through which I have travelled in arriving at the stated philosophical orientation, methodology and intended method to realise the declared aims. At this stage of the proposal I hadn't envisaged the pitfalls that research inevitably emits nor the sense of hopelessness that this can evoke. I now proceed to detail the more conspicuous elements of how this study panned out in reality and offer an account of the difficulties, personally and research related that beset my endeavours.

### 3.10

## METHODOLOGY

(The Process)

### 3.11 Introduction

A friend and colleague who has extensive knowledge of the research process informed me, when approached for advise to always expect the unexpected – in her words, “*Bad things always happen to researchers who make assumptions*”. I didn’t truly understand the implications of this statement when proffered but the implications of this (with hindsight) sage advice became clear to me when I started the sampling procedure and interviews.

I started out on my research odyssey with a confident belief that I would in the first instance gain the number of interviewees that I had set out to recruit and secondly that I would have no difficulty in conducting unstructured interviews as that constituted a major element of my professional role. However the road that I had envisaged to be clear and smooth allowing unimpeded progress was soon littered with perceived hurdles and potholes full of challenges. At times it seemed that fate was intervening in order to scupper my chances causing frustration, abject disillusionment and a sense that progress was elusive and at worse undesirable. This apathy and indolence regarding my proposal and the prospects of completing it in the required time scale – given the apparently simplistic methodology – lasted a period of months exacerbating the delays incurred with standard procedures such as ethics committee approval. I hope this section gives a flavour of the difficulties encountered, associated anxiety and sense of ennui that enveloped me for a period of time.

### 3.12 Philosophical stance

Whilst pondering as to what aspect of the CBT service and treatment to conduct my research I had as a matter of curiosity and routine when ending treatment made enquiries with clients regarding their general feelings of the treatment and service received; I had also made a habit of enquiring from colleagues 'What do you think made the difference?' In some respects I was, albeit informally, conducting a series of mini pilot- interviews and constructing mental field notes. However at this informal stage it was unclear as to how I could make sense of let alone make use of the incoherent raw 'data' that I had been collecting and jotting down in a research diary. It occurred to me whilst conducting the in-depth interviews proper that at this embryonic phase I was attempting to apply positivistic principles to the process that I was about to undertake. In retrospect I was expecting a series of 'facts' to emerge from which I could validate further inquiry.

This in many respects mirrored *my* sense at the research ethics committee meeting where in an attempt to gain clarity of the proposal the committee challenged me as to the 'use of the study' without a clear interview structure, such as a standardised questionnaire, and a wider sample frame; the obvious implication being lack of generalisability. My reply centred upon the richness of data obtained using this methodology, and its lack of prominence in the psychotherapy field. This for me illustrated the in-built bias for positivistic research. However this questioning forced me to examine my stance and whether or not it would be easier to commence the study with a detailed questionnaire to all past clients of the service.

Rightly or wrongly I remained fixated with my original plan, determined to adhere to what I considered to be a purely qualitative approach attempting, albeit it a minor way, to redress the balance from a discipline largely driven by positivistic measures to one that can also encompass qualitative methodologies.

### **3.13 Personal Reflections**

Due to my earlier ruminations and informal discussions regarding the nature of treatment and the service that we offered I had decided against conducting a series of pilot interviews. In reality this decision was also due to time restraints incurred as a result of getting the proposal through my trust ethics committee, which insisted on a peer review and a plethora of detail despite already having LREC clearance and truthfully also as a result of a hiatus incurred due to being dispirited and unmotivated throughout the procedure of penning earlier chapters of the dissertation.

It appeared to me that the working environment I thought I knew well and was confident of negotiating was not as navigable as I had imagined. It equally appeared as a practitioner I existed in an almost eleemosynary system where I felt obliged to beg for the tools necessary not only to perform my duties but also to conduct a relatively small scale study. This sense caused initial resentment, after all wouldn't the organisation benefit from my work as well? and proved to be the midwife to a generalised malaise.

I have been well versed in offering clients caveats about the dangers of inactivity and procrastination (avoidance!) and yet had fallen into a vicious cycle of my own, paralysed with a sense of futility regarding the progress of my own study and a fear that the eventual outcome would render the whole exercise otiose. This dilatory period lasted for some time, I had underestimated the strain the process would exert upon my personal resources, and overestimated my ability to remain focused for long periods of time. Once again underway however this stress was transformed into momentum as my energy and enthusiasm was renewed by the prospect of interviewing clients. However even when sampling and interviewing commenced events did not run as smoothly as I had either anticipated or wished for.

### 3.14 Sampling

As previously established I was initially confident that I would achieve my goal of recruiting twelve interviewees that had been treated by clinicians within the department other than myself; Twenty-five letters had been dispatched to clients with this aim. I am aware that some authors when utilising the standardised postal questionnaire advocate follow-up letters or phone calls to candidates that do not reply to the initial letter in an attempt to boost return rates (Bryman, 2004). However I felt it important from an ethical perspective not to 'harass' prospective interviewees, as I was acutely aware that I was asking a lot of clients, with whom I had no personal contact, to give up at least an hour of their time to assist in a project that they would not derive personal benefit.

The paucity in the reply rate surprised me and underlined the difficulty in conducting research. From the twenty-five letters sent out I received three positive replies – barely an 12% return rate. This realised my worse fears and forced me to reformulate my reluctance in acquiring feedback from clients that I had previously treated. Due to the time limitations imposed by the educational institution to complete the study coupled with a dread of not achieving a sufficient sample I decided to include clients that I had previously treated and from a 120 target population (clients that I had treated within the past two years) a further 15 clients were identified using the method previously described. The letters sent out were identical as those previously mailed.

Whilst this challenged my initial stance of impartiality this change did not require an amended ethics committee application as my previous one had been generic in specifying the target population as clients that had previously received treatment. If I was previously disappointed with the reply rate I was delighted with the number of affirmative replies from this second batch of letters. A further ten clients were willing to become involved in the study – an acceptance rate of approximately 66.5%. The reasons for this variation can

only be guessed at; My initial concern, as previously outlined, is that clients with whom I had a previous working knowledge might have felt in some way morally obligated. It may be that my relationship with the clients proved a sufficiently strong factor to overcome the apathy that research evokes in the general public. I have mused at length as to why my initial acceptance rate was so low; my hunch is that as the service is principally focused around 'short-term' treatment (i.e. six to twelve sessions) within a primary care arena then the clients do not have a vested interest in maintaining links with the service and the prevailing view might be one of wanting to 'move on' and put their treatment behind them. This may be especially potent a reason if the client experiences any sense of shame or embarrassment regarding their link to a psychological service. As it transpired only a further seven clients were able to engage in the study process in the time allowed, making ten clients in total.

### **3.15 Interviews**

I entered the data collection phase mindful of the advice Rubin and Rubin (1995) offer, that it is unwise to rely on mechanical aids such as tape recorders as they need regular attention and are prone to malfunction. I have regularly taped clinical sessions for supervision purposes and thought I was fully aware of potential pitfalls; I ensured I had replacement batteries, additional tapes and a spare tape recorder. I was all set to conduct my first interview and arrived at the scheduled location with plenty of time to spare. I had acquired tapes long enough to record an hours interview but much to my Chagrin they were the wrong size for the machines I had; I had erroneously assumed that all micro recorders were they same size. This resulted in an hectic dash across town back to my base in order to obtain a further tape recorder and audio tapes.

I had equally assumed that I was proficient at interviewing people in an unstructured way as assessment of clients and socratic dialogue formed a large aspect of my role. However when entering these interviews I always

had a format in my mind – one which allowed deviation admittedly, but a format nonetheless. At my first interview I had fallen into the trap of thinking that an unstructured interview was completely without structure at all – despite knowing to the contrary, as Legard et al (2003 p141) contest ‘even in the most unstructured interviews the researcher will have some sense of the themes they wish to explore’. I remember having a clear thought that ‘I’d see what turns up’ and not entering the dialogue with any rehearsed questions other than one;

**What did you make of your experiences with the cognitive therapy service?**

I thought this was a good starting open ended question which would promote discussion and allow me to follow on with more detailed and information gathering questions (Rubin and Rubin, 1995). Whilst this did indeed prove to be a good opening gambit for some respondents it also proved too vague for others, which surprised me as I imagined all interviewees to be familiar with discursive dialogue as a result of their treatment experiences. In the initial interviews I felt that I was ‘running out of steam’ and on reflecting whilst making my interview notes I wondered if this was because of the brevity of some of the replies.

When the time came to analyse the interview data I admit to being acutely embarrassed by a number of my questions, one of which contained a number of questions in one and yet didn’t really ask anything at all, as it was more of a summary:-

**So that suggests that that for some people there’s an ongoing system of work that’s necessary in order to continue to challenge those interpretations that it’s not necessarily a cure all; that’s it’s an understanding of where you’re at; an understanding what the systems are, in terms of physical symptoms, and reminding ourselves of, hang on where’s the evidence? Nothing bad’s going to happen. Could I do this if I was losing control?**

Other questions were simply leading;

**That seems quite empowering?**

However, as the interviews progressed I once again became accustomed to the doubt centred around each encounter and almost thrived on not quite knowing where we could collectively end up, electing to either discuss an issue in greater depth or leaving a statement unchallenged. This was not always a conscious decision it seems and may have been 'a flight of fancy' on my behalf but added to the intrigue and enjoyment of the exercise. Consequently, acknowledgement is given that personal experiences, knowledge of the service and interests are bound to filter observations, shape and determine the questions raised in each interview. This again goes to the heart of the debate of impartiality within the qualitative interview.

Within the constructivist paradigm the data obtained is viewed as the result of the interaction between the researcher and the researched. These often conflicting versions are bound to be effected by the relationship between the researcher and researched, thus the context of the interview is useful data. The aim for the constructivist is to analyse how the interaction produced the 'trajectory of talk and how specific versions of reality are co-constructed' Rapley (2004). I am one of those active speakers and therefore influence the process – the product may be a reality that is co-created in the interview process.

I found the interviews immensely enjoyable; a process already alluded to as being rejuvenating. I was impressed by the enthusiasm all clients showed for their treatment and greatly impressed by their willingness to volunteer their time. Analysis of qualitative data is often referred to as 'immersing oneself in the data'. At the time of completing the interviews I did not realise how immersed I would have to become in order to extract any meaningful conclusions. What I found fascinating others might find banal, potential nuggets of information I missed might have been ceased upon by other

analysts. The analysis is therefore ultimately my interpretation and reflects the process of the 'local interactions' as I see them.

### **3.16 Ethical Considerations**

The primary concern throughout the study has been the past, present and possible future relationships with all clients approached for involvement in the study. I wanted to prevent a situation where clients were reluctant to re-contact the service because they had declined to participate. It is clearly difficult to quantify this; I ensured the letters sent out were explicit in there being no consequences to either involvement or lack of involvement in the study and this is all the researcher can do.

One unexpected consequence of my research efforts was that of my relationships with my colleagues – the therapists that treated the clients involved with whom I had no previous contact. Not surprisingly they were keen to discover what their clients had made of the process of treatment and their perspective on the service generally as it was easy for these therapist to assume that my research was personal reflection upon their professional practice and character. I did not want this sense of pressure to inhibit my questioning of clients at interview. This curiosity and pressure from colleagues extended to my data analysis phase of the study with repeated questioning of where I was up to and did I have any conclusions? Whilst this in part helped me to sustain a sense of interest when mine began to wane it also became somewhat of a personal millstone and sore point within the department causing not a little friction with some colleagues offering unsolicited opinions that reflected their fatigue with my personal endeavours – a sense of pressure to 'get a move on, you've had long enough!'

I had not, perhaps foolishly, considered the prospect of interviewing clients who's personal circumstances I had previously knowledge of as I act as clinical supervisor to other therapists in the department. I interviewed two such clients; As discussion of the process of treatment inevitable threw-up

some of the personal difficulties I felt uneasy and rather duplicitous in not disclosing that I was familiar with their case. To do so would perhaps have caused greater discomfort for us both and may have affected the purpose of the interview. It was the relationship with all the clients that I had interviewed that helped spur me on to complete the study as I felt morally obliged *to them* to finalise it as to do anything other would have been a betrayal of the time and efforts that they had invested in me and the service that I represent.

As previously outlined I had intended to interview only clients that had not been personally treated by myself in an attempt to avoid any sense of role conflict between therapist and researcher, but principally to avoid possible bias being introduced to the research process. Rubin and Rubin (1995) argue that the interviewer must be empathic without being over involved and in many respects this mirrors the process of therapy itself. My primary concern did not centre upon my ability as an interviewer to remain neutral but that of my clients telling me what they thought I wanted to hear. I was concerned that interviewing clients that I had treated may result in a positive gloss being provided due to an already established relationship, out of a sense of loyalty. This is discussed in the following chapter.

### **3.16 Conclusion**

I have attempted to convey many of the difficulties that I have encountered throughout the process of this study, culminating in an examination of ethical considerations. I am acutely aware that in many of the ten completed interviews that I conducted I became preoccupied with a sense of 'getting it right', 'making' the interview last long enough so to be of sufficient detail and worth. This again goes to the heart of the study's philosophical stance – it ought not to matter if every interview lasted only ten minutes – if that was all each interviewee had to express then so be it! I hope that every interviewee felt they were listened to, dealt with respectfully and courteously and also gained from the opportunity to reflect upon their treatment process some (many for a number) months down the line after completion.

## 4.0

## CHAPTER FOUR

### DATA ANALYSIS AND DISCUSSION

#### 4.1 Introduction

The construction of meaning is the task of qualitative research (Krauss, 2005), thus I approached the analysis phase as an opportunity to elicit the various themes locked within the data obtained. The data is wholly derived from the ten interviews conducted as detailed in the previous chapter. Kvale (1996) considers the data not to be 'collected' but 'co-authored' as this represents the collaborative nature of the interview, as one question informs the next. As previously outlined partial transcripts of audiotapes have been utilised rather than verbatim transcripts; a conscious decision was made to omit para-linguistics such as, 'erms', 'you know' and pauses or minor stammers which make transcribing and reading of transcripts a laborious process. This has not detracted from the themes identified, though I concede that they are *my* themes and another researcher may have chosen to focus on alternative aspects of the audiotapes.

The data analysis is presented in the following manner; I initially introduce the clients interviewed, speculate as to why the participants chose to involve themselves in the study, then briefly discuss the data in its totality before discussing the various themes revealed by the analysis and offer a concluding chapter.

#### 4.2 Study Participants

The data obtained are the result of ten interviews conducted over a two-month period. I had originally sought to interview twelve clients but in the time available this proved too difficult a number to recruit. All interviewees

are past clients of the primary care cognitive behaviour therapy team, aged between sixteen and sixty five, having been treated for a variety of mild to moderate psychological disorders. Due to issues of confidentiality their true identity is not revealed and any information that relates to personal circumstances has been omitted. For reasons of practicality each interviewee has been allocated a name.

### **4.3 Why get involved?**

I have briefly alluded to possible difficulties in recruiting participants for research purposes in the primary care arena. This may be particularly salient in mental health services where there remains a stigma to psychiatric and psychological disorders. Clients may not want reminding of their difficulties or simply may wish to move on and commence a new chapter in their life. Joanne, who expressed her initial concern with engaging in therapy, touched upon these issues.

**“When I first came I was anxious – depression and anxiety are a stigma – and I didn’t find that. The service didn’t stigmatise it at all.” (Joanne)**

So why did ten volunteers agree to be recorded for the purpose of research? As with much research the participants were not to gain directly from their contributions and were not paid for their time. I contend that the comments as detailed, offered without prompt, give an indication of the underlying intent. Simply as a way of thanking the department, or the therapist, for the treatment they received.

Sharon was typical in this when she stated;

**“That’s why I wanted to come today, because it really has been very helpful to me.” (Sharon)**

My concerns regarding clients with whom I had worked feeling obliged to become involved in the study was partly borne out with comments made

here, though they were representative across all clients interviewed. As Daphne stated;

**“When you wrote to me and phoned me up I was thrilled to come and help, it’s the least I could do.” (Daphne)**

In using identical words Vanessa echoed these sentiments;

**“It was the least I could do, You’ve helped me so much.”**

or Louise when she stated,

**“I felt as though I had to give something back, as I got so much out of it.” (Louise)**

This theme of repaying the service, or therapist, for the treatment received proved to be a constant throughout all interviews conducted, bar one. Given the positive gloss that this gives the commencement of the data analysis it is reasonable to discuss briefly the validity of the data. If it was the positive experiences of treatment that drove individuals to attend interview wouldn't they just give positive feedback about the service? Perhaps. The feedback regarding the service as a whole was indeed positive, yet the target population was individuals that had completed a course of treatment whether this was deemed successful or not. It can only be guessed at why individuals with a less than positive opinion of the service did not take up the opportunity to attend an interview. That's not to say that the service, as will be illustrated, escaped without criticism. This issue should not detract from one of the principal aims of the study being to gain an insight into the treatment process and the data constructed with the participants proved fertile in this respect.

#### **4.4 Breadth and depth of data**

I had no preconceptions regarding the issues that each interviewee would raise and very few pre-set questions other than 'What did you make of the service that you received?' asked in a variety of guises. However as my

interviews progressed there was a snowballing effect where each interview, in part, informed the next. I deliberately chose to introduce subjects that had intrigued and surprised me from previous conversations. This illustrates the importance of data analysis being an ongoing activity built into the entire research process rather than being a discrete phase (Bryman, 2005; Rubin and Rubin, 1995). However on reflection I wish I had allowed each interview to influence the next to a larger degree than I did. I had become too consumed with not wishing each interview to be driven by my concerns and perhaps too focused upon being unstructured to the extent that I did not gain access to the range of views that I might have. As a result it is my somewhat rueful opinion that themes have not been explored to the degree they might have been. At another time, in another place, this might have been different. Notwithstanding this discontent, the themes in the main, are the issues that the *clients* chose to raise and this was the function of the study. The apparent brevity of themes does not however detract from the intrigue of the analysis nor did it diminish my surprise regarding some perceptions that clients hold.

The product of the relationship between client and therapist appeared to be what exercised clients most and took on a portentous aspect of the data; as a clinician this engenders no astonishment as it is what clinicians in all areas of mental health practice and psychotherapy engage in day to day. Non-the-less this is an interesting aspect of cognitive behaviour therapy when placed aside the 'mechanics' of treatment and this, along with other themes identified, is now discussed.

## **4.5 ORGANISATIONAL ISSUES**

When the service was established in March 2000 it was done so with the intention of treating individuals with mild to moderate psychological difficulties of recent onset, within an eighteen-month period prior to referral. It was hypothesised that psychological difficulties of this relatively short duration would not require a great number of treatment sessions. As such there was

a six-session treatment limit imposed upon clinicians and clients alike. Thus in its conception the service was predicated upon ensuring rapid access to treatment by limiting its 'admission criteria' and placing a cap on treatment sessions to obviate the need for waiting lists. It would appear appropriate to commence the analysis with waiting time for assessment appointments.

#### **4.6 Rapidity of assessment appointment**

**“When you’re feeling down and depressed you need help then, you don’t want to carry on feeling like that.” (Sharon)**

Sharon’s statement typifies many in articulating the importance attached to a rapid response to the GP initiated referral; she went on to reveal what her GP had led her to expect.

**“Doctor said It could only take a few weeks and I thought ‘oh yeah’, but it was only three weeks. I was amazed at how quick I got an appointment.” (Sharon)**

Other clients also identified this sense of surprise in statements;

**“It was quick, perhaps four or five weeks....I thought that I would have to wait for a long time..” (Andrea)**

**“It was quite quick, quicker than I expected, which has to be a good thing.” (Catherine)**

**“It was a matter of a two weeks; I was quite amazed.” (Gareth)**

Whilst positive about the CBT service these statements also reveal a perception regarding the level of expectancy of the NHS generally, which I have termed 'perceived state of the NHS', considered later in the chapter. Unfortunately Joanne’s experience did not mirror the apparent satisfaction of the other interviewees;

**“The negative thing about it was the waiting time.. Your head is going round and round and it must have taken six weeks I think before I got to you.... I would have done better If I had been seen earlier. By the time I got to you I was feeling a little better anyway!” (Joanne)**

And emphasises this wait by continuing,

**“ If you were feeling that desperate you’d be dead within six weeks!” (Joanne)**

Daphne also revealed some frustration for the referral process and reflected the theme of personal urgency that Joanne had expressed;

**“I had to wait four weeks; I would have preferred it to be quicker, but who wouldn’t. The sooner that you can see somebody and solve your problems, the better it is for you.” (Daphne)**

However Sharon’s assertion gives an insight into a neighbouring authority;

**“I was lucky to have seen somebody...my mates in (authority) have been waiting five months now.” (Sharon)**

Clearly for clients the quicker that they are seen the better they feel. All clients were seen within a six-week period, which is the department’s standard as a non-emergency service. Eight out of ten clients were happy with the length of time they waited; of the two that were not, their waiting period were six weeks and four weeks. Both appear excellent when compared to the anecdotal five-month period that Sharon cites her friends as experiencing in a neighbouring authority. It would appear that the dissatisfaction expressed is more an illustration of the sense of despair that both clients were experiencing at point of referral rather than harsh criticism of the service. Catherine, who waited a comparable four or five weeks, thought that this was “quite quick”. Currently, the department does not have a prioritising system for addressing matters of urgency, as Joanne identified – ‘If you were that desperate you’d be dead within six weeks’ – and can only base decisions on the information that the referrer provides. The process of changing this is replete with difficulties as to prioritise one over another results in a longer wait for those not prioritised.

## **4.7 Venue and time of therapy**

The scheduling of appointments proved an area of discussion for some clients, with a generally positive reflection upon the service and a clear indication of negotiation in the setting of venue and appointment times. For many the venue proved their main initial concern.

**“Actually wonderful, it was my local doctors. If you have anything on your doorstep, rather than 20 miles away, it’s a bonus isn’t it?” (Daphne)**

**“All my appointments were in the same place. It was originally going to be at the doctors, Which I thought I would have preferred but having come here it was much better because it was quieter.” (Sharon)**

**“The location was very important for me. I couldn’t have gone anywhere else.” (Andrea)**

**“You’d give me a couple of options, which was really good actually as I didn’t want to tell anybody that I was seeing you.” (Vanessa)**

It is clear that all clients were satisfied with the venue of treatment. However the excerpts also indicate that for some the session’s location wasn’t just a preference but essential in facilitating their attendance as they were unable to travel elsewhere. For Vanessa it appeared also to be a matter of maintaining the confidentiality of meetings. One client, Sharon, raised the importance of the quietness of location for treatment, used solely for therapy sessions. This is interesting as many prior to treatment express a preference for their GP practice, such as Daphne, but clearly locations away from public arenas also hold advantages. This quiescence may have been important for Vanessa who’s priority was ensuring discretion. It can be demonstrated that appointments were collaboratively arranged for those who expressed a preference.

**“The flexibility of the appointments was very good. I could see you when and where I wanted.” (Joanne)**

**“There was always a lot of options. Michelle decided when to see me again, but there was no problems, she was very good at making appointments around things that I had to do. She was very flexible.” (Sharon)**

**“As for time there was some leeway, I could say I prefer a later time slot and this would be okay.” (Andrea)**

**“You’d always ask me what was best and rearranged on a couple of occasions for me.” (Daphne)**

However there did appear to be an exception;

**“You asked me if I was willing to come to a different location; I had all the time in the world, so any time was okay for me.” (Gareth)**

This statement by Gareth indicates an element of collaboration in the setting of venue – ‘you asked me if I was willing’. But it seems that Gareth felt that this collaboration was in short supply as he also suggested the timing of appointments were at the therapist convenience;

**“I think it was you saying this is the best time, but it wasn’t a problem. I thought ‘I’ll fit in with him.’” (Gareth)**

Viewed collectively the feedback regarding the when and where? aspects of the service is positive, as all clients expressed satisfaction with the location with only one client expressing some sense of pressure at fitting in with the therapist diary. This is an important aspect of the data as an aim of this study is to ascertain if the client is effectively at the centre of the service and identify ways in which this might be improved. It would appear that the service is offering the clients choice about their appointment times and venue of treatment. This mirrors the notion of consumerism in the health service (Almond, 2001; Fox, 2003) that was designed to bring about greater choice and client influence.

## 4.8 Treatment contract

The introduction detailed the imposition upon clinicians and clients of an upper treatment limit. This in part makes sense for a small service that attempts to treat as many clients as possible without incurring lengthy waiting list. All texts on cognitive therapy refer to it as being a 'time limited treatment' (Beck, 1976; Beck et al, 1979; Hawton et al, 1989; Bennett-Levy, 2004), so why shouldn't there be a restriction placed upon clinicians as to how many sessions they can offer?

As a clinician the difficulty I have with this blanket approach is that it stymies flexibility and prevents the legitimate process of the clinician negotiating with the client a treatment contract based upon their findings at assessment. To impose a session number without any real discourse is not collaborative and runs contrary to the principles of a client-centred service. The *NSF* (DoH, 1999a p8) states that patients should 'have access to the full range of services which they need'; the spirit of which does not encompass the limiting of those services.

All clients, without exception raised the matter of session number. Sharon explained her initial concerns;

**“Right at the beginning the doctor had said this and I thought ‘well that’s how many they give you!’ I just accepted it, though I must admit it did make me a little nervous; what if it’s not enough?” (Sharon)**

Sharon it appears had been advised by her GP regarding the number of treatment sessions and had resigned herself to this, prompting questions of what could be achieved in that time. The number of sessions required for any particular disorder is a difficult one to judge as it depends upon the presenting complaint, the chronicity of the difficulty and how quickly the client is socialised to the model of treatment (Beck, 1995). Despite this, recent NICE publications offer guidance for the clinician; for example citing 6-8 sessions for mild to moderate depression (NICE, 2004a) and an optimum

range of 7-14 hours for panic disorder (NICE, 2004b). However there is a danger here of clinicians' capacity to make clinical judgements being reduced due to over adherence to published guidelines (Goodwin, 2002). It is possible that the clinician and client can collaboratively arrive at a cogent clinical decision with regard to the required number of treatment sessions that is not detrimental to wider service issues.

Doubts regarding the number of sessions available are also reflected in the following statements;

**“The number of sessions placed a pressure on me, but it was a pressure that I needed.” (Matthew)**

**“We initially set eight, but had twelve. I didn't think we could achieve what we did in that amount of time.” (Louise)**

**“I was worried when you said we may only have six sessions, in fact we had eight, because I didn't think it was possible to change in that space of time.” (Paul)**

Matthew clearly articulates a sense of pressure that accompanied his treatment. His declaration suggests there was a pressure for him to get better within the allocated number of sessions and this was reflected by many that were interviewed. However it would appear that Matthew also suggests that he responds positively to a finite number of sessions as this provides a goal and focus. Anecdotally this marries with my personal experience, having a notional limit at the commencement of treatment provides the focus that clinicians and clients need. The discussion here is not whether therapy should be unlimited but whether the number of sessions should be strictly imposed without flexibility for the clinician and client to negotiate extensions in treatment. Matthew's comment illustrates this nicely;

**“You have to have so many sessions for one person, It can't be open-ended, but If it was needed to be continued then it could be looked at again.” (Matthew)**

It is evident that Louise expressed surprise at what could be achieved in a finite number of sessions, though her treatment was extended. Whilst Paul

and Louise disclose their initial concerns regarding the upper limit of treatment sessions their answers also reveal how clinicians are negotiating this limit; they are, where they deem necessary, simply ignoring it. All ten clients interviewed had exceeded the six session limit, as the following quotations illustrate.

**“I’m glad she saw me for another couple of sessions, because I did need it. I was surprised but very pleased.”  
(Sharon)**

**“Initially we had agreed six sessions, but you decided that we needed nine, which I was very happy about.” (Joanne)**

**“It was initially for six sessions, but therapist wanted to extend this for a further two.” (Sharon)**

**“We had agreed eight sessions from the start.” (Andrea)**

From the excerpts above it is demonstrable that the clinicians and clients were able to make informed decisions regarding treatment necessities without this descending into a free-for-all. The majority of clients interviewed had eight sessions, though it would appear that three people had more than this; Daphne and Gareth, who both had twelve sessions and Vanessa, who had ten. Beck (1995 p7) considers that ‘most straight-forward patients with depression and anxiety disorders are treated for 4-14 sessions’. The therapists, given this measure, were clearly on the right tracks. In these excerpts clients explain the process of how their sessions were extended and why, in their view, it was deemed necessary.

**“I was pleased that we decided to extended the sessions. This was certainly necessary. Without this I might not have got through my course, I don’t think that six sessions would have been sufficient. We reviewed my progress and amended my goals and decided upon another four sessions.” (Vanessa)**

**“We used to discuss it together and say we’ll do another x-amount of sessions. I was so frightened of going back into the system and someone forgetting about me, and I wouldn’t get any help. I don’t think you can put a time onto someone who has a mental problem, which is what I had. So the flexibility in my case is what I needed.” (Daphne)**

**“She said ‘I think that you need one more, what do you think?’ It was nice to have somebody guide me, this is what you do and this is what we are going to do.” (Catherine)**

In her statement Vanessa suggests that she may have failed a course had her treatment been limited to fewer sessions either indicating an ongoing sense of support or an active ingredient to her sessions. Her language also suggests that this was a collaborative process of increasing her session number – ‘we reviewed, we decided’ – and drawing up of new treatment goals as a result. These elements indicate continued active work and not a sense of therapeutic drift (Wells, 1997). It is demonstrable that the flexibility exhibited by the therapist was essential for the clients, as many did not feel equipped for discharge after six sessions.

**“You suggested from the outset that I would need about twelve sessions. I would have liked more than twelve. You said it was twelve sessions and that’s what I thought I was allowed.” (Gareth)**

In considering Gareth’s statement it appears that the therapist was clear at the outset that he needed double the six session limit, and was, as he infers, informed ‘that’s the limit’; ‘You said it was twelve and I thought that’s what I was allowed’. Despite this increase in session number Gareth felt he needed more, both at the time and also when interviewed;

**“This was detrimental to me because I slipped back again and needed to see you again.” (Gareth)**

Similarly Daphne remained displeased that she was discharged from treatment, indicating that it was a unilateral decision on behalf of the therapist;

**“In fact I would have still carried on. No I didn’t want them to end. It was your decision, definitely not mine.” (Daphne)**

Interestingly Gareth commented further upon his allocation of sessions and appears to concede that there may be a cost to individuals receiving a greater amount of sessions;

**“But then you’re limiting yourself to the number of other people that you can see, which is unfair because you should be able to share this with other people as well, unless you get more staff to see more people. It’s better to get a broader amount rather than a few for a longer period.” (Gareth)**

Others also recognised that treatment must end at some stage;

**“It was a joint decision to finish. I understood that it couldn’t go on forever.” (Louise)**

**“I think that I had eight over the course, six to seven months, which was sufficient at the time. There’s nothing more that I could learn from her that she’s already taught me.” (Andrea)**

**“I suppose you can’t carry on for ever.” (Joanne)**

**“I could probably see a therapist for the rest of my life. In one sense yes, I could probably have done with carrying on, but at what point do you say, I’m okay now, I can cope on my own?” (Vanessa)**

The statements regarding discharge are also important as they indicate the readiness of the client to become their own therapist, as Andrea stated ‘there’s nothing more I could learn.’ Towards the end of therapy, sessions are spaced out in increasing periods in order to prepare the client for this eventuality.

Louise offered this statement in describing the discharge process;

**“I felt that you were more distant and you did that on purpose, so that I could let go. I thought ‘come on, you’re on your own, get on with it’.” (Louise)**

and Sharon illustrates the importance of ensuring there is adequate time for discharge planning;

**“If I’d have been discharged then I would have coped, but certainly not as well. It helped me to sort myself out and get used to not coming here.” (Sharon)**

Preparation for discharge is often known as 'blueprinting'. Whilst this activity is often discussed at length in the final meeting preparation for discharge in reality commences from the first session onwards, by explaining the time-limited nature of treatment, establishing the client's expectations of progress and the nature of setbacks (Beck, 1995). Few clients referred to this process, but of those that did they felt adequately prepared, for example;

**"The blueprint was important for me. I still have all my notes, so if I ever do begin to feel down then I've got them and can go back to them. I like things written down so I can refer back to them."  
(Sharon)**

An aspect of disengagement can be to offer the client a follow-up appointment, something that Beck (1995) refers to as 'booster sessions'. This enables the therapist and client to review any difficulties that have occurred since treatment discontinued and also lessens the impact of leaving treatment. This facility proved effective for all clients questioned on this subject, many of whom raised this without prompt. From ten interviews five clients mentioned their follow-up appointment;

**"It was an important safety net, It keeps you focused rather than letting things get out of hand." (Andrea)**

**"I'm pleased that we had the follow-up appointment. I couldn't wait for it to come, It gave me an opportunity to tell you what had been going on!" (Gareth)**

**"The follow-up appointment gave me something to work towards. If anything happened I'd say to myself 'I'll tell Mark about that when I see him'; It kept me on track and made me question if I was misinterpreting things again." (Vanessa)**

**"It was useful because I knew that I would be seeing you again in case I had had any difficulties, as it happens I hadn't but I think its a really good idea. I have still got all my notes that I refer to."  
(Paul)**

**"It was just good to see you again and let you know what I'd been up to. I am doing so much more now that I was before." (Louise)**

Both Andrea and Vanessa give the impression of the follow-up appointment providing structure for their continued work – ‘it keeps you focused’ and ‘something to work towards’. For Paul however the six-month appointment proved to be purely a safety net, which he did not need to use, but suggests that his work also continues as he still refers to his therapy notes. Louise and Gareth, appeared to want to update the therapist as to what they had been doing in the intervening period.

In reviewing the threads of data on appointment times, venues, session number and discharge from treatment it would appear that the service has the basic ingredients right. The clients all appeared to agree that they were involved with decision making in their treatment, had choices regarding the timing and location of treatment and felt able to express their preferences. At this level it would appear that the client is placed at the centre of the service.

## **4.9 Reports**

Since the service inauguration It has been routine for all clients to get a copy of their ‘assessment report’ and treatment ‘closure’ report. This was designed to increase the sense of inclusion in the client’s own treatment and the commencement of establishing a collaborative working relationship. The reports, whilst primarily designed for the referrer and client’s GP, were also intended to be a useful educative tool in explaining the presenting disorder and socialise the client to the model of treatment.

Of the ten clients interviewed nine appreciated receiving their reports, all expressing similar reasons. The fact that one client did not and expressed a strong reaction to receiving the assessment report is a striking contrast and worthy of exploration. Joanne described her sense of disquiet;

**“Getting my report was upsetting to be completely honest. I didn’t like seeing it in black and white and to be honest I destroyed my report; I burnt it!” (Joanne)**

The response of actually burning the report indicates the degree of distress caused; it appears to have been a visceral response which on further reflection during the interview didn't diminish. Joanne continued;

**“I really think that some things should not be written down. I don't like it. When you see it written as clear as that it's like seeing something on the movies. You think 'who else is going to see it?'" (Joanne)**

The upset and anger (?) is palpable. It would seem that there are a number of concerns Joanne expressed. Firstly that the sensitive nature of her difficulties should not be recorded, in the minutiae that it was, due to the risk of others accessing the report. Clearly this is an important point for individuals that may already have a self perception based on being 'strange' due to the thoughts that they are experiencing. It should be routine practice that the therapist enquires whether or not there are details the client would rather not be detailed. Clearly this did not happen to the degree it should have. It appears that it was not receiving a report in principle that Joanne objected to as she also stated,

**“I am glad that I saw it as I need to know what was in it.” (Joanne)**

Perhaps here the message for the department is to ensure that the writing of the reports are what they initially intended to be, a collaborative exercise. This requires active discussion with the client as to the content of the report without jeopardising its integrity. For reports that may contain sensitive detail that is required to be included, such as risk issues, it is important that both parties have a shared understanding of the presenting difficulty and a shared language to describe these difficulties. This may be achieved by the client receiving a draft copy before it is circulated to other professionals.

Secondly there appears to be a feeling that seeing 'it in black and white' somehow makes Joanne's thoughts more real; this may explain the degree of distress. As both Gareth and Louise alluded to this;

**“When you see it in black and white it makes you think; My God I’m a bit depressed aren’t I? It helps you put a label on it. The report told me what was up with me.” (Gareth)**

Likewise Louise commented upon completing her homework forms;

**“I didn’t like filling them in because I was admitting that’s how I felt. When you see it in black and white it makes it much more real.” (Louise)**

All clients shared the sense of it being important to know what clinicians are communicating to each other. A selection of comments are listed;

**“You need to see the report; I felt as though I was being looked after. You do want to know what’s being said to your doctor.” (Sharon)**

**“There was an initial one, about what I had said and it made me feel secure. This is how it was, it made sense, somebody knew about it and something was going to happen about it.” (Vanessa)**

**“I think its nice to know what others have written bout you. I think that there’s too many hidden agendas in the NHS. If people knew what everybody was writing, then, well... Can’t see how it can be negative, because it makes people face up to their problem, you can talk about it but still deny it’s a problem.” (Gareth)**

**“For me receiving the first report was very important; it made me realise what had been happening to me, what was going to be done and gave me a sense of somebody’s going to help. It’s important that I know what’s being said about me, you promised there would be nothing in it that you weren’t saying to me.” (Matthew)**

The quotations above reveal the importance that clients placed upon receiving their report. Clearly being aware of what was being communicated about them and their disorder was of primary concern. There are additional themes contained within the dialogue, one of which appears to be the reports being educative – ‘It made me realise what was happening to me’ (Matthew), ‘This is how it was, it made sense’ (Vanessa). The comments also highlight an impression of hope that the reports generated, ‘a sense of somebody’s going to help me’ (Matthew), ‘I felt as though I was being looked after’ (Sharon) and ‘something was going to happen about it’ (Vanessa). The

clinician places a high level of importance on the generation of hope at the commencement of treatment as this helps symptom reduction, increase adherence to treatment and assists in the collaborative and therapeutic relationship (Beck et al, 1979). It is noteworthy that for Matthew, who's experience appears diametrically opposed to that of Joanne's, the report was indeed the commencement of a collaborative relationship – 'you promised there would be nothing in it that you weren't saying to me', indicating a prior discussion of the report's content and the establishment of trust.

**"I think it's a lot better. Things before were always hidden and you never knew what people wrote, so I think it's important that you know what the person is writing about you. You could be writing rubbish about me and I wouldn't know anything about it."  
(Daphne)**

For Daphne it was perhaps the only opportunity to corroborate the validity of what was written – 'you could be writing rubbish' – and she went on to comment regarding the reports accuracy;

**"You used to give me a lot of reports and feedback and they were always accurate, very, very accurate." (Daphne)**

A number of other clients referred to the accuracy of the report, giving a sense of confidence in the therapist's ability and in the treatment process.

**"I thought it was spot on." (Gareth)**

**"The report was very good, summed me up." (Andrea)**

**"My assessment report described what I'd been feeling like for years, it was just me. I didn't like the scores though." (Louise)**

The 'scores' that Louise refers to in her discussion relate to the psychometric questionnaires that are routinely sent out to all clients prior to assessment and end of treatment. Whilst this wasn't mentioned by every client it is worth exploring as a thread, as many clients who did, viewed them differently pre and post treatment. For example, in mentioning her assessment report

Louise commented 'I didn't like the scores though.' This contrasted with her view on completion of treatment;

**"It showed you how far I've come, I feel so much better now, I'm doing much more" (Louise)**

Here Louise uses her lowered questionnaire scores as a demonstration of progress and improved level of functioning, conversely at assessment her elevated scores were seen as reinforcement of her sense of despair. The positive reinforcement gained from reduced measures at discharge was also reflected in Sharon's remark;

**"The questionnaires were important because it made me feel much better – the difference in my 'scores' was remarkable." (Sharon)**

Commonly used questionnaires are Beck's Depression Inventory (BDI) (Beck et al, 1961), and Beck's anxiety inventory (BAI) (Beck et al, 1988) which are self-report scales measuring severity of depressive symptoms and physiological and cognitive anxiety symptoms respectively, both of which are presented as having reliability and validity. However, as discussed in the literature search, this notion of validity and reliability is not without contention as observed by Gareth;

**"To honest at the time I thought that these were pointless, but you have to assess somehow don't you? I could have put anything down, could have made anything up, so are they really true to the person?" (Gareth)**

He emphasises his point by expressing what for him is the futility of sending out the questionnaires prior to treatment;

**"You can put bad, bad, bad, ....I want loads of treatment....People can exaggerate their difficulties, doesn't mean that it's a true reflection. It's open to abuse. Perhaps some people are encouraged to see cognitive therapists when they don't need to." (Gareth)**

This observation goes to the heart of the ontological debate discussed in chapter three; Is there a truth? Clearly for Gareth he does not view the measures as being either reliable or valid; that individuals can exaggerate their symptoms in order to access treatment and thus scores are not necessarily a true reflection of an individual's presentation.

## **4.10 COGNITIVE BEHAVIOUR THERAPY IN ACTION**

I have elected to distinguish the concepts relating to the practice of cognitive therapy under this heading as the themes identified are discrete to the course of therapy as opposed to service issues previously examined.

### **4.11 Therapeutic relationship**

**'Effective cognitive therapy requires a good therapeutic alliance. Many patients will not acquire or use new skills to change their cognitions, behaviour, and emotional responses unless such learning takes place in the context of a supportive empathic relationship.'** (Beck, 2005 p63)

When cognitive behaviour therapy was in its infancy it was frequently unjustly criticised as being too mechanistic, that is it concentrated too much on the technical aspects of modifying thoughts and belief structures to the extent that relationship factors were either ignored or minimised (Pearsons, 1989). The therapeutic relationship was such a ubiquitous one in the data that its significance to the study is difficult to overestimate and demonstrates that this skill of developing and maintaining a good working alliance remains pivotal to psychotherapy. The centrality of the importance of the relationship each client held with their therapist was expressed in a number of ways. I have identified three themes, inevitably with some overlap, primary amongst them was viewing the therapist as a friend, trust in the therapist and qualities of the therapist.

## 4.12 Therapist as a friend

The following are a selection of quotations from the data concerning the therapeutic relationship viewed as a friendship.

**“It wasn’t like a teacher pupil relationship, or a doctor patient relationship. I looked on you as a friend; somebody that I could come to with a pile of problems and If I wanted to sit crying I, could do. I would say that it was a friendship and I still feel that way.” (Daphne)**

**“You either feel comfortable with someone or you dislike them, so for me it was very important that we had a friendship...Two mates together, sorting it out.” (Gareth)**

**“She didn’t judge me at all, she was more like a friend, that’s how I feel.” (Sharon)**

**“I just felt as though you were a friend, you see. I felt as though we were friends more than just the service.” (Louise)**

The above quotations illustrate the relationships that the therapists and clients established, friend-like because in many respects the process of therapy mirrored that of what we’d like from our friends. Viewed as non-clinical, ‘not like a pupil/teacher or a doctor/patient’ (Daphne), ‘non-judgemental’ (Matthew and Daphne) and collaborative, ‘two mates sorting it out together’ (Gareth). The importance of the relationship was clearly important to all interviewees and this is referenced in all psychotherapy literature and has been defined as a key ingredient in cognitive therapy (Beck et al, 1979; Layden et al, 1993; Persons, 1989; Padesky and Greenberger, 1995) but is it a simple process to foster, and how is it achieved?

**“If you’re good at your job, then that job appears easily done and the patient doesn’t always know that you’re doing it.” (Daphne)**

The pronouncement offered by Daphne in many respects exemplifies the difficulty in attempting to define how any interpersonal therapy is conducted and what makes it successful. The data concealed many opinions as to how this relationship was developed and maintained throughout the therapy.

### **4.13 Trust in therapist**

If clients consider the relationship developed with the therapist to be safe and trustworthy they are more liable to be open and discuss difficulties with a greater degree of honesty (Padesky and Greenberger, 1995). The data effectively illustrated the importance of trust, highlighting that trust in the therapist appeared two-fold; That the therapist was able to maintain discretion, acting as confidant and also trust in the judgement of the therapist – that the therapist ‘knew best’. For many the therapists’ role of confidant was compared to that of a spouse or trusted other, with objectivity being a often expressed value.

**“You can talk to family and friends, but it’s not the same. She was on my side and here to help me and I told Michelle things that I never told anybody else.” (Sharon)**

**“It has to be somebody qualified in this, you can’t discuss it with your wife.” (Paul)**

**“I could tell you more things than I’ve told anybody before. There were some things that I’d told you that I’ve never told my family.” (Louise)**

This sense of revealing sensitive information about oneself to the therapist, often referred to in the data as ‘getting inside my head’ clearly required a high degree of trust and confidence as demonstrated by a number of comments;

**“When I came I was anxious and frightened because I don’t like people to see the ‘inside me.’” (Joanne)**

**“I was very dubious initially, to let my guard down and let you come into my head, to my thoughts. I didn’t want anybody from the NHS to come into it again.” (Gareth)**

**“I think I felt that you weren’t going to pry into what was going on emotionally for me, and play with my head; you were just going to help me deal with being able to do things that I couldn’t do any more, a sort of practical aspect.” (Vanessa)**

Sharon, on discussing various treatment techniques, indicates confidence in the therapist's abilities were particularly important for her when experiencing self-doubt;

**"They were all things that I knew myself, but you can't always tell yourself, but somebody that you trust, then you think I was right to think that!" (Sharon)**

For Sharon the trust in the therapist was manifest in the process of treatment which appears to have reinforced knowledge that she was previously aware, whilst Daphne suggested that things had been drawn from outside her immediate consciousness and this help foster trust in the therapist;

**"You saw things in me that I wasn't aware of on many occasions and I learned to trust you more and more." (Daphne)**

In addition to this it would appear that Daphne also gained a sense of trust from her therapist's curiosity regarding her difficulties.

**"It was your inquisitiveness that started to look into what was actually wrong, no one had actually done that. The tablets that *you* suggested, the doctor didn't suggest them, *you* did, I'm still taking." (Daphne)**

**"You established that, nobody else did, you did. Nobody thought to enquire." (Daphne)**

For Sharon and Paul this trust was established by the therapist through active listening and a reassuring manner;

**"She listened very, very well and she does get her point across very well. She explains things in a very clear way, always calm and reassuring." (Sharon)**

**"I took to you straight away, the way you presented yourself. You're always prepared to listen and you're prepared to discuss it, it wouldn't matter what I said, you were always calm." (Paul)**

Similarly for Vanessa the level of trust was demonstrated by the empathy shown by her therapist;

**“By taking me seriously, by taking what I was saying seriously, you took my fears seriously. It’s very empathetic to get on the same wave length as somebody who’s believing that something’s bad is going to happen, when you know for a fact that it’s not.” (Vanessa)**

#### **4.14 Qualities of the therapist**

The view of the therapist being a friend and trustworthy overlapped into the qualities of the therapist which appeared to be a pivotal aspect of the psychological work undertaken. Clients did not focus upon mechanics of treatment, but chose to focus upon what they saw as the qualities of the therapist. In the main this translated into characteristics that Beck (1995 p5) considers the basic ingredients of any counselling session: ‘warmth, empathy, caring, genuine regard and competence.’ These qualities can be traced back to Carl Rogers’ early work (1951).

Daphne amplifies the relevance of the relationship in expressing;

**“How can you talk to somebody you can’t trust or don’t like? You can’t open your heart out to somebody you don’t like. How can you talk to a total stranger like that?” (Daphne)**

**“You’re a nice guy and I’d come every week; It wouldn’t be any good if you didn’t like the therapist.” (Joanne)**

The relationship between therapist and client is however not just a matter of engagement but also an integral aspect of a collaborative relationship as Beck (2005) explains;

**“Sometimes a problem arises in the collaborative relationship because of therapist error. Therapists may be too directive, overbearing or confrontational.” Beck (2005 p65)**

Clearly Michelle as a therapist had got the balance right for Amanda who cited the lack of dominance in her sessions, indicating collaboration;

**“She was just a nice person, she didn’t have an aggressive or domineering approach, she was just a nice person to talk to. She was just lovely.” (Amanda)**

Sharon also identified this collaboration;

**“Michelle would suggest things..... What do you think about this? Nothing ever threatening.” (Sharon)**

#### **4.15 Teamwork**

Collaboration with the client is a cornerstone of cognitive therapy (Padesky and Greenberger, 1995); the therapist and client should jointly make decisions about therapy, for example which problems to focus on during therapy and how frequently to meet (Beck, 2005). Padesky and Greenberger (1995) add collaboration to their list of essential qualities important to the therapeutic relationship. The outlining of the format of treatment and expectations of the client’s involvement has been termed socialisation to therapy (Beck et al, 1979; Beck 1995; Blackburn and Davidson, 1995) and has been ‘found to decrease premature discontinuation of treatment and increase response to therapy’ (Beck et al 1979 p74). This is particularly considered important as many clients enter therapy with an expectation of a passive role, such as ‘treat me’ (Padesky and Greenberger, 1995). Collaboration with the client has previously been highlighted in the venue and time of therapy section (4.12) and is also explored in the process and tools of therapy section (4.30). However due to its centrality in the treatment process it is pertinent to briefly explore other statements that highlighted collaboration in action; it was raised a number of differing ways, generally mentioned as an aside rather than referred to directly. Matthew was typical of this when discussing his homework assignments.

**“It was a bit pushy in a good way. I needed somebody strong to push myself.” (Matthew)**

The degree of collaboration is questionable in Matthew’s statement, as he gives the impression of being driven rather than an open discussion taking

place; though it appears he responded to the therapist guidance suggesting that without this he would have lacked the motivation or confidence to proceed. When working collaboratively the therapist acts as a team with patients, assuming the role of a guide with certain expertise (Beck, 2005).

**“She always asked me if I understood. Michelle would suggest things...What do you think about this?” (Sharon)**

**“It was more conversational...working together, she didn’t give me instructions to do things, it was a more gentle approach.” (Andrea)**

Many clients highlighted the sense of teamwork by referring to the frequency in which the therapist enquired if they understood the treatment rationale or specific points in therapy sessions. In this way rapport can be strengthened and illustrates that the therapist cares about what the client thinks (Beck, 1995).

**“You were always very clear and asked me if I understood everything.” (Louise)**

**“It was teamwork, that’s what it was. If I didn’t understand anything you’d always go over it again.” (Gareth)**

**“Sometimes you had to explain things to me again and you always told me what we had done in each session, or asked me do that – I hated doing that!” (Daphne)**

However collaboration isn’t only established by the therapist but is clearly a joint venture between therapist and client, with the client having a clear responsibility in the treatment process. Matthew perhaps articulates this best;

**“You don’t have a responsibility to make it work. It’s my responsibility to do it, having been given all the information and strategies, what else could you do? It’s down to the individual.” (Matthew)**

The element of client responsibility for active involvement in treatment and change is inherent in the cognitive model of treatment, and is, as previously

referred to termed socialisation to the model. The sense of the client accepting this responsibility can be gauged by assessing their optimism regarding possibility of change and likelihood of treatment being successful.

#### **4.16 Treatment expectations**

Beck et al (1979) offered a conceptualisation of cognitive therapy for depression, where an individual's perception of self, experiences and their future contribute to low mood. It is therefore not surprising, given this model, that an individual's expectation of treatment effectiveness is considered a powerful predictor of outcome in psychotherapy (Meyer et al, 2002). Beck et al (1979 p95) describe the principal therapeutic goal at the first interview to be symptom relief as this 'increases rapport, therapeutic collaboration and confidence in the efficacy of therapy'. This appeared to be the case for Sharon, who described when she first noticed an improvement,

**“When we started doing the activities, because I just couldn't be bothered doing anything, this is when I felt better. I felt better because I had accomplished doing something.” (Sharon)**

Meyer et al (2002) reported that not only did patients' pre-treatment expectations of therapy efficacy indicate a more positive outcome to treatment but also predicted patients' contribution to the therapeutic alliance. The patient is more likely to become an integral component of their own treatment if they have belief in the process. The importance of this optimism regarding possibility of change is perhaps best exemplified by the inclusion by Safran and Segal (1990) of this as a criterion for the therapist in assessing a client's 'suitability for CBT'.

The expectations of therapy appeared to vary between all interviewees, some didn't know what to expect, conversely some actively requested the treatment. Here the attitude of the referring agent, in all cases the client's general practitioner, appeared to be seminal. For example, Sharon explained her experience.

**“My Doctor recommended I see Michelle and said ‘she would sort me out’.” (Sharon)**

Sharon’s statement can be viewed with ambiguity; was it the treatment that the GP recommended or Michelle as a therapist, or both. For Gareth there was no doubt, the GP sold the therapist not only the treatment, though again the GP may have been ‘selling’ either therapist or treatment modality.

**“I had been fighting it a long time and didn’t trust anybody, she said ‘I’ve known him for along while now and think you will get a lot of benefit from seeing him.’” (Gareth)**

Matthew’s experience was similar and indicated an element of optimism regarding therapeutic outcome as he believed the therapist was good and also experienced in treating similar difficulties;

**“GP said that ‘you were very good’ and that you’d seen others with similar problems.” (Matthew)**

In an interesting use of words Catherine clearly hands initial responsibility to the GP for fostering a sense of belief in the service and treatment;

**“The GP needs to sell the service or you wouldn’t go.” (Catherine)**

And indicated how the GP achieved this;

**“She briefly explained what it was and told me that it would help me there and then but also with events in the future. I still use the techniques now.” (Catherine)**

This comment communicates detail about the treatment modality; that it is focused on the here and now, with applicability to a variety of difficulties; that it is a practical therapy involving the use of techniques and also that work doesn’t stop with treatment.

## 4.17 Treatment or Talking?

An unexpected concept revealed by the interviews undertaken was the lack of unanimity regarding the appropriate term for therapy. The discussion was introduced midway through the data collection phase, which informed each interview thereafter. I had routinely used the word 'treatment', which I generally use interchangeably with therapy, when asking respondents about their experiences during therapy, when Andrea corrected me;

**"I didn't see it as treatment....It was a help, a great help, It might have been a treatment in a broad sense but I didn't see it as a treatment for a medical condition. The approach was more on a general chat." (Andrea)**

Similarly Joanne was uncertain as to the appropriate term for the work that she undertook, though she appeared to equivocate;

**"It's not really a treatment."  
"Well, it's friendly. It was a friendly treatment." (Joanne)**

For some, the apparent relaxed manner and friendly attitude of the therapist appeared to contradict the impression of treatment being a serious process and concluded that it wasn't strictly treatment but a matter of 'talking things through'. Moreover there was a distinction between treatment being manifestly for physical complaints;

**"I don't know...No, not really. Treatment is more like taking medication, something that you take. We were just talking really, it helped me greatly, but we were just talking." (Sharon)**

**"Not really, You sorted me out, but I don't know if it was treatment in the conventional sense. It was just talking to each other." (Daphne)**

**"I wouldn't say treatment. I didn't feel as though it was like that. This is a relaxed atmosphere. It was talking things through; though I can't think of another word." (Louise)**

However for Gareth the identification of psychotherapy being a talking therapy wasn't incongruent with it being considered a treatment.

**“Oh yes definitely treatment, but in a way where it's just a matter of being able to talk and open up. I didn't trust anybody enough to do that.” (Gareth)**

Others also agreed the term treatment appeared an apt one;

**“Yes I suppose it was. I suppose it has ‘treated me’, I don't think that there's another word to describe it. I was able to use that to treat myself to a better way of feeling.” (Catherine)**

Whilst Matthew generally accepted that his contact with the service could be described as treatment he also shared the perception that the term is utilised in the context of physical ailment and preferred just to view it as cognitive therapy.

**“Treatment seems to be such a general term; Like being treated for a physical wound or a cold. It could be for a mental illness as well, long term. It would fall under that umbrella I suppose. I think of it as CBT rather than a treatment.” (Matthew)**

Vanessa adopting my language proffered;

**“I think that you've referred to it as treatment, so I refer to it as treatment....”**

**“...I don't really see any other way in which I could see it. No I see it as treatment. I used to go home after our sessions and write down what I had said and what you had said, so I worked hard at it, took it seriously, so it was like treatment.” (Vanessa)**

The dichotomy between treatment being for physical illness and psychotherapy as talking and thus not treatment is an intriguing one. For Szasz, (1998) the terminology strikes at the origins of CBT as he asserts that CBT is increasingly referred to as cognitive behavioural psychotherapy, viewed as treatment, the word 'treatment' being part of the medical legacy of psychotherapy's origins. As will be highlighted later in the study, all clients preferred the term 'patient', as this indicated a sense of care and trust in the

clinician. Additionally the term patient inferred expertise on behalf of the clinician and the notion of 'being treated'. This appears to contradict the stance of CBT not being a treatment.

#### **4.18 Main Message of therapy**

Beck (1995) offers an interesting insight into the clients expectations of therapy ;

**'Most patients want to know their general diagnosis, that they are not crazy, and that their therapist has helped others like them before and does not think that they are strange'. (Beck, 1995 p38)**

These factors can be identified as the client requiring reassurance regarding their condition, trust in the therapist competence, a sense of hope and acceptability. All these factors can be discerned from the interviews conducted. There appeared to be a consensus amongst all clients interviewed regarding what they considered to be the main message of treatment; One of normalisation; that their emotions and responses were normal given the context of their difficulties and the fears they experienced, that their thoughts were *just thoughts*. For example,

**"You needn't feel ashamed of what you are thinking or feeling."  
(Joanne)**

**"That there are a lot of people out there feeling exactly like you and it's not wrong to feel upset about things; you can get out of it and move your self forward; you do feel as though you are the only one; it does make you feel better." (Sharon)**

**"She stressed what I was experiencing was a normal reaction to what I had endured, if you like." (Andrea)**

This normalisation process was clearly important for Joanne who mentioned feeling 'normal' on a number of occasions and considered this message to be the most forceful, a perspective with which Louise agreed.

**"It was the most powerful aspect of what we did. You make me feel quite normal! You were a lifeline." (Joanne)**

**“It made me feel normal.” (Louise)**

For Daphne, whilst the main aspect of treatment was ‘talking around her problems’ she also considered the primary message from treatment and major benefit to be the normalisation process;

**“You made me realise that I wasn’t the only cookie in the pot. It makes you become a more sane person, it makes you aware that there are other people with problems, it’s not just you.” (Daphne)**

Catherine illustrates that it is not just the sense of ‘normality’ being reinforced that is important but also that the process of normalisation legitimises ones response to stressful situations.

**“I was allowed to be upset and I was allowed to be angry. I used to think that it was wrong for me to be upset that it was wrong for me to be angry.” (Catherine)**

The benefits of realising that others have similar problems are very clear; it reduces the sense of anxiety, diminishes, and in some cases eradicates, the fear of ‘losing ones mind’.

**“I thought it was me and I thought I was actually loosing my mind. I just thought that they were going to put me in a ‘loony ward’ and shut the door and throw away the key.” (Daphne)**

**“Important just to know that you weren’t going mad.” (Andrea)**

However for Paul the main message appeared more related to his personal difficulties;

**“It was about trying to change my outlook on life. The ‘What ifs’, Nothing terrible is going to happen if you think about it.” (Paul)**

However he also offered a statement that, as his therapist, makes me question my skills in guided discovery and socratic dialogue!

**“You pointed out to me that I’m a bit stubborn!” (Paul)**

## 4.19 What is Cognitive Behaviour Therapy?

**‘Cognitive therapy is an active, directive, time-limited, structured approach used to treat a variety of psychiatric disorders. It is based on an underlying theoretical rationale that an individual’s affect and behaviour are largely determined by the way in which he structures the world’ (Beck et al, 1979)**

Beck et al (1979) continues to explain that the therapeutic techniques in CBT are designed to identify, reality test and correct concepts based upon distorted beliefs. From the data obtained it would appear clients largely subscribed to this central message, though for Sharon it was also a matter of positive thinking as this mirrored the positive attitude of her therapist;

**“I have put it on my mobile phone...Always look on the bright side of life! You do have to think positive and that’s quite right.” (Sharon)**

Though she later stated,

**“I am going to think a different way. I’m not going back to that!” (Sharon)**

which suggests that she was aware of the importance of her thought processes on her mood without simply thinking positively. Catherine shared Sharon’s perception but also gave an indication that treatment consisted of looking at and changing thoughts rather than selectively attending to the negative aspects of her own behaviour.

**“I think it is positive thinking. Everything I seemed to express had negative aspects, so it was looking at those and turning them round. To look at what you are doing and look at the best bits and build on that. It’s looking at yourself and changing the things that you are doing for the better.” (Catherine)**

Others made direct reference to their thoughts. When Gareth was asked whether CBT was positive thinking he asserted;

**“It’s about retraining your thoughts, it’s not positive thinking, it’s retraining your thoughts and then you can think positively about what you know, but without the techniques you’re not going to know how to do it. I had tried for years to think positively, for years, and it didn’t work, so no.” (Gareth)**

**“It’s about challenging your thoughts, understanding what’s going on.” (Joanne)**

**“I understood the therapy and the way I had to think, or think alternatively.” (Louise)**

**“It just normalises your thought processes and how you think can escalate the fear.” (Andrea)**

Vanessa concurred that it was not simply a process of positive thinking and also passed comment on the notion that CBT was a assortment of various techniques thrown together, but reinforced that work does not stop once that treatment has finished and important aspect to therapy explored when discussing the tools of therapy;

**“It’s not positive thinking and I don’t think it is just a collection of techniques, it’s a state of changing your mind! I wouldn’t say it complete, it’s an ongoing process.” (Vanessa)**

Interestingly in explaining the therapy two clients used the analogy of the brain being a circuit, or a track, which for them had become faulty requiring a different way of thinking.

**“It helped me to change my thinking. It gave me a great understanding of ‘The circuit’, you taught me to challenge my thinking.. You showed me a way to stop those thoughts.” (Joanne)**

**“I think its about putting your thoughts onto a different track. I don’t know if they still do that old shock treatment, that’s a mechanical way of doing really what you’ve done, to shock your mind off what you’re thinking about and put it onto another track. Without a machine you’ve done it with words, which is less painful and more beneficial.” (Paul)**

Louise also chose metaphor to explain how she perceived CBT;

**“I know a lot about it now. It’s looking at things in a different way. Before if something was bothering me it would escalate onto something else and something else until I got panicky. But now I’ve learnt to, it’s like a book, I’m looking at a different page, so I just look at one thing at a time now, so I don’t get overwhelmed.” (Louise)**

Joanne and Louise indicate that they have been through a learning process, 'you taught me to challenge my thinking', 'now I've learnt to..'; Whilst Paul recognises that he has changed his thinking he attributes the change primarily to the therapist, indicating a more passive view of his therapy, not necessarily the work he put into treatment. This notion of having 'something done' to oneself during the treatment process is reflected in Andrea's perception of treatment,

**"We were just talking, but obviously she was doing something to me to alter the way I thought about my symptoms." (Andrea)**

**"Don't know which bit worked for me, whether it's what she did to me or not." (Andrea)**

Likewise Gareth gives the therapist credit for the treatment outcome, finding it difficult to remember specific techniques,

**"I don't know, whatever you did, it worked! I got something out of every session that I had. I can't put my finger on each technique." (Gareth)**

## **4.20 Process and Tools of therapy**

**'The more a client learns to solve problems independently, the greater the chance of continued improvement' (Padesky and Greenberger, 1995).**

The quotation above illustrates that acquiring knowledge and techniques in the process of treatment is not an academic one, as a central theme in cognitive behaviour therapy is the client becoming their own therapist. The treatment process should thus be directive, collaborative and educative (Beck et al, 1979, Padesky and Greenberger, 1995). This therefore begs the questions, what did the clients learn? and are they able to identify the methods by which change occurred? It has been demonstrated that all clients focused upon their relationship with the therapist, considering this to be of primary importance; however this section focuses on the tools of CBT in an attempt to examine possible factors contributing to change.

The therapeutic relationship is necessary but not sufficient in creating change (Beck et al, 1979; Blackburn and Davidson, 1995); Padesky and Greenberger (1995 p6) assert that a 'warm therapy relationship without visible progress in solving presenting problems can actually make a client feel worse'. Therefore it is to be assumed that there is another active ingredient in addition to the therapeutic relationship that contributes to change. This was also borne out by the data; each client also made reference to the techniques utilised during therapy aimed at modifying their thoughts and behaviour. As CBT centres upon both thoughts and behaviour, utilising 'behavioural experiments' as a method to amend thoughts, it is not surprising that some clients focused upon cognitive techniques whilst others centred upon behavioural aspects of treatment.

#### **4.21 Agenda Setting**

Sharon indicates a process of being guided throughout her treatment;

**“She’s obviously very good at steering you in directions that she thought would be good for you.” (Sharon)**

Vanessa echoed this sense of being lead when discussing the structure of her treatment sessions,

**“Well, If I had been coming for just a chat I would have just come along and off-loaded onto you and quite often you wouldn’t let me do that because you’d steer me away from whatever I was trying to.... If I had just been coming for a chat I don’t think that I would have got better really. I had to work at it.” (Vanessa)**

Here Vanessa alludes to a process of being guided to perhaps the main body of work in a session rather than what she views as 'just chatting', which for her would have been ineffective. This oblique indication to a form of session structure is an interesting parallel to the opinion that the therapy undertaken was 'just talking' which offers an unstructured (goless?) flavour to therapy. Yet similarly to Vanessa other interviewees alluded to a 'session format'.

The session format in CBT is referred to as an agenda; Many authorities consider this to be the initial stage of forming a collaborative relationship as the agenda is established in discussion with the patient (Beck, 1979; Beck, 1995; Padesky and Greenberger, 1995). Blackburn and Davidson (1995) also consider the formation of an agenda to be essential in establishing a professional manner;

**'The professional must always be professional and business-like in his manner...He keeps to an agenda which is agreed with the patient...and takes responsibility for using the patient's time in an effective way'. Blackburn and Davidson (1995 p49)**

However this sense of professionalism for Gareth is incongruent with the notion of the therapist being a friend as explored earlier;

**"Teamwork was pivotal. It has to be a one-on-one and friendship rather than a patient and professional. People get frightened of a professional I think." (Gareth)**

**"I wanted a relationship of two mates, to be relaxed and enjoy each others' company. I didn't want another barrier to step over." (Gareth)**

Whilst for Gareth a professional manner is clearly at odds with teamwork his comments also help to demonstrate the importance of a collaborative relationship; the therapist responding to the client's perspective and forming a relationship in which the client feels comfortable. Essentially an agenda is established in order to ensure that the difficulties as identified at assessment remain the focus of therapy; this agenda dictates the main body of work. Joanne alludes to being guided in an attempt to remain on track with the main business of the session.

**"You were very relaxed about it, you stuck to the point, but whenever I came you got into the therapy, you weren't nastily firm but pushed on with what you wanted me to help myself with." (Joanne)**

Vanessa offers the clearest description of how an agenda was established and describes what she saw as the benefits of doing so;

**“At the beginning of each session you’d write down things that we’d cover, so that we could set the agenda. You asked me what I would like to discuss and you’d add things if you thought there was anything important. I liked having an agenda, it helped me to stay focused.” (Vanessa)**

It appears that the majority of clients interviewed had engaged in treatment sessions that were structured in some manner, the structure having been collaboratively agreed. An element of this structure is the ending of sessions which some clients mentioned.

**“You were always very clear. At the end of the sessions you’d make sure that I had understood everything that we had done, in fact you checked this throughout.” (Vanessa)**

Whilst the structure of sessions was apparent in the data, it is more difficult to ascertain a clear picture regarding therapeutic techniques utilised, such was the emphasis upon the relationship with the therapist. It is possible that the questions posed didn’t facilitate this debate or the leads that I chose to follow did not allow exploration of this area. However the data is not barren of references to strategies employed, as the following excerpts demonstrate;

**“She would do horrible things on that board, positives and negatives.” (Sharon)**

**“It made me aware that I was learning something, you know with the diagrams and everything. I think it’s nice to feel that you’re not in a clinical atmosphere really. We also had the forms, they were difficult to fill in. I would do better with them now.” (Joanne)**

**“The major thing was when I had to fill in these, and I didn’t like filling in, *awful* sheets, about dysfunctional thoughts, you know I did things and had to write about. I found it *very, very* difficult to fill in.” (Sharon)**

Michael referred directly to CBT being a tool kit and illustrates perfectly the importance of the client understanding the treatment process;

**“It gave me a one, two, three of what to do, and I did it and it worked. I needed to carry that tool kit away with me because I wasn’t going to see you once that treatment had finished.” (Michael)**

Matthew and Vanessa described their experiences of treatment in more behavioural terms, though also relate this to their thoughts changing, illustrating that their treatment wasn’t purely behavioural.

**“It was hands on experience and replicating the symptoms, experiencing the fears and holding onto the thoughts until they diminish, it was very much hands on experience and replicating and going back to the experiences to face them. Without it and going through my experiences it wouldn’t have worked. It was the practical side that worked even though it was quite frightening.” (Matthew)**

**“I think it was perhaps experience over a period of time; repeatedly putting myself into situations that I thought were going to have a horrible outcome or that I felt like, that it was something horrible that was going to happen and then experiencing that it didn’t. And I’m just assuming that gradually my mind sort of realised that nothing bad was going to happen in those situations. If you’re in that situation and nothing bad does happen then it’s a very strong message.” (Vanessa)**

## **4.22 Homework**

Such is the importance attached to homework in treatment that Beck (1995) considers it an integral and not an optional part of therapy. Persons et al (1988) found that clients who carry out their homework assignments progress better in treatment compared to those that do not. Homework in cognitive therapy is designed to provide a bridge between one session and the next; providing an opportunity for clients to gather data in relation to their thoughts, mood and beliefs. Given the level of significance attached to homework assignments it is not surprising that it emerged as a thread in the data. Interestingly there were a number of themes within this theme; foremost amongst them appeared to be the sense of pressure that accompanied homework assignments;

**“I thought I’d better do this because I had to report back. I need to do this. A lot of good things came out of it.” (Matthew)**

**“It makes you do it because I’m going to see you instead of putting it off all the time.” (Daphne)**

**“It was my homework, I knew that I needed to do it! I didn’t realise how many negative thoughts I had.” (Sharon)**

**“I had to do it because Michelle had asked me to.” (Andrea)**

Interestingly Catherine also referred to pressure of homework but chose to focus upon her perceived lack of pressure to complete tasks, indicating good collaboration;

**“She set me homework to do and that was negotiated. It was hard work doing that, but it was very valuable. If it had been instructed I would have felt more pressure than I did.” (Catherine)**

The importance of collaboration is manifest in the setting of homework as clients who routinely set their own homework are more likely to do so once therapy is over (Beck, 1995). In addition to this it is more likely that the client who understands the rationale for their homework and contributes to the setting of it carries out the task. Louise offers a good example of this;

**“It was jointly decided upon. I did it because I could prove that I could, because I don’t like to be beaten at anything.” (Louise)**

in her comment Louise also alludes to the motivational aspect of treatment that homework can provide; she completed her homework not only because she had agreed, but also because she wanted to demonstrate to herself that she was capable of doing so. Louise also suggests that her homework was set incrementally in keeping with her treatment sessions;

**“It was set in degrees, I wrote down what I wanted to achieve and then we just progressed and discussed it.” (Louise)**

Gareth and Vanessa provided a more overt link with treatment sessions;

**“Homework was difficult at times, because I couldn’t always do what I had agreed, but you were fine about it and we always looked at it in the next session.” (Gareth)**

**“Without the homework, or behavioural experiments, I don’t think that I would have made as much progress as I did. I thought the homework was really important, you always asked me what I thought I could do between sessions and then discussed it when we met again.” (Vanessa)**

Matthew’s and Sharon’s observations appears to neatly link all the aspects of collaboration, connection with treatment sessions and an incremental approach;

**“It was jointly decided upon. I informed you of where and when things got too much for me and we decided to revisit those areas to re-live and re-experience situations where previously I had panicked but using the strategies that you had explained.” (Matthew)**

**“I think all these things I had to fill in did me good because otherwise you come to the therapy sessions and talk, and you wouldn’t do anything again until the next session, but because you have to fill in something every day it makes you think every day.” (Sharon)**

#### **4.23 Therapy versus medication**

Medication is not seen as being contraindicated to psychotherapy. Recent NICE guidelines for psychological disorders include advice regarding the prescribing of medication. Following a ‘stepped care model’ the guidelines for depressive disorders is typical of guidance; It recommends that medication be prescribed for moderate to severe depression. The guidelines also address patients’ concerns regarding dependence and withdrawal specifically stating;

- In moderate depression, offer antidepressant medication to all patients routinely, before psychological interventions.
- Discuss the patient’s fears of addiction or other concerns about medication. For example, explain that craving and tolerance do not occur.

- When starting treatment, tell patients about the risk of discontinuation/ withdrawal symptoms and possible side effects (NICE, 2004, p8).

Beck (1995) makes reference to the therapist's duties when working with those individuals taking medication for their psychological difficulties.

**'The therapist also suggests that while medication may be responsible *in part* for her feeling better, the patient's own efforts have probably also contributed to her improvement. If the patient is not taking medication but the therapist believes a psychopharmacological intervention is indicated, he suggests a medical or psychiatric consultation.'** (Beck, 1995, p48)

However for the majority of clients interviewed there appeared to be a straightforward choice between either having medication or engaging in psychotherapy, not a combined approach. Of all those that expressed an opinion on this matter the need for medication was viewed censoriously. Joanne when affirming that she would recommend CBT to friends reinforced her stance by suggesting that medication is prescribed too readily;

**"If they go to the doctors for it, they'll only get tablets for it."**  
(Joanne)

For Matthew the issue of medication appeared to be one of concealing and avoiding difficulties rather than finding a solution.

**"It wasn't to do with pills and running away from it. It wasn't hiding away from it. It wasn't covering things up, it was facing it, standing up to it. Medication for me has a different outlook on it, certainly for mental health issues."** (Matthew)

For some however receiving medication would have been a critical comment on their state of mind and an illustrative of deterioration.

**"I didn't want medication, that would have made me feel even worse, it would mean that I was really bad! It was painless treatment, no drugs, just talk."** (Paul)

**“CBT was a much better option than having to take medication. If I had to take medication than this would have made me feel worse, that’s further down the line....from a personal point of view I would have viewed medication as meaning I am not coping at all.” (Catherine)**

This may be due to media attention to medication, in particular antidepressants, and the suggested psychological addiction to and difficulties incurred in withdrawing from, as Andrea explained;

**“I didn’t want to take medication.... they haven’t had a good press....I didn’t want to take that chance.” (Andrea)**

#### **4.24 PERCEIVED STATE OF THE NHS**

**“I think that it’s a very positive thing for me to have done and I’m very lucky that I’ve had such good treatment on the NHS, I can’t quite believe it!” (Vanessa)**

Vanessa’s proclamation in describing her treatment sets the tone for much of the feedback received. Whilst positive data for the CBT service, implicit in this statement is general resignation to a variable standard of treatment available through the NHS. She continued;

**“My assessment appointment was about a month. I thought it would be a lot longer than that because you hear horror stories. He also referred me to a private therapist because we didn’t know how long it would be.” (Vanessa)**

There appears in the statement above that there is a greater chance of ‘being seen private’ than receiving the same treatment under the NHS umbrella. This perception of a tired and unresponsive organisation pervades the data; given the context of high profile additional investment that the NHS has luxuriated in, this is an intriguing phenomenon. According to official budgets the NHS has received historic levels of sustained growth in the five-year settlement plan announced in 2002 (DoH, 2005). In addition to this there is an average increase of 7.1% above the rate of inflation for the periods 2005-

06 and 2007-08 (DoH, 2005). Unfortunately for the CBT service this apparently pervasive attitude also questions the value of positive feedback; if the service is simply being viewed in context of such low expectations is it worthy of note? Matthew directly compares his experiences to other services.

**“I’ve had contact with mental health services in the past and you can wait an awfully long time and that can be despondent. So this was quite impressive in comparison to other services.”  
(Matthew)**

Gareth held a withering judgement of the general service expected from the NHS, articulated when questioned about his referral to the department;

**“I would have thought that people wouldn’t have bothered, ‘he’s just another number, just another statistic!’ ” (Gareth)**

Unfortunately Daphne also echoed these sentiments of being depersonalised when describing investigations into her condition by other services, which also strikes at the heart of formulating a trusting relationship considered as so important by interviewees;

**“I’ve seen a lot of doctors who just look down their noses and say ‘how very bizarre’; end of consultation. How can you build up trust with somebody who spends quarter of an hour looking at their watch or write everything down and low-and-behold the next time I get there they’ve forgotten who you are, what your problems are and they can’t be bothered looking at their notes and you’re going through the same process all over again. I’m thinking ‘why am I bothering’, I’m thinking ‘I’m just a number, just a piece of paper, just a folder in a file!’ ” (Daphne)**

This fear for Daphne translated to being so insignificant that it is easy for professionals to lose sight of the individual concerned.

**“I was frightened of being lost in the system, so I used to bully you into offering me more sessions. I was so frightened of going back into the system and someone forgetting about me.”  
(Daphne)**

It was not just the sense of a kafkaesque experience (1992, 2000) that exercised respondents' thoughts but also the perception of the NHS being under pressure, limited by finite resources, as Joanne and Gareth expressed;

**“What I’m thinking is ‘have I taken somebody else’s appointment?’ – who else is waiting, somebody could be worse than me, though I was pretty desperate.” (Joanne)**

**“I couldn’t wait for my follow-up appointment to come; I wanted it earlier, but didn’t want to deny somebody else from having their appointment. If I have my appointment it’s going to deny somebody else from having theirs.” (Gareth)**

For Daphne her experiences have merely reinforced a sense of disorganisation and lack of a decision making process;

**“They’ve decided to send me to that place, which is something you said over two years ago! They’ve got to write to each other and then write to my Doctor. I’m still being past from pillar to post! It’s frustrating that you came up with this within six weeks of seeing me and two years down the line they’re just deciding it. It’s disgusting.” (Daphne)**

It is interesting given the extra investment the NHS has received that opinions of this sort continue to permeate the consciousness of the CBT clients, though they appear representative of the wider public. MORI (2004) reported in their winter 2003 survey that public perceptions continue to lag behind user perceptions and this has been consistent for a number of years. The report also confirmed that there is a difference in the minds of the public between the ‘national’ health service that they hear and read about in the media and the ‘local’ health services which they and their family and friends use and are broadly positive about (Mori, 2004). Perhaps this is the key here; Clients of the CBT service may derive their impression of the NHS from the media and thus form a negative impression of services. When they come to utilise services they do not match their pre-conceived perceptions. The CBT service would be viewed as a ‘local health’ service as it is rooted within primary care with many clients seen at a GP practice, if not their own GP’s.

## 4.25

## PATIENT OR CLIENT?

It seems appropriate to conclude the data analysis where the literature search began. It was just by chance, on my fourth interview that I questioned a *client* as to her preference of address. Vanessa was sure which one she preferred.

**“Client always makes me think of business. Whereas patient, well, that I was ill!”**

*Which is more apt?*

**“I still think patient, it’s not nice to think of yourself as being unwell and needing help, but you have to face up to it, that I wasn’t very well and I did need help.”**

This short passage indicates the psychological aspect of viewing oneself as ill. This may be more of an issue in a short-term psychological service, where those being treated expect to move on quickly without the stigma of having a mental health label. Clearly the term ‘patient’ corresponds to receiving care, indicating ill-health, which for many may exacerbate the sense of alienation from the wider community.

This didn’t appear to chime with Vanessa as I then put the perspective that patient may give an image of a passive recipient of care whereas a client indicated a more collaborative relationship. Vanessa became more unequivocal in her judgement.

**“I didn’t see my treatment as passive. I wouldn’t have had the same confidence in you. Perhaps I do see myself as a sort of patient, because it’s believing that you can help me to get better; and rather than us working together, I feel that you know more than me so you’re going to help me; and if I didn’t feel like that and I felt like I was your client working together I wouldn’t have the same sort of confidence in you, the same, trust.” (Vanessa)**

Clearly for Vanessa the term patient and client were much more than semantics; it is not just about how *she* is perceived within the system but how she viewed herself, her therapist, and his level of competency. For Vanessa

a patient gets better and it is the practitioner that facilitates this 'healing process', a clinician with a greater knowledge base and experience. It was a matter of trust, a matter of confidence in the therapist. Also indicated in her assertion is that as the treatment itself was collaborative – “I didn't see it as passive” – the term patient was less problematic as the connotation of a passive recipient of care didn't apply. This reflects the discussion at the commencement of the data analysis on the therapeutic relationship and lack of perceived hierarchy.

Joanne and Louise reflected the sense of trust in and assistance from the therapist that Vanessa had expressed in deciding upon their preferred option. Certainly for Louise the matter appeared simplistic – she was treated and got better, therefore she *must be* a patient:-

**“I would say patient. I see you as a professional that knows what he's doing; I've got better so that makes me your patient.”  
(Louise)**

**“I prefer patient. I suppose I'm traditional like that, I'm coming to you for help and trust your judgement and opinion. Client doesn't feel right.” (Joanne)**

This sense of it being 'traditional' to be viewed as a patient acknowledges that there are differing titles for those treated within services and suggests that it may be outdated; though this isn't what she was driving at, similar to Vanessa the principle concept for Joanne was one of being assisted by someone with whom she has trust and confidence, somebody with a greater knowledge base. Tallis (1999) reflects this when he considers the term patient to capture what is 'positive about the special relationship between health workers and ill people'.

Matthew also made reference to the sense of tradition in his expression of preference and also introduced the notion of the 'client' being outside of the NHS and embodied Vanessa's conviction that client is the province of business.

**“A client to me is somebody in business, paying for a service. Perhaps I’m old fashioned, but I’d use patient, that’s what I prefer. Patient is somebody who is receiving medical treatment for either a physical or mental difficulty. The patient’s role is to be treated and in this particular case means having access to the information that is going to help him recover from his illness and using whatever methods are advised. I just see a client as being somebody outside the NHS, it’s a private situation.” (Matthew)**

Its interesting that for Matthew the role of the patient is ‘to be treated’, which brings us full circle to the connotation of the patient being a passive recipient of care. Although Matthew also acknowledges the ‘patient’s’ role’ in treatment as he states it, also entails the patient ‘using whatever methods are advised’, indicating an active role. It became clear as the interviews progressed that there appeared a strong preference for the term patient over that of client. For the clients of the primary care CBT service this term wasn’t viewed as having a submissive role as they viewed their therapy as collaborative. The term indicated a level of trust and confidence in the clinician that they worked with.

In their study McGuire-Snieckus et al (2003) found that the majority of psychiatric outpatients in a London Clinic preferred the term ‘patient’ though the study also found that there was no statistical difference in preference between the terms ‘client’ and ‘patient’ for those receiving treatment for psychological therapy. Tallis (1999) concurs that the term client is better suited to lawyers and also eschews the terms ‘customer’ and ‘consumer’ on the grounds that this relates more to a transaction, such as buying goods, which ‘erases the compassion and trust’ that exist at the heart of medicine between the patient and clinician. Crawford (2001) builds on this theme of trust in analysing the British Medical Association’s shift in recognising that a paternalistic approach to patient care is no longer viable and ought in stead be based upon a ‘partnership of mutual trust’ in which doctors should encourage patients to help decide treatment and care.

Perhaps Hodkiss (2000) has legitimacy in his assertion that there is no reason why the connotations of passivity cannot be dropped from the term patient as, he argues, patient participation and patient partnership are now

phrases in general usage. It is therefore time to modify my personal language and utilise the favoured term of all interviewees, that of patient. I had not previously enquired which term was preferred. I now know! The remainder of this dissertation therefore uses this term above that of client.

#### **4.26 General impressions of the service**

There was a number of comments made that did not appear to fit the previously identified themes. Each interviewee was asked their opinion on possible improvements to the service. I have accordingly selected a number of these and offer them as an indication of individuals' general perceptions;

**“Abiding memory is success and can I use this for something else? It was hugely successful for me.” (Gareth)**

**“It was very successful. I feel a sense of freedom because I can do these things. I gained a lot.” (Louise)**

The above comments relate to the modality of CBT, which for all patients interviewed was a positive experience and viewed as being efficacious, as attested;

**“Extremely successful, which surprised me because of the short period of time we saw each other.” (Matthew)**

**“I don't know if you can improve something that's been a success. The location has been fine, ideal, the times ideal because they've been jointly arranged. Why mess with it when it's not broken?” (Paul)**

**“I Have thought about it, I was very impressed and pleased. I can't think of anything.” (Sharon)**

**“No improvements needed. Everything was fine for me.” (Andrea)**

**“No, there aren't any. I think that the way that I received the treatment was good and I think that I was, as you say, at the hub of the service.” (Catherine)**

## **5.00**

# **CONCLUSION**

This final section attempts to make sense of the study in its totality, examining the research outcomes and implications for the service before exploring the study's veracity.

### **5.1 Research outcomes**

Much of the data revealed a favourable impression of the service and treatment process. It would appear that there was general satisfaction with the waiting time for appointments with eight out of ten patients considering their waiting time to be shorter than expected; of the two that considered their wait too long, both were within the department's standard and both waiting times were comparable to other interviewees.

Organisational issues such as appointment times, venue of treatment and therapist flexible approach were similarly viewed positively with a clear strand of collaboration emerging from the data. This collaboration mirrors the process of treatment itself and here the lines between a collaborative treatment process and a patient-centred service becomes fused. One inevitably feeds the other. However in terms of session contract it appears that this patient-centred approach was borne out of the therapists preparedness to flex guidelines rather than service-led initiatives.

It is illuminating that all patients interviewed had received more than their supposed six-sessions, indicating that this needs a clear review by managers of the service if clinicians' practice of extending treatment sessions is to be legitimised. This impacts upon the commissioning process and needs to be considered should the service contract be re-addressed. It is apparent that clinicians are negotiating their own contracts with patients of the service and remaining within recommended NICE guidelines. This was one of only three suggested improvements to the service.

**“You need a greater amount of flexibility for continuing treatment.” (Daphne)**

It appears that all interviewees were pleased with their progress throughout treatment. Every patient questioned focused upon the relationship with their therapist as being the most important aspect of treatment but also recognised the importance of the techniques they acquired and continued to utilise.

Louise and Daphne were the only patients who expressed the need for service improvements. Louise’s suggestion appears to be more related to her personal treatment rather than a service issue *per se*;

**“The appointments should be no longer than two-three weeks apart, because when you have achieved something, I wanted to talk to you about it, as I’d done it.” (Louise)**

In her comment Louise gives a flavour of having been excited by her advancements but disappointed at not being able to update her therapist of the progress made. It is understandable that she wishes to relate this information at the time of her achievement and perhaps the service needs to make it clearer that patients can contact the therapist or department whenever they need to, even to leave a message of achievement.

Daphne’s suggested improvement also appears to be personal to her treatment in the wider sense and links the sense of dissatisfaction with the NHS; That she trusted her individual therapist more than others involved in her care and would have preferred one central person to be facilitating and co-ordinating all necessary investigations, a comparable role to that of GP.

**“I don’t know how much push you have got. I would much have preferred if you could have sent me for x-rays and scans, and you make those decisions. I felt that I could trust you with anything and whatever you had decided I would have done.” (Daphne)**

## 5.2 Implications for the service

The study's implications for service change, in some respects, are limited due to the positive data obtained. However there are clear themes within the data that need to be incorporated into the 'system' in order for changes to occur; without this change the aims of the study, principally that of identifying possible improvements to service delivery, would be meaningless, as would therefore the study. However this complimentary data is not meaningless. Clearly the affirmations need relaying to the clinicians and administrative staff that play their part in service delivery. It is equally as important for clinicians to know when they are doing something well as it is for them to be aware when they get things wrong. Occasionally we can inhabit organisations that feel punitive in their approach to staff, this positive information when discovered can redress this skewed balance. It is not only the staff team that needs informing of this, but also the managers and commissioners of the service. As the service reaches its sixth anniversary it is cause for optimism that the team are getting so many things right. At a time when it appears that NHS trusts are under financial pressure and attention focused on areas of possible savings this positive information is evidence that should not go unnoticed as it stakes a claim to maintain the status quo. As one interviewee, Paul, stated "Why mess with it when it's not broken?"

All aims of the study had the objective of placing the patient at the centre of the service. In this respect it would appear that the service does just that, in that all therapists within the service operate collaboratively with patients, not just within treatment sessions, but in their general approach. This collaboration extends to the scheduling of appointments, venue of appointments and the number of treatment sessions engaged in. All patients considered that they were listened to and involved throughout the treatment process.

The clearest negative comments from the study, and thereby areas identified for possible modification arose in connection with details contained within clinical reports sent to patients and connected professionals, the number of

treatment sessions that the service currently restricts, and the terminology used for addressing patients. These issues need greater discussion within the department. In addition to this the data highlighted the import of treatment expectations in therapy. Whilst all patients benefited from treatment and extolled the therapists and treatment process it also became clear that the referrer's attitude to the therapist and treatment modality proved pivotal. All these issues, and the consequences upon the service are now discussed in greater depth.

Firstly, It is demonstrable that patients need to be made aware of what *may* be included in clinical reports. There is a clear need for patients to be consulted in the writing of their report, without compromising detail such as risk factors, which need to be conveyed accurately. This may be achieved by a greater dialogue with patients where this may be an issue and effective clinical supervision where deliberations may be explored in detail. It is quite innovative that the service provides reports routinely and this service characteristic should not be lost or go unnoticed due to a lack of collaboration at the stage of constructing the report. The function of patients receiving reports was to increase collaboration and commence the process of education regarding their particular disorder. From the data it was also transparent that patients valued their reports and the knowledge of its content. This practice needs to continue.

Secondly, the issue of treatment contracts proved contentious. It has been highlighted that in its conception the CBT service was designed to facilitate quick throughput of patients, thus lessening the probability of waiting lists for treatment. This was predicated upon the belief that psychological difficulties of short-term duration required less sessions and thus clinicians were limited to offering six treatment sessions. This number was not evidence based, rather it was a figure plucked from the ether to serve the purpose as described. Whilst it may be the case that some disorders require less therapy it is not always possible at point of assessment for the clinician to be definitive about the exact number of treatment sessions required, as occasionally problems are more entrenched than initially realised. This study

has argued for the flexibility in which the clinician and patient can come to an understanding regarding an appropriate number of sessions needed to complete treatment. It has been illustrated that all patients received more than the 'allowed' six treatment sessions. This flexibility has to become a recognised feature of the service and legitimised at the level of trust management level and inherent in the commissioning process. Only in this way can the clinicians move away from a sense of nefariously conspiring with patients, or openly challenging the system, to a feeling of legitimacy in acknowledging the need for greater scope in prescribing treatment sessions. This has obvious implications for planning of services, possible waiting lists for treatment and budgeting. Anecdotal evidence however informs one that despite this disregard for the session limit there has never been a waiting list for treatment in the six years that the service has operated. However experience also suggests that when there is pressure on the service clinicians become more aware of throughput issues.

The notion that it is more economical and saving of clinicians' time to offer fewer sessions can be viewed as spurious. Gareth was interviewed for the study and highlighted the fact that he was readmitted to the service due to needing more treatment sessions at time of his six-month follow-up session. It cannot be demonstrated that this would not have occurred had he been given more treatment at the time of his discharge; but it most certainly reduces the likelihood of that. The example triggers the debate and can also be viewed with an ethical dimension. Is it ethical to discharge individuals from treatment prematurely, resulting in increased distress to them and possibly their families?

Thirdly, it has been demonstrated that whilst the service works effectively with the patients of the department there is work to be done with the professionals that refer to it. The study emphasised the importance of treatment expectations in effective outcomes of therapy. Clearly some patients had a greater knowledge and expectancy than others; some had conducted their own research, others were better informed from their general practitioner. The department therefore needs to invest a greater amount of

time dedicated to the education of referrers, principally GPs, in explaining the modality of the treatment and how to 'sell' it effectively to the benefit of their patients. This again has implications for the service, as time invested here is also time away from clinical work, but may prove economical in the long-term.

Fourthly, the importance of language was again highlighted by the study. There has been a thrust within mental health services for some time to refer to individuals that engage in treatment as 'clients'. This is the term, since becoming a therapist that I favoured. However it is clearly not the term that these individuals prefer. There was an overwhelming case, articulately argued, in favour of the term patient. This term was viewed as more caring, indicating a professional with a wider knowledge base and experience. For some this also related to a sense of trust in the clinician. Client was unanimously viewed as the domain of business without a place in the clinicians' lexicon. It is therefore time that the service collectively recognised the wishes of the population that it serves and modifies, just as this dissertation has done, its language in adopting the term patient.

### **5.3 Limitations of the study and the research process**

I would like to reflect upon the research process and explore further my initial assumptions. Chapter three discussed the perceived limitations of qualitative research, in particular its validity and applicability to the wider field. I articulated my philosophical stance by asserting that a qualitative inquiry, adopting a relativist ontology and subjectivist epistemology would be best placed to uncover the multiple realities that may exist in the perception of the CBT service.

It is worthy of note that the relationship between the therapist and patient was seen as pivotal in the change process, yet just like qualitative research, it is seen to have less scientific credibility, due to inherent difficulties in quantification than evidence gleaned from psychometric measures espoused

to be positivist in nature. Yet the study has clearly illustrated the importance of this relationship along side the classic tools of cognitive therapy, such as thought records, behavioural experiments and homework assignments.

I am aware that the data obtained is a product of my interactions with the patients interviewed and as such accept that another researcher may have uncovered alternative viewpoints, as Rapley (2004) puts it 'in other interactions, with other questions other truths would emerge'. Obviously this prompts the question whether I would have formed a differing picture of the service had I asked alternative questions, or structured the study differently. The answer to both of these has to be yes, but as a constructivist I would argue the answers thrown-up from an alternative study would have no more validity than this. The data would have been for that time, with that method only. I was researching a local service, with an idiosyncratic operating system, findings are not easily generalised to other services, nor have I made any such claims.

As has been discussed earlier in the dissertation I held reservations regarding interviewing patients that I had worked with due to concerns regarding the integrity of feedback. I had been concerned that these individuals may give an overly positive gloss to their experiences as not to spoil the perceived relationship with me. However it transpired that the criticisms of the service that emerged during the interviews were from the patients that I had treated, not the others. It may well be a paradoxical effect where patients I worked with actually felt more comfortable, not less, to offer their true thoughts on the service. In addition to this the positive feedback that they did give was mirrored in all interviews and not particular to that subgroup of patients. This suggests that their experiences were consistent with the whole of interviewees, indicating validity of feedback.

There is scope however for extending a study of this nature; It would be interesting to interview the individuals that had discontinued treatment and establish the reasons for this. It may be that the treatment wasn't for them, that the therapist wasn't for them or due to service issues. Without

interviewing these patients the reasons will not be established. This process may be replete with sampling difficulties. In this study it proved difficult enough to recruit a satisfactory sample size, where patients viewed their treatment as positive. It is less likely that those who held a neutral or insouciant perspective would engage in a dialogue with the service that they had detached themselves from. The exception to this may be the patients that held an intense dislike for either a therapist, the process of therapy or service issues.

Clearly the patients interviewed had all completed treatment; treatment which they considered successful. Although the sampling procedure included all patients who had finalised a course of treatment within the past two years, no patient contacted the department where their treatment was deemed unsuccessful. Another study may be to specifically target these individuals and explore the perceived reasons for the lack of accomplishment. Again a study of this nature may run into achieving a satisfactory sample size, though this in itself should not dissuade the researcher.

Similarly reference was made to the limited breadth and depth in data related to service issues; this was perhaps due to the questions posed, the leads I chose to follow and perhaps the interpretations placed upon the data. On reflection however, once patients had discussed their treatment contract, venue of therapy and times of appointments it appears that there are not many other service issues that preoccupy their machinations. In its totality I believe that this study provides a good insight into a singular service and a psychological treatment, cognitive behaviour therapy. That the patients appeared happy with the service is clearly heartening news. That they considered their relationship with the therapist of primary importance should, on reflection, surprise no one.

## 6.0

## REFERENCES

Almond, P. (2001) What is consumerism and has it had an impact on health visiting provision? A literature review. **Journal of Advanced Nursing**, **35 (6)**, pp 893-901.

American Psychiatric Association (1987) **Diagnosis and Statistical Manual of Mental Disorders III edition (revised)** Washington DC.

American Psychiatric Association (1994) **Diagnostic and Statistical Manual for Mental Disorder (DSM) IV edition**: Washington DC.

Bachelor, A. (1995) Client's perception of the Therapeutic alliance: A qualitative analysis. **Journal of Counselling Psychology** **42 (3)** pp323-337

Barnes, M. and Shardlow, M. (1997) From Passive Recipient to active citizen: Participation in mental health user groups. **Journal of Mental Health** **6 (3)** p289-300.

Beck, A.T., Ward, C.H., Mendelson, M., Mock, J., and Erbaugh, J. (1961) An Inventory for measuring depression. **Archives of General Psychiatry**, **4**, pp561-571.

Beck, A.T. (1976) **Cognitive Therapy and The Emotional Disorders**. London: Penguin.

Beck, A.T., Rush, A.J., Shaw, B.F. and Emery, G. (1979) **Cognitive Therapy of Depression**. New York: The Guildford Press.

Beck, A.T., Epstein, N., Brown, G., and Steer, R.A. (1988) An inventory for measuring clinical anxiety: Psychometric properties. **Journal of Consulting and Clinical Psychology**, **56**, pp893-897.

Beck, A.T., and Freeman, A. and associates (1990) **Cognitive Therapy of Personality Disorders**. New York, London: The Guildford Press.

Beck, J. (1995) **Cognitive Therapy: Basics and Beyond**. The Guildford Press: New York. London.

Beck, J. (2005) **Cognitive Therapy for challenging problems**. New York: Guildford.

Bennett-Levy, J., Butler, G., Fennell, M., Hackman, A., Mueller, M. and Westbrook, D. (2004) **Oxford Guide to Behavioural Experiments in Cognitive Therapy**. Oxford: Oxford University Press.

Bertram, G. and Stickley, T. (2005) Mental health nurses, promoters of inclusion or perpetrators of exclusion? **Journal of Psychiatric and Mental Health Nursing**, **12**, pp387-395.

Bischoff, R.J., McKeel, A.J., Moon, S.M. and Sprenkle, D.H. (1996) Therapist conducted consultation: Using clients as consultants to their own therapy. **Journal of marital and family therapy** **22 (3)** pp359-379.

Bischoff, R.J. and McBride, A. (1996) Client perceptions of couples and family therapy. **American Journal of Family Therapy** **24 (2)** pp117-128.

Blackburn, I. and Davidson, K. (1995) **Cognitive Therapy for Depressions and Anxiety**. Oxford: Blackwell Science Ltd.

Bohart, A.C., O'Hara M., and Leitner, L.M. (1998) Empirically Violated Treatments: Disenfranchisement of Humanistic and Other Psychotherapies. **Psychotherapy Research**, vol 8, no2.

Bowling, A. (2002) **Research Methods in Health: Investigating health and health Services** 2<sup>nd</sup> edition. Buckingham: Open University Press.

Bryman, A. and Burgess, R.G. (1994) Developments in Qualitative Data Analysis: An Introduction. In Bryman, A. and Burgess, R.G. (Eds) **Analysing Qualitative Data**. London: Routledge.

Bryman, A. (2004) **Social Research Methods** 2<sup>nd</sup> edition. Oxford: Oxford University Press.

Bush, B. (2004) Mental health service user involvement in England: lessons from history. **Journal of Psychiatric and Mental Health Nursing**, **11**, pp313-318.

Campbell, P. (1996) The history of the user movement in the United Kingdom in Heller, T., Reynolds, J., Gomm, R., Muston, R., and Pattison, S. (Ed's) **Mental Health Matters**. Basingstoke: The Open University: Palgrave Macmillan.

Campbell, P. (2000) The role of users of psychiatric services in service development – influence not power. **Psychiatric Bulletin**, **25**, pp87-88.

Clark, D.M. and Fairburn, C.G. (Eds) (1997) **Science and Practice of Cognitive Behaviour Therapy**. Oxford: Oxford University Press.

Charmaz, K. (2002) Qualitative Interviewing and Grounded Theory Analysis in Gubrium, J. F. and Holstein, J. A. (eds) **Hanbook of interview Research: Context and Methods**. Thousand Oaks, Calif: Sage.

Chalmers, S. (1980) **What's this thing called Science?** London: Open University Press.

Cole, A. and Oxtoby, K. (2002) Patient Power. **Nursing Times**, 17<sup>th</sup> December, 98, pp22-25.

Coulter, A. (1999) Paternalism or partnership? **British Medical Journal**, 319: pp719-720.

Crabtree, J.W. and Miller, W.L. (Eds) (1992) **Doing Qualitative Research**. Newbury Park: CA. Sage.

Crawford, M. (2001) Involving users in the development of psychiatric service – no longer an option. **Psychiatric Bulletin**, 25, pp 84-86.

Crawford, M.J., Aldridge, T., Bhiu, K., Rutter, D. Manley, C., Weaver, T., Tyrer, P. and Fulop, N. (2003) User involvement in the planning and delivery of mental health services: A cross sectional survey of service users and providers. **Acta Psychiatrica Scandinavica**, 107: pp410-414.

Cresswell, J. W. (1998) **Qualitative Inquiry and Research Design, Choosing Among Five Traditions**. London: Sage.

Crotty, M. (1998). **The Foundations of Social Research**. London: Sage.

Davidson, J.R.T. and Meltzer-Brody, S.E. (1999) The under-recognition and under-treatment of depression: What is the breadth and depth of the problem? **Journal of Clinical Psychiatry** 60, pp4-9.

Department of Health, (1989) **Caring for People, Community Care in the Next Decade and Beyond** London: HMSO.

Department of Health, (1990 a) **The Care Programme Approach for People with a Mental Illness Referred to the specialist Psychiatric Services**. London: The Stationary Office.

Department of Health, (1990 b) **National Health Service And Community Care Act 1990** London: The Stationary Office.

Department of Health, (1991) **The Patient's Charter**. London: The Stationary Office.

Department of Health, (1997) **The New NHS: Modern, Dependable**. London: The Stationary Office.

Department of Health, (1999 a) **The National Service Framework for Mental Health: Modern Standards and Service Models**. London: The Stationary Office.

Department of Health, (1999 b) **Saving Lives; Our Healthier Nation**. London: The Stationary Office.

Department of Health, (2000) **The NHS Plan: A plan for investment, A Plan for Reform**. London: The Stationary Office.

Department of Health, (2001a) **Treatment Choice in Psychological Therapies and Counselling**. London: The Stationary Office.

Department of Health, (2001b) **The Expert Patient: A New Approach to Chronic Disease Management in the 21<sup>st</sup> Century**. London: The Stationary Office.

Department of Health, (2005) **Departmental Report: The Health and Personal Social Services Programmes**. London: The Stationary Office.

Dohery, T.L. and Horne, T. (2002) **Managing Public Services: Implementing Changes – A thoughtful Approach**. London: Routledge.

Douglas, J.D. (1985) **Creative Interviewing**. California: Sage Publications.

Eastman, N. (1999) Public Health psychiatry or crime prevention? Government's proposals emphasise doctors' role as public protectors. **British Medical Journal**, **318**, pp549-551.

Foucault, M. (1967) **Madness and Civilisation**: London: Tavistock.

Fox, J. (2003) Consumerism 1: The Different Perspectives within Health Care. **British Journal of Nursing**: March 13-26. 12, 5.

Freud-Loewenstein, A. (2004) In Search of madness. **American Journal of Psychotherapy**, **58**, **1**.

Garside, P. (1998) Organisational context for quality: Lessons from the fields of organisational development and change management. **Quality in Health Care** **7** (suppl) 8-15.

Geanellos, R. (2004) Nursing based evidence: moving beyond evidence-based practice in mental health nursing. **Journal of Evaluation in Clinical Practice**, **10**, (2) pp177-186.

Goldberg, D. and Huxley, P. (1992) **Common Mental Disorders: A Biosocial Model**. London: Routledge.

Goldberg, D. and Gournay, K. (1997) The General Practitioner, The Psychiatrist and The Burden of Mental Health Care. **Maudsley Discussion paper No1** Maudsley Institute of Psychiatry: London

Goodwin, N. (2002) Creating an Integrated public sector? Labour's plans for the modernisation of the English health care system. **International Journal of Integrated Care** vol. 2, March.

Gordon, N.S. (2000) **Researching Psychotherapy, the importance of the client's View: A Methodological Challenge**. The qualitative report vol 4 No 3 and 4 March 2000 <http://www.nova.edu/ssss/QR4-3/Gordon.html>

Gove, S. (1982) **Deviance and Mental Illness**. London: Sage.

Griffiths, R. (1988) **Community Care:- Agenda for Action**. London: The Stationary Office.

Gross, R.D. (1995) **Key Studies in Psychology**. London: Hodder & Stoughton.

Grossman, J. And Mackenzie, F.J. (2005) The Randomised Controlled Trial: gold standard, or merely standard? **Perspectives in Biology and Medicine**, **vol. 48, no. 4** (autumn 2005): 516-534. The John Hopkins University Press.

Guba, E.G. and Lincoln, Y.S. (1989) **Fourth Generation Evaluation**. Newbury Park, CA: Sage.

Guba, E.G. and Lincoln, Y.S. (1994) Competing Paradigms in Qualitative Research. In Denzin N.K., Lincoln, Y.S. (eds) **Handbook of qualitative research**. Thousand Oaks, C.A: Sage.

Ham, C. and Alberti, K.G.M.M. (2002) The medical profession, the public and the government. **British Medical Journal** vol. 324 6<sup>th</sup> April.

Hammersley, M. (1992) **What's wrong with ethnography?** London: Routledge.

Hammersley, M. and Atkinson, P. (1994) **Ethnography Principles in Practice** (2<sup>nd</sup> Edition) New York: Routledge.

Hansen, T., Hatling, T., Lidal, E. and Rudd, T. (2004) The User Perspective: Respected or rejected in mental health care? **Journal of Psychiatric and Mental Health Nursing**, **11**, pp292-297.

Hart, N. (1985) **The sociology of health**. Ormskirk: Causeway Press

Hawton, K., Salkovskis, P.M., Kirk, J. And Clark, D.M. (1989). The developments and Principles of Cognitive Behavioural Treatments. In: **Cognitive Behaviour Therapy for Psychiatric Problems, A Practical Guide**. Oxford: Oxford University Press, pp1-12.

Heller, T., Reynolds, J., Gomm, R., Muston, R., and Pattison, S. (1996) **Mental Health Matters**. Basingstoke: The Open University: Palgrave Macmillan.

Hewitt-Taylor, J. (2003) Issues involved in promoting patient autonomy in health care. **British Journal of Nursing**, vol **12**, no **22**, pp1323-1330.

Hodgkiss, A. (2000) User, Client or Patient: What do we call people receiving treatment for mental health problems? **Psychiatric Bulletin** (**24**), p441.

Holden W (1998) **Shell Sock: The psychological impact of war** Channel Four Books, London: MacMillan Publishing.

Hossack, A. and Wall, G. (2005) Service users: Undervalued and underused? **Psychologist**, **18**, **3**. pp134-136.

Howe, D. (1996) Client experiences of counselling and treatment interventions: A qualitative study of family views of family therapy. **British Journal of guidance and counselling** **24** (**3**) pp367-375.

Jones, L. (1996) George III and Changing views of madness (Chapter 15, pp121-131) in Heller, T., Reynolds, J., Gomm, R., Muston, R., and Pattison, S. (Eds) (1996) **Mental Health Matters**. Basingstoke: The Open University: Palgrave Macmillan.

- Kafka, F. (1992) **The Trial**. England: Everyman's Library Classics.
- Kafka, F. (2000) **The Castle**. England: Penguin Books Ltd.
- Kendell, R.E. (1996) The nature of psychiatric disorders. (chapter 3) (pp 17-26) in Heller, T., Reynolds, J., Gomm, R., Muston, R., and Pattison, S. (Eds) (1996) **Mental Health Matters**. Basingstoke: The Open University: Palgrave Macmillan.
- Kennedy, I. (2003) Patients are experts in their own field. **British Medical Journal** **326**: p1276-1277.
- Kernick, D. (2001) Lies, damn lies and health care outcomes. **British Journal of Health Care Management, Vol 7, No 1**.
- Kozart, M. (1996) A sociological perspective on the therapeutic alliance: Ethnomethodology and conversation analysis. **Psychotherapy** **33 No.3** pp361-371.
- Krauss, S.E. (2005) Research Paradigms and Meaning Making: A Primer. **The Qualitative Report. Vol 10 No 4**. <http://www.nova.edu/ssss/QR10-4/Krausws.pdf>
- Kvale, S. (1996) **Interviews: An introduction to Qualitative Research Interviewing**. London: Sage. Thousand Oaks.
- Lader, A. (1973) **The history of British Psychiatry from 1700**. London: Smith Kline.
- Lamont, S.S. (1999) Letters, **British Medical Journal** **vol 319**, p783.
- Layden, M.A., Newman, C.F., Freeman, A. and Morse, S.B. (1993) **Cognitive Therapy of Borderline Personality Disorder**. Massachusetts: Allyn and Bacon.
- Legard, R., Keegan, J., and Ward, K. (2003) In-depth interviews. in **Qualitative Research Practice: A Guide for Social Science Students and Researchers** London: Sage. (pp 138-169).
- Lester, H. And Sorohan, H (2003) Barriers and organisational development needs for effective primary care trust commissioning of mental health services. **Primary Care Mental Health, Vol 1**, pp 37-44.
- Lincoln, Y.S. and Guba, E.G. (1985) **Naturalistic Inquiry**. California: Sage.

Lott, D.A. (2002) Are studies misguiding the choice of first-line treatments? **Psychiatric Times, March, Vol XIX, Issue 3.** <http://.psychiatrictimes.com/>

Lythcott, J. and Duschl, R. (1990) Qualitative Research: From methods to conclusions. **Science Education. Vol 74,** pp449-460.

Maione, P.V. and Chenail, R.J. (1999). Qualitative Inquiry in Psychotherapy: Research on the Common Factors. In: MA Hubble, *et al* (Eds), **The Heart and Soul of Change: The Role of Common Factors in Psychotherapy.** Washington DC: American Psychological Association Press pp57-88.

Mangione, T.W. (1995) **Mail Surveys: Improving the Quality.** Thousand Oaks, Calif: Sage

May, T. (2001) **Social Research: Issues, Methods and Process** 3<sup>rd</sup> Edition. Maidenhead: Open University Press.

McLeod, J. (1998) **An Introduction to counselling** (2<sup>nd</sup> Edition). Buckingham: Open University Press.

McGuire, R., McCabe, R. and Priebe, S. (2001) Theoretical frameworks for investigating and understanding the therapeutic relationship in psychiatry. **Social Psychiatry and Psychiatric Epidemiology, 36:** pp557-564.

McGuire-Snieckus, R., McCabe, R. and Priebe, S. (2003) Patient, Client or Service User? A survey of patient preferences of dress and address of six mental health professions. **Psychiatric Bulletin 27:** pp305-308.

Melville, M. (1979) Consumerism: Do patients have Power in Health Care? **British Journal of Nursing 6** (6) pp337-339.

Meyer, B., Pilkonis, P.A., Krupnick, J.L., Egan, M.K., Simmens, S.J., and Sotsky, S.M. (2002) Treatment Expectancies, Patient Alliance, and Outcome: Further Analyses from the National Institute of Mental Health Treatment of Depression Collaborative Research Program. **Journal of Consulting and Clinical Psychology, Vol 70, No 4,** pp1051-1055.

Miller, G. and Silverman, D. (1995) Troubles talk and counselling discourse: A comparative study. **The Sociological Quarterly 36 (4)** pp725-747.

Mishler, E.G. (1979) Meaning in Context: Is there any other kind? **Harvard Educational Review 49,** pp1-19.

Mori (Market and Opinion Research International) Ltd (2004) **Public Perceptions of the NHS Winter 2003 for the Department of Health.** <http://WWW.mori.com/publications/bp/nhs-tracker>

Murphy, E., Dingwall, R., Greatbatch, D., Parker, S. and Watson, P. (1998) **Qualitative Research Methods in Health Technology Assessment: A review of the literature.** Health Technology Assessment. 2 (16)

Neuberger, J. and Tallis, R. (1999) Do we need a new word for patients? **British Medical Journal 318:** pp1756-1758.

NICE (2004a) **Depression: Management of depression in primary and secondary care, Quick reference guide,** Clinical Guideline 23. London: NICE

NICE (2004b) **Anxiety: Management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care, Quick reference guide,** Clinical Guideline 22. London: NICE

Noble, L.M. and Douglas, B.C. (2004) What users and relatives want from mental health services. **Current Opinion in Psychiatry 17:** pp 289-296.

Onyett, S. (1997) The Challenge of Managing Community Mental Health Teams. **Health and Social Care in the Community 5 (1)** pp40-47.

Padesky, A. and Greenberger, D. (1995) **Clinician's Guide to Mind over Mood.** New York: The Guildford Press.

Parahoo, K (1997) **Nursing Research: Principles, Process and Issues.** London: MacMillan.

Persons, J.B., Burns, D.D., and Perloff, J.M. (1988) Predictors of dropout and outcome in cognitive therapy for depression in a private practice setting. **Cognitive Therapy and Research, 12,** pp557-575.

Persons, J.B. (1989) **Cognitive Therapy in practice: A case formulation approach.** New York; London: W. W. Norton.

Phillips D. (1990) Post-Positivistic Science: Myths and Realities. In Guba E. (Ed) **The Paradigm Dialogue.** Newbury Park. CA: Sage pp31-45.

Rapley, T. (2004) Interviewing, In Seal, C., Gobo, G., Gubrium, J.F., and Silverman, D. (eds) (2004) **Qualitative Research Practice.** London: Sage.

Rennie, D. (1990) Toward a representation of the client's experience of the psychotherapy hour. In Lietaer, G., Rombauts, J. And Van Balen, R. (eds) **Client-centred and experiential therapy in the nineties**. Leuven University Press, Leuven. Belgium pp155-172.

Rennie, D. (1992) Qualitative analysis of the client's experience of psychotherapy: The unfolding of reflexivity. In Toukmanian, S. and Rennie, D. (eds) **Psychotherapy process research: Pragmatic and narrative approaches**. Newbury Park: Sage pp211-233.

Rennie, D. (1995) Strategic choices in a qualitative approach to psychotherapy research. In Hoshmand, L. and Martin, J. (eds) **Research as praxis: lessons from pragmatic research in therapeutic psychology**. N.Y. Teachers College Press.

Rhodes, R.H., Hill, C.E., Thompson, B.J. and Elliot, R. (1994) Client retrospective recall of resolved and unresolved misunderstanding events. **Journal of counselling psychology 41 (4)** pp473-483.

Richman, J. (1997) **Medicine and Health**. London: Longman.

Ritchie, J., Lewis, J. and Elam, G. (2003) Designing and Selecting Samples. In Ritchie, J and Lewis, J (2003) **Qualitative Research Practice. A Guide for Social Science Students and Researchers**. London: Sage.

Robson, C. (2002) **Real World Research 2<sup>nd</sup>** edn. Oxford: Blackwell Publishing.

Rogers, C. (1951) **Client-Centred Therapy**. Constable and Co Ltd: London

Rose, D., Fleischmann, P., Tonkiss, F., Campbell, P., and Wykes, T. (2004) User and Carer Involvement in Change Management in a Mental Health Context: Review of the Literature (revised edn). Report to the **National Coordinating Centre for NHS Service delivery and Organisation R&D**.

Rubin, H. J. and Rubin, I. S. (1995) **Qualitative Interviewing, the art of hearing data**. London: Sage.

Safran, J.D. and Segal, Z.V. (1990) **Suitability for Full-term Cognitive Therapy**. New York: Basic Books.

Salkoskis, P.M. (1996) (Ed) **Frontiers of Cognitive Therapy**. London: The Guildford Press.

- Silverman, D. (1985) **Qualitative Methodology and Sociology** . 1st Ed Aldershot: Gower.
- Silverman D. (1993) **Interpreting Qualitative data: Methods for analysing talk, text and interaction**. London: Sage.
- Smith, J. (1984) The problem of criteria for judging interpretive inquiry. **Educational Evaluation and Policy Analysis** 6, pp379-91.
- Smith, D. (1987) The limits of positivism in social work research. **British Journal of Social Work** 17: pp401-416.
- Stancombe, J. and White, S. (1997) Notes on the tenacity of therapeutic presupposition in process research: Examining the artfulness of blaming in family therapy. **Journal of family therapy** 19 (1) pp21-41.
- Sullivan, M. (2003) The new subjective medicine: Taking the patient's point of view on health care and health. **Social Science Medicine** 56: 1595-1604
- Szasz, T. (1971) **The manufacture of madness**. London: Routledge.
- Szasz, T. (1972) **The Myth of mental illness**. London: Paladin.
- Szasz, T. (1979) **The Myth of Psychotherapy**. New York: Open University Press.
- Szasz, T. (1998) The healing word: Its past, present, and future. **Journal of Humanistic Psychology**, 38 (2).
- Tallis, R. (1999) Do we need a new word for patients? **British Medical Journal** 318: 1756-1758.
- Tarrier, N., Wells, H., and Haddock, G. (1998) (Eds) **Treating Complex Cases: The Cognitive Behavioural Therapy Approach**. Chichester: Wiley.
- Todd, J., Bohart, A.C. (1999) Research in Psychotherapy in **Foundations of Clinical Psychology**. 3<sup>rd</sup> ed. Longman.
- Tomb D A (1994) The phenomenology of post-traumatic stress disorder **Psychiatric Clinics of North America :- PTSD Volume 17, No 2**, June pp 237-250.

Tomson D. And Shiers D. (2003) Primary care mental health: A new dawn. **Primary Care Mental Health vol 1, No 1** pp 5-8.

Waitzkin, H. (1990) On studying discourse of medical encounters . A critique of quantitative and qualitative methods and a proposal for a reasonable compromise. **Medical Care**, 28: pp473-88.

Watson, D.R. and Weinberg, T.S. (1982) Interviews and the interactional construction of accounts of homosexual identity. **Social Analysis 11: 56-78**.

Weedon, C. (1987) **Feminist Practice and Poststructuralist Theory**. M.A. Blackwell.

Wells, A. (1997) **Cognitive Therapy of Anxiety Disorders: A practice manual and conceptual guide**. Chichester: Wiley.

White, P. (2002) Power sharing is not a takeover bid. **British Medical Journal 324**, 7347, 214

Wilmot, S. (2003) **Ethics, Power and Policy: The Future of Nursing in the NHS**. Basingstoke: Plgrave:

World Health Organisation (1992) **International Classification of Diseases of Mental and Behavioural Disorders (ICD) 10<sup>th</sup> Edition**: Geneva.