An evaluation of, "A counsellor's experience of practicing in the context of NHS Primary Care: A heuristic exploration of external influences that could influence the therapeutic relationship".

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Abstract.

An evaluation of, "A counsellor's experience of practicing in the context of NHS Primary Care: A heuristic exploration of external influences that could influence the therapeutic relationship".

The original research was submitted as part of the Professional Doctorate in Counselling. This heuristic research was an exploration of the experiences of a counsellor practicing in the context of an organisation, a NHS Primary Care Trust. The research explored external influences that may possibly influence the therapeutic relationship. The researcher concluded that external influences to the therapeutic relationship do in fact have an effect on the therapeutic relationship either constructively thus benefiting therapy or detrimentally affecting the therapeutic process. The evidence from the research suggested that if therapists have an awareness of external influences to the therapeutic relationship this comprehension provides increased understanding of the therapeutic relationship thus improving therapist's competencies especially empathy. The research findings facilitated the researcher's existing avid interest in the role of empathy in therapy and in the development of empathic awareness within organisations and individuals.

An evaluation of the original research as an MPhil submission has encouraged the researcher to reflect on and analyse the original research comparing how the research literature has contributed to theory and knowledge pertaining to the delivery of psychological therapies in organisational contexts in particular an Improving Access to Psychological Therapy (IAPT) service. Due to the heuristic nature of the research, the researcher has reflected on the experience of conducting the research and evaluating the original research as well as the resulting further acquired knowledge and theory obtained by secondary heuristic process. The researcher has considered how this learning has had a positive influence, on professional practice and continual development as a researcher.

The researcher considered implications for further research including the utilisation of appropriate research methodologies. That would enable research in this subject matter to continue to be studied and researched in order to gain further comprehension of the theory and knowledge relating to external influences that influence the therapeutic relationship. The researcher suggests that this would concurrently inform organisational provision of therapy and the professional practice of individuals who provide psychological therapy practice within an organisational context. The thesis contribution to the development of appropriate innovative research methodologies has been evaluated.

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CHAPTER 3. CONCLUSION

APPENDICES.

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CHAPTER 1. INTRODUCTION TO MPHIL.

1.1 Overview of the thesis.

Chapter 1 is the introduction chapter of this MPhil thesis whereas Chapter 2 is the original submitted research (Gavaghan, 2009) in the original format, and Chapter 3 consists of a comprehensive conclusion.

The MPhil thesis, examines previous assignments submitted as part of the Professional Doctorate Programme (Gavaghan, 2009). I have referred to the original research Gavaghan (2009) throughout this MPhil thesis in order to elucidate the difference between the Professional Doctorate Programme thesis (Gavaghan, 2009) and this MPhil thesis. I am aware that the third person style may distance myself as the author and may not be considered congruent with my heuristic approach (Moustakas, 1990) or heuristic self-search inquiry (Sela-Smith, 2002) that advocate writing in the first person, such as "*I who feels*" Sela-Smith (2002). Gavaghan (2009) is written in the first person as a heuristic study whilst the MPhil thesis is an evaluation of Gavaghan (2009).

Gavaghan (2009) was a heuristic exploration of external influences that could influence the therapeutic relationship in the context of NHS Primary Care. I have reviewed the background and context of Gavaghan (2009) as well as the rationale of the research. I have also evaluated my learning, professional and personal development resulting from the undertaking of Gavaghan (2009) and considered the subsequent feedback comments from the examiners (Appendix: 1). I analysed Gavaghan (2009) comparing how my original research has contributed to the theory and knowledge relative to the delivery of psychological therapies in organisational contexts, in particular an Improving Access to Psychological Therapies (IAPT) service. (Annex: 2. contains information regarding IAPT services).

The heuristic nature (Moustakas, 1990) of Gavaghan (2009), facilitated my ability to reflect on the experience of conducting the research assignments and in evaluating Gavaghan (2009). The experience of examining Gavaghan (2009) and re-evaluating the heuristic process involved in the original research promoted further spontaneous

heuristic process. As I re-examined each section of Gavaghan (2009) the heuristic research process moved backwards and forward through the phases of the heuristic research process (Moustakas, 1990) facilitating total "*immersion"* and further heuristic process that initiated new emerging findings concurrently expanding my knowledge and understanding as well as confirming original depictions by means of triangulation. Due to the limitation and scope of the MPhil thesis, I have included relevant new emerging findings within annexes and guided the reader to relevant annexes. According to Fielding and Fielding (1986) triangulation enhances a researcher's comprehension of the phenomenon and Guba (1981) advocated the use of data obtained from documents and other method to validate research.

The process of completing the MPhil has enabled me to demonstrate how the original research has had a positive influence, on my personal development, professional practice and continual development as a psychological therapist and researcher as well as contributing to the knowledge base of theory and knowledge within the context of providing therapy within an organisational context.

I have considered implications for further research relating to external influences to the therapeutic relationship within an organisational context. That would enable research to continue in order to gain further comprehension of the theory and knowledge that would inform organisations provision of therapy and the professional practice of individuals who deliver therapy within an organisational context. I have deliberated on contribution to the development of appropriate innovative research methodologies pertaining to this area of research.

I have referred the reader to supplementary information contained in annexes that provides further understanding of theory and knowledge that augments this MPhil. This information is from completing Gavaghan (2009) and secondary heuristic processing (Moustakas, 1990) during the MPhil process.

1.2 Overview of chapter 1.

The introduction chapter of the MPhil thesis provides the reader with a background, context and rationale for the initial assignment (Gavaghan, 2009).

This chapter also takes account of the choice and appropriateness of the qualitative heuristic research methodology and the underlying philosophical basis underpinning this methodology. Additionally, I have deliberated on the rationale of selecting a qualitative approach to methodology rather than a quantitative methodology. The strengths and limitations of heuristic research (Moustakas 1990) including the validity of the heuristic research methodology are also considered in this chapter. The background and context of the research topic provides a rationale for the research questions that emerged. These facilitated the stages of heuristic research and the heuristic process (Moustakas, 1990). (The stages of heuristic research are covered in additional detail in Annex: 1).

1.3 Experience of research and training.

As part of the MA programme at Durham University (Gavaghan, 2002) I completed training in research, which included; research methodologies, collation of research data, research design, appropriate methods for generating and collecting data, the principles of data analysis, ethical research and ethical considerations to research, as well as the creation of research proposals. I completed the taught part of the Professional Doctorate in Counselling programme at Manchester University, which incorporated elements of research training. I attended additional research training and research seminars and conferences as part of my continual professional development as well as read substantial literature on the subject of research and methodologies.

I completed a Post Graduate Diploma (PGDip) in High Intensity Psychologically Therapies (CBT) at Newcastle University in 2010. A considerable amount of the course content was reading academic and medical research papers primarily quantitative in nature, and then debating in group seminars and tutorials. Consequently, training was provided in order to facilitate understanding of the methodologies underpinning the academic literature. Experience of qualitative research (Gavaghan, 2002, 2009) improved my ability to contribute meaningfully in academic debates. I was able to be the "*devil's advocate*" engaging others in a constructive argumentative discussion identifying potential limitations to the research

and questioning the reliability and validity whilst encouraging colleagues to be open-minded and unbiased by considering other research methodologies rather than only qualitative methodologies. Gavaghan (2002, 2009) and learning from the DGDip facilitated my academic writing in a coherent accepted academic style. I was also able to effectively analyse and interpret relevant research literature of both qualitative and quantitative methodologies

1.4 Choice and appropriateness of the methodology.

The methodology of Gavaghan (2009) is "*heuristic research"* (Douglass and Moustakas, 1985; Moustakas, 1967, 1990, 1994, 2001). I have also considered the studies of Patton (2002) *"heuristic inquiry"* and Sela-Smith (2002) "*Heuristic Self-Search Inquiry"* (HSSI). The term '*heuristic'* originates from the Greek word heuriskein, meaning to discover or to find and "*it refers to a process of internal search through which one discovers the nature and meaning of experience*" (Moustakas, 1990, p. 9).

Douglass and Moustakas (1985) define heuristic research as a search for the discovery of meaning and essence in significant human experience that illuminates a focused problem, question, or theme. I consider heuristic research (Moustakas, 1990) to be the most appropriate choice of methodology since it corresponds with my natural personal quest for increased self-awareness and my self-reflective approach and use of reflexivity as a therapist and researcher. I also considered Sela-Smith (2002) critique of heuristic research (Moustakas, 1990) especially Moustakas resistance and avoidance of his loneliness (Moustakas, 1961). Sela-Smith (2002) suggested that Moustakas research focus shifted from the experience of self to focusing on the idea of the experience. I endeavoured to be aware of any resistance in myself during the heuristic research process.

The examiners comments (Appendix: 1) relating to Gavaghan (2009) citing that I should have commented further on the differences between reflexivity and self-reflection. This suggestion encouraged further self-reflection in which I discovered being reflexive is not a straightforward matter. I have incorporated the discussion of

reflexivity and self-reflection in this chapter, conscious of emphasising the differences.

Schon (1987) described how professionals could use reflection as a method to develop their practice also describing that it is possible to gain tacit knowledge implicit in our actions and experiences through a process of observation and reflection. I have always considered my enthusiasm to reflect on my 'self' and experiences to be an essential aspect in the development of professional practice and research. Nonetheless, I have became more conscious that self-reflection is a method of personal and professional development and relates to the 'self' as a means of improving future professional practice through a retrospective analysis of experiences or actions. Moreover, self-reflection influences the development of reflexive practice that involves more intense introspection, reflecting upon one's own views, beliefs and experiences while considering how these might affect professional practice and research. The reflexive process involves a concentrated inward searching into every interaction and experience. The reflexive process requires "*interactive introspection*" (Rothman, 1997) as an instrument to improve interactions and comprehension of experiences by evaluating behaviour, thoughts, emotions, and feelings within a context.

Reflection occurs after an interaction when I reflect on the experience. In order for me to be reflexive, I investigate experiences via introspection into each interaction as they occur spontaneously.

I concur with Schön (1983, 1987) concept of reflective practice who argued that reflection is a critical underpinning of growth and learning. I also suggest that therapists who endeavour to become reflexive practitioners will develop their reflective practice due to the positive impact on personal and professional development but also reflexive practice encourages critical deep introspection hence facilitating enhanced, personal development growth and change as well as conceptualisation and improvement of 'self' and subsequently professional practice.

Reflexivity has become an accepted aspect of qualitative social science research and is commonly used in qualitative research and is accepted as a method where

qualitative researchers can validate their research (Cutcliffe, and McKenna, 2002; Pillow, 2003; Etherington, 2004; Kingdon, 2005). The development of the significance of reflexivity may be associated with the paradigmatic changes that relate to modern cultural, social, and economic developments. Indeed, Etherington (2004) associates reflexivity with the researcher's capability to identify how their own experiences and contexts, including the social and cultural, and economic inform processes and conclusions. Etherington (2004) defines reflexive practice as;

> *"To be reflexive we need to be aware of our personal responses and to be able to make choices about how to use them. We also need to be aware of the personal, social, and cultural contexts in which we live and work and to understand how these impact on the way that we interpret our world."* (p. 19).

I agree with Etherington (2004) who said that counsellors develop reflexivity as a skill and gain an ability to notice their responses to the world, other people and events and then use that knowledge to inform actions, communications and understandings. I have always been an innate self-reflector persistently self-questioning, evaluating, developing, and improving my self-awareness, which has facilitated my reflexivity. McLeod (2001) describes reflexivity as a continuous process of the researcher '*turning back*' awareness on their self. I recognise that critical self-reflection is an essential aspect of my professional practice and research because it promotes my reflexivity and enhances my professional and personal development as a therapist and researcher. Sandelowski and Barroso (2002) advocate that a researcher whom is both reflective and reflexive demonstrates characteristics for excellent qualitative research.

Moustakas (1967, 1990) introduced the use of 'self' as an instrument in the research process. Heuristic research (Moustakas, 1990) embraces and utilises my natural self-reflective and reflexive qualities in a manner described by Ethrington (2004) who said that reflexive methodologies appear to be associated with practitioners who value transparency in relationships and the use of their selves in all areas of their practice including research. Guba and Lincoln (2008, p. 278) emphasise the heuristic nature of reflexivity depicting self-reflection as, *"a conscious experiencing of the self as both inquirer and respondent, as teacher and learner, as the one coming*

to know the self within the processes of research itself". I concur with Savin-Baden (2004) that the skill of reflexive practice in an individual's research is paramount because it assists in situating oneself in relation to the data, thus encouraging the data to be explored further to understand how these experiences may relate to a broader context.

The philosophical core of my therapeutic approach is Rogerian (Rogers, 1951, 1957, 1959, 1961,). I integrate other therapeutic approaches nevertheless remain true to the person-centred Rogerian philosophical foundation. I believe that my chosen heuristic methodology (Moustakas, 1990) is appropriate as it has similarities to the philosophy and process of person-centred therapy.

Heuristic research (Moustakas, 1990) is consistent with my modality of psychological therapy in particular the interrelationship with the therapeutic relationship. Means and McLeod (1984) acknowledge the importance of the professional relationship between the researcher and participant when using a person-centred approach to research. McLeod (2001, p. 82) states that, "*The richness and relevance of findings may depend more on the quality of the relationship between researcher and informant than it does on the rigour of the analysis of the data".* O'Hara (1986) and Barrineau and Bozarth (1989) in studies of human science inquiry concluded that Rogers core conditions (Rogers, 1957) are essential for person-centred therapy as well as consistent with the concepts of qualitative research and a foundation for heuristic research (Moustakas, 1990). Barrineau and Bozarth (1989, p. 470) describe the similarities of heuristic research and the person-centred modality of therapy as;

> "*The similarities of application of the core conditions of the person-centred approach between the person-centred therapist and the heuristic researcher are obvious. There are few differences in the fundamental stance of the therapist and researcher. The stance of the researcher is an empathic attitude accompanied with the attitudinal values of genuineness and unconditional positive regard that are the core of person-centred therapy".*

O'Hara (1986, p. 174) cites conclusions regarding the interrelationship with heuristic research and the therapeutic relationship,

> *"In the dialogical process of client-centred therapy, both therapist and client become engaged in a joint study of the rich and mysterious world of the client. Client-centred therapy, is, itself, a heuristic investigation into the nature and meaning of human experience"*

The sharing of power in the therapeutic relationship is associated with the philosophy of the modality of Rogerian therapeutic approaches, (Rogers, 1951, 1957, 1959, 1961, 1978; Thorne, 1992; Raskin, 2004a, 2004b; Mearns and Cooper, 2005; Mearns and Thorne, 1988, 1999, 2000; Mearns et al. 2000, 2013). I also believe that the therapeutic relationship ought to be characterised by equality with therapists striving to share power with the client, thus establishing and maintaining an equal relationship. This concept is comparable to the relationship between the researcher and participant in heuristic research Moustakas (1990) uses the term co-researcher to describe people participating in the research.

I deem that my heuristic approach to research is congruent with me as a person and as the researcher. I concur with Etherington (2004, p. 71) *"When setting out on any research journey I need to find ways of working that fit with who I am"*. I sought to participate in research that focused on my personal experiences and allowed me to reflect on my 'self' a method of research that was congruent with my individual being and would evoke feelings of exhilaration and anticipation regarding the process of research and in what I may discover.

I selected a qualitative research method to explore the complex empirical data of the phenomenon that would be unattainable via quantitative research methodologies (Moustakas, 1990, 2001; McLeod, 1999, 2003, 2010, 2011; Woolfe, 2003; Denzin and Lincoln, 2011; Silverman, 2013). I deliberated that my research would have emphasis on the subjective perspective. Reason and Rowan (1981, p. 217) cited Rogers (1964) thoughts pertaining to the presuppositions of the behavioural sciences,

> *"It would be a very healthy emphasis in the behavioural sciences if we could recognise that it is the dedicated, personal search of a disciplined, open-minded individual which discovers and creates new knowledge. No refinement of laboratory or statistical method can do this."*

I consider myself self-reflective, reflexive, and open-minded yet disciplined according to Moustakas (1990) who states that the researcher should seek to understand the wholeness and the unique patterns of experiences in a scientific organised and disciplined manner. In addition, I agree with Wilkinson (1998) who summarises the meaning of reflexivity as disciplined self-reflection and Kvale and Brinkmann (2009, p. 242) whom consider reflexivity as *"striving for objectivity about subjectivity*". In order to have disciplined self-reflexivity I argue that one must also have a developed insightful self-awareness. In heuristic research, I explore my inner 'self' and my personal experiences thus facilitating further discoveries; this process enhances my self-awareness, self-knowledge and consequently self-development. The process of self-actualisation and personal growth (Rogers, 1961) experienced by a client is comparable to my journey of discovery as a heuristic researcher. Moustakas (1990, p. 13),

> *"In the process, I am not only lifting out the essential meanings of an experience, but I am actively awakening and transforming my own self. Self-understanding and self-growth occur simultaneously in heuristic discovery."*

Hanley et al. (2013) recommended that a "*good fit*" should be present between the research question and the chosen methodology. I consider that my choice of methodology corresponded appropriately with the research question and consequently produced rich deep data. Maxwell (2005) acknowledges that the research question moulds the research design providing guidance on how to conduct the study, as different types of research questions require different methodologies. I concur with Hanley et al. (2013) that the research question is at the core of any research project because the question provides insight into the appropriate chose of research methodology. I therefore made an informed decision to adopt a

methodological approach to, "*meet the needs of the question posed, not the needs of the person doing the research."* (Hanley et al. 2013, p. 104). I consider heuristic research (Moustakas, 1990) to be my favoured methodology however, the research question determined the choice of methodology, not my preferred choice of methodology.

Maxwell (2005) said that the research question focuses the research and Hanley et al. (2013) state that research question holds the research together in terms of what is included in the literature and how one presents and makes sense of the findings. The choice of research anchored me to the purpose of the research during the complex heuristic process (Moustakas 1990).

I have explored my choice and appropriateness of my methodology. The results of this exploration accentuates the affiliation between my therapeutic approach to therapy and heuristic research and also how heuristic research has a correlation with my self-reflective and reflexive approach as a person, a therapist, and as a researcher. I have also argued that a qualitative research method would enable an exploration of the complex empirical data of the phenomenon that would be unattainable via quantitative research methodologies. I therefore considered heuristic research (Moustakas 1990) to be the most appropriate choice of methodology. Schwandt (1997) defined methodology as the theory of how inquiry should proceed. Consequently, the term methodology describes the theoretical assumptions, underlying philosophical basis, guiding principles, and strategies that inform the research process.

1.5 Underlying philosophical basis.

> *"When setting out on any research journey I need to find ways of working that fit with who I am: my underlying values, philosophies on life, my views of reality and my beliefs about how knowledge is known and created."*
> *(*Etherington, 2004, p. 71)

I concur with Etherington's (2004) and have already proposed how heuristic research correlates with who I am as a person. When contemplating the appropriateness of research methodology it is therefore essential to understand the underlying philosophy of the research method. Research accomplishes internal consistency when the chosen methodology is coherent with the philosophical perspective on which the research is based and correlates with the researchers underlying values, philosophies on life, and views of reality as well as the person's beliefs about how knowledge is known and created. I consider that Gavaghan (2009) attains this criterion moreover; I propose to validate this claim.

Epistemology constitutes valid knowledge and how knowledge is obtained, whereas ontology is what comprises reality, and how we understand existence. Epistemology and ontology consequently underpin the theoretical perspective and methodology.

The researcher's theoretical orientation is part of epistemology, which, in turn, inserts into a bigger framework called "*paradigm"*. Guba and Lincoln (1994) define "*paradigm*" as "*the basic belief system or worldview that guides the investigator, not only in choices of method but in ontologically and epistemologically fundamental ways"* (p. 105). Guba and Lincoln (1994) also emphasise that paradigms are *"human constructions, that is, they are all inventions of the human mind and hence subject to human error"* (p. 108). A paradigm consists of three elements, epistemology, ontology and methodology. Epistemology refers to the researcher's knowledge base of how people know the world consisting of their assumptions, beliefs, and knowledge of reality. Epistemology also provides the prerequisite and the validation for using certain methodologies in research. Ontology pertains to the form and nature of reality and existence that defines '*reality'* for the researcher. Methodology endeavours to answer the question of how people gain knowledge about the world. Accordingly, epistemology, ontology and methodology function as the conceptual and theoretical background knowledge for conducting research and form the foundation that underpins the '*methods'* which are the pragmatic procedures, tools, and techniques employed for data collection and analysis.

The process of knowing involves making use of practical methods that are derived from an epistemology, which is consecutively grounded in ontology. Decisions

regarding research by qualitative researchers such as chosen methodology, or ways of collating and analysing data can only be determined by resorting to underlying epistemological and ontology principles. An awareness of philosophical issues is vital to the heuristic researcher because heuristic research does not constitute a fixed agreed method but keeps changing in response to individual, social and cultural circumstances.

Methodology, epistemology and ontology are interrelated as indicated in the following questions. *'What is the form and nature of reality?'* is an ontological question in which I answered, 'There is no objective meaning to reality'. The epistemology question, '*What can be known*?' The answer to this question is influenced by the answer to the ontological question, my answer therefore is, 'There is no inherent in reality any meaning in life is a human creation influenced by social and cultural factors'. The final question, the methodological question, '*How can the researcher go about finding out whatever he believes can be known*?' This question is constrained by the answers of the ontological and epistemology questions since not just any choice of methodology can be appropriate. My theoretical orientation or epistemological standpoint coherently influences the choice of methodology, which, in turn, also determines the selection of appropriate methods. My chosen heuristic methodology is consistent with the following perspective of reality (ontology) and knowledge (epistemology) according to Lynch (1996, p.46).

> *"The purpose of such research is not to enable us to know the objective truth about reality (as there is none) but to give us descriptions and explanations of reality that help us to go on, that help us to live in ways that we find meaningful and purposeful."*

I believe that by developing an awareness of philosophical issues attains consistency between practical method as well as epistemological and ontological concepts, therefore rather than the methodology question just be converted into a question of methods. I concur with Guba and Lincoln (1994,p.108) who state that; *"Methods must be fitted to a predetermined methodology.*" (Gergen (1994) states that qualitative research is derived from a social constructionist standpoint. I agree with Gergan (1994) because this perspective regards the reality we experience as

created by the actions, beliefs and culture of the particular social context in which we live. In this view, no knowledge is truly objective; there is no single objective truth but instead a variety of local truths or realities. A specific social group or cultural group may see knowledge as objectively true because that group believes that particular piece of knowledge to be true. McLeod (1999, p. 22) acknowledges this viewpoint,

> *"There are therefore multiple realities, reflecting the interests and worlds of different cultural groups. Moreover, it is important for the researcher to locate himself or herself within their own cultural tradition."*

I conducted my research within the culture of the NHS and with participants that included NHS staff and therapy clients from the same NHS cultural background. Nevertheless, I was mindful of the social constructionist concept because many sub-cultures exist within the culture of the NHS thus the potential for various local truths and realities. I endeavoured to produce plausible descriptions and explanations of my experience as a counsellor employed within the NHS. The person-centred counselling belief of existence is compatible to my research methodology and person-centred counselling emphasises the manner in which people create meaning through the way in which they interpret their world and does not make claims about any objective truth.

The essential instrument of the heuristic method of research (Moustakas 19990) is the actual researcher who is engaged in a process of constructing knowledge, aware that there is no one truth. I judge myself a reflective agent in a manner described by McLeod (2001, p. 190) *"Qualitative research is rooted in a philosophical stance characterised by relativism, an image of the person as a reflective agent, an image of the researcher as involved."*

As a heuristic researcher, I embrace relativism and believe that points of view have no absolute truth or validity but only relative, subjective value. Ultimately, the research depends on the capacity of the researcher to struggle with the task of knowing. To be a proficient heuristic researcher I believe I need to have a philosophical understanding of the nature of knowing in order to provide an authentic

description of my experience. The outcome of my research is not to produce objective knowledge but to assist me to reflect upon and conceptualise my experiences and to facilitate my search to establish descriptions and explanations that will assist me to exist with a sense of meaning and purpose. I agree with Lynch (1996. p. 146) who states, *"There is no objective meaning to reality; all meaning is a human creation influenced by social and cultural factors."*

I have considered the underlying philosophical basis of heuristic research (Moustakas 1990, 1994) and I regard that my choice of research achieves internal consistency, for the reason that the methodology is coherent with the philosophical perspective on which the research is based. The research methodology also correlates with my underlying values, philosophies on life, and my views of reality as well as my beliefs about how knowledge is known and created. I believe as a qualitative researcher using heuristic research I need to have a philosophical understanding of the nature of knowing as this informs the process of knowing that involves the use of practical methods that are derived from an epistemology, which is consecutively grounded in ontology. Creswell (1998) claims that heuristic research may be a difficult process for inexperienced researchers as the researcher must have a reliable knowledge of the philosophical basis of heuristic methodology. I contend that I have knowledge of the underlying philosophical basis of heuristic research and that I have conducted heuristic research previously (Gavaghan, 2002).

I studied the philosophical development of heuristic research (Moustakas, 1990, 1994) and the underlying philosophical basis. Moustakas (1994) defines heuristic research as phenomenological and cites the philosophical influence of phenomenology and hermeneutics in the development of heuristic research (Moustakas 1990, 1994). Moustakas was inspired by German philosopher, Edmund Husserl. Vandenberg (1997, p.1) regarded Husserl as *"the fountainhead of phenomenology."* Husserl named his philosophical method "*phenomenology*" the science of pure phenomena (Eagleton, 1983, p. 55). Husserl rejected beliefs that objects in the external world exist independently and disputed that information about objects is reliable, instead he argued that people can be certain about how things appear in, or present themselves to, their consciousness (Eagleton, 1983; Fouche, 1993). To arrive at certainty, anything outside immediate experience must be

ignored; therefore, the external world is reduced to the contents of personal consciousness. Realities are thus treated as pure phenomena and the only absolute data from where to begin. Moustakas, (1994, p. 26) proposed that the aim of phenomenology is the return to the concrete, to the beginning, encapsulated by the adage "*back to the things themselves.*" Eagleton (1983) and Kruger (1988) suggested a similar perspective.

The phenomenological paradigm including heuristic research for exploring reality refutes the existence of an objective reality but believes in multiple realities each a social construct of the human mind (Kane and O'Reilly-de-Brún, 2001). Meaning is created when the object as it appears in our consciousness, mingles with the object in nature. Moustakas (1994, p. 27) describes this process as, "*what appears in consciousness is an absolute reality while what appears to the world is a product of learning.*" Moustakas (1994) considers the theoretical underpinnings of phenomenology embracing the common features and qualities of human science. Qualitative research including hermeneutics, phenomenological and heuristic research, particularly focus on the wholeness of experience and a search for essences of experiences, as well as viewing experience and behaviour as an integrated and inseparable relationship. Wertz (2005, p. 175) summary of phenomenological research illustrates similarities to that of heuristic research

> "*Phenomenology is a low-hovering, in-dwelling, meditative philosophy that glories in the concreteness of person-world relations and accords lived experience, with all its indeterminacy and ambiguity, primacy over the known."*

Gadamer (1976) influenced Moustakas view of hermeneutics. According to Moustakas (1994,) hermeneutics involves the art of reading text or experiences in such a way that the intention and meaning behind the appearances are understood. Therefore suggesting that reflective interpretation of the text is required in order to achieve a fuller more meaningful understanding an enlightenment what Gadamer (1976, xviii) describes as, *"something that otherwise happens behind my back."* Fundamentally, hermeneutics aspires to identify method through which experience and understanding of a phenomenon being researched can act as a connection to enlighten and interpret the phenomenon's meaning (Titleman, 1979).

I acknowledge Moustakas (1994) perspective that heuristic and phenomenological, hermeneutic research have common qualities nevertheless I considered heuristic research (Moustakas, 1990) to be the most appropriate methodology in order to explore fully my research questions.

Douglass and Moustakas (1985) comparison of heuristic research with a phenomenological research approach assisted me to decide on heuristic research. According to Douglass and Moustakas (1985), heuristic research accentuates connectedness and a relationship with the research while phenomenology encourages a detachment from the phenomenon. The areas of my research are personal and I feel that I would only be able to relate subjectively. Douglass and Moustakas (1985) argued that phenomenology sanctions the researcher to conclude definitive descriptions of the experience whereas heuristic research produces depictions of essential meanings and portrayals of personal significance attempting not to have definitive meaning, which is more appropriate to my underlying philosophical foundation. Douglass and Moustakas (1985) said that heuristic research involved reintegration of derived knowledge itself an act of creative discovery, a synthesis that includes intuition and tacit understanding. This aspect of heuristic research excited me to endeavour to unchain the door to reality, in an area of flux and conditioned phenomena. In comparison, Douglass and Moustakas (1985) suggested that phenomenological research usually concludes with a presentation of the refined structures of experience. Phenomenology loses the person in the process of descriptive analysis and ends with the essence of experience; in heuristic research, the researcher remains visible in the exploration and examination of the data and retains the essence of the person in experience (Douglass and Moustakas, 1985).

In summary, I choose heuristic methodology because it attempts to discover the nature and meaning of phenomenon via internal self-search, exploration, and discovery. Heuristic research encourages the researcher to explore and follow a creative journey that commences inside one's being and eventually uncovers its direction and meaning through internal discovery (Douglass and Moustakas, 1985).

Gaining further comprehension regarding the philosophical development of heuristic research (Moustakas, 1990) and by investigating phenomenological and hermeneutics research has enhanced my knowledge of the underlying philosophical basis of my chosen methodology heuristic research.

1.6 Considering a quantitative or qualitative methodological approach.

Osborne (1992) proposes that heuristic research is a descriptive philosophy of experience. My research was enthused by my experiences as a counsellor practicing within the NHS and an aspiration to construct meaning around these experiences. I selected heuristic research a qualitative research methodology to explore the complex empirical data of the phenomenon that I considered would be unattainable via quantitative research methodologies (Moustakas, 1990, 2001; McLeod, 1999, 2003, 2010, 2011; Woolfe, 2003; Denzin and Lincoln, 2011; Silverman, 2013). I determined that a quantitative methodology would not be able to explore completely the multifaceted selected area of my research. Consequently, personally I would be unable to be an objective quantitative researcher employing standardised methods, measures and instruments, as it is at variance with me as a self-reflective person, reflexive therapist and researcher. Quantitative methodologies are associated with positivism and linked with modernist notions of a knowable world and the existence of universal properties (Gergen, 1992). Quantitative research is associated with positivist evidence-based epistemology and a quest for objective knowledge using the application of scientific method. The quantitative perspective is a world of regularity, reliability, uniformity and rigid principles compared to the "*uncertain, ambiguous, idiosyncratic, changeful world we know at first hand*" (Crotty, 1998, p. 28).

In contrast, qualitative inquiry (Denzin and Lincoln, 2008) involves research within natural settings, and uses research methods that depict experiences and meanings in people's lives. Qualitative research involves the researcher's immersion in data (Moustakas, 1967, 1981, 1990; Douglass and Moustakas, 1985; Cresswell, 2007). The significance of reflexivity in accordance with Etherington (2004) in the qualitative researcher is paramount, when conducting qualitative research such as heuristic research Moustakas (1990).

1.7 Strengths, limitations and difficulties conducting heuristic research.

The strength of heuristic research (Moustakas 1990) is that it uses the direct experience of the researcher not predicting any outcomes and not striving to prove theories, but conveys the facts and data, as accurately as they are. Subsequently the material in this research will speak interestingly and authentically for its self and portray the thoroughness that the researcher has investigated the research questions.

Heuristic methodology nevertheless has also limitations and difficulties for the researcher. Frick (1990) highlighted that even though creative freedom with few restraints on its procedures epitomizes a positive element of heuristic research, it conversely may lead to lack of judgment by the researcher thus detrimentally influencing the research. The process of heuristic research means that a researcher can research indefinitely. A heuristic researcher has to be disciplined in order to experience all stages of the heuristic research process (Moustakas, 1990) thoroughly within a given time period. I found this difficult however submitting three assignments as a single dissertation enabled me to complete Gavaghan (2009) with fidelity to the heuristic process according to Moustakas (1990) with consideration to Sela-Smith (2002). I argue that I attained meaningful data that may not have been achievable in three individual research assignments.

I did become apprehensive of the heuristic approach (Moustakas, 1990) when I was deliberating having to complete the research as three individual assignments. I was conscious that I could focus on the problem of timescales rather than on the true essence of heuristic research. I was aware of Sela-Smith (2002, p. 81) highlighting a difficulty of focussing on an external problem rather than the heuristic process, "*They might find themselves focusing on some external problem rather than doing a self-search in relation to the problem that draws them inward." Once* liberated from short-term research deadlines, I was conscious facilitated the heuristic process beneficially. Evaluating my experience I concur with the following statement by Sela-Smith (2002, p. 66)

> "*When heuristic research is initiated to fulfil dissertation requirements for graduation instead of growing out of the very being of the researcher, it is possible that the researcher may not be intimately and autobiographically connected to the question."*

The heuristic process (Moustakas, 2009) overwhelmed me especially during the immersion phase, which took up practically all my time including my dreams. This however is part of the heuristic process *"The researcher lives the question in waking, sleeping, and even dream states" (*Moustakas, 1990, p. 28). Reviewing the material repeatedly for each individual and then for the group is a crucial and time consuming process in the data analysis and feeling overwhelmed for me was part of the heuristic process. I often felt I was drowning due to the amount of data I was processing. In particular, during the interviews with co-researchers I experienced difficulties focusing on co-researchers 'internal frame of reference', as they often resembled my own. I experienced a parallel process trying to comprehend their stories whilst concurrently having awareness to my own thoughts and feelings. I endeavoured to be non-directive, mindful of my boundaries as researcher, so not to contaminate their stories and experiences with my own experiences.

Due to the protracted time, completing the heuristic process (Moustakas, 1990) correctly in a self-disciplined manner confirmed that combining the assignments into one inclusive written thesis Gavaghan (2009) was the correct decision. Conversely I agree with the comment by examiners (Appendix: 1) stating three assignments would be, *"helpful to your progression and development of writing".*

I was conscious that in heuristic research (Moustakas, 1990) I would become the subject of the enquiry, therefore, according to Sela-Smith (2002) I would discover aspects of myself normally out of my awareness entering into a discourse with myself that potentially may activate anxiety due to the unknown. Conversely, this perspective would be congruent with what I was striving to achieve as a self-reflective and reflexive researcher. I aimed to explore my experiences from the position of "*I who feels*" (Sela-Smith, 2001). I realised I would be exploring the phenomenon of how I had experienced external influences that could influence the therapeutic relationship in an organisational context. I had reservations regarding

would I have the fidelity to remain with the process or would I exhibit resistance if it related to painful personal experiences? Having an understanding of Moustakas' resistance to explore his loneliness (Moustakas, 1961) highlighted in Sela-Smith (2002) critique of Moustakas' heuristic methodology facilitated my self-awareness especially concerning the potential for resistance if my heuristic process exposed distressing experiences.

Criticism may be directed towards the limitations and validation of this type of research because it depends on the judgement and interpretation of the researcher (McCall and Simmons, 1969; Kirk and Miller, 1986; Schaffir and Stebbins, 1991; Atkinson et al. 2003). I was mindful to remain diligent reviewing data from participants as this data was from another perspective of a phenomenon and I was conscious of remaining in participants' 'internal frame of reference'. I was aware I was collecting data about phenomena that was individual to participants with its own truth. I aspired to have integrity and courage in order that I would not misconstrue data in order to be consistent with my research and findings. I am aware of potential of colluding with participants and leading interviews rather than creating a climate that encourages participants to reflect accurately on their experiences. I evaluated my experience of heuristic research via the MPhil process which authenticated the value and complexity of my co-researchers' experiences and encapsulated the meanings of our journeys. I appreciate that the concept of the '*internal frame of reference'* was essential and underpinned the acquiring of authentic data. Moustakas (1990, p. 26)

> *"To know and understand the nature, meanings, and essences of any human experience, one depends on the internal frame of reference of the person who has had, is having, or will have the experience"*

To recapitulate Combs et al. (1976) if the researcher fails to respect individuals' '*internal frame of reference'* that is their internal experience of the phenomena, the possibility is that the individuals' experiences, thoughts, feelings, perceptions, and meanings will be distorted.

My experience as a person-centred therapist assisted me to be non-directive with research participants and to remain in their '*internal frame of reference'*. I discovered Rogers core conditions (Rogers, 1957) are essential not just for person-centred therapy but also heuristic research (Moustakas, 1990). The importance of the relationship between researcher and participant is clearly acknowledged (Means and McLeod, 1984; Barrineau and Bozarth, 1989; O'Hara, 1986; McLeod, 2001). I therefore endeavoured to convey Rogers core conditions (Rogers, 1957) in order to form a trusting non-directive relationship with participants, thus encouraging them to reveal and communicate significant data from their frame of reference. This is an informative, sincere manner of obtaining accurate, genuine qualitative data providing access to material that maybe unable to attain by other research methods. Rogers (1970, p. 133) stated *"This kind of study often scorned by psychologists as being "merely self reports" actually gives the deepest insight into what the experience has meant."*

A potential limitation is that heuristic methodology (Moustakas, 1990) places importance on the subjective experience of the phenomenon and this may influence the researcher's bias. The researcher has direct experience of the phenomenon, which may subjectively influence the research process and interpretation of findings. The researcher's bias could affect the selection of co-researchers that could positively confirm the researchers own experiences of the phenomenon or influence the essence of the phenomenon because in heuristic methodology findings are attributable to the researcher's interpretation. Due to an awareness of possible subjective biases, I was self-aware and conscientious to be unbiased for instance when selecting co-researchers. The assignment was a consequence of my pursuit of knowledge obtained by a subjective disciplined approach to the fidelity of the heuristic methodology (Moustakas, 1990). My finished assignment was in concurrence with Polanyi (1969) who emphasised that the researcher must make the eventual ultimate judgement of what is presented as truth or what is removed as inconceivable.

Heuristic research is a subjective process and regarded by many as unscientific (Given, 2008). Moustakas (1990) concurs that heuristic research is a subjective process but declares that heuristic research is also a disciplined subjectivity.

Kirschenbaum and Henderson (1989) cited Rogers (1964) view of disciplined subjectivity as he argued for the use of qualitative research in behavioural sciences, "*personal search of a disciplined, open-minded individual which discovers and creates new knowledge" (*Kirschenbaum and Henderson, 1989, p. 273). Wilkinson (1998) describes reflexivity as disciplined self-reflection. I determine that by remaining disciplined to the fidelity of the heuristic methodology process (Moustakas 1990), I can achieve what Kvale and Brinkmann (2009) define as having 'objectivity about subjectivity'.

1.8 Validity of my heuristic research.

The subject of validity in qualitative research is problematic as validity is related to positivist concepts of objectivity hence quantitative methodology. Quantitative research adheres to meticulous methodological procedures and principles to guarantee that sufficient distance exists between any subjective biases of the researcher and the study. From a heuristic methodology perspective the use of objectives and measures are problematic as knowledge as a phenomenon relates to subjectivity. Consequently, quantitative measures regarding validity are incompatible with heuristic methodology because it is a qualitative not a quantitative method of research. Moustakas (1990, p. 32) states that in heuristic research validity is not, "*determined by correlations or statistics.*" Nevertheless, as an alternative, Moustakas (1990, p. 33) suggests when evaluating the validity of heuristic research, the researcher should be concerned with meaning, achieved within the process of discovery and the researcher is the principal evaluator of validity and that, *"the scientist must make the ultimate judgement.*" According to Moustakas (1990, p. 33) trustworthiness of the data is a direct consequence of "*constant appraisal of significance*" and "*checking and judging to facilitate a valid depiction of the experience been investigated."*

Shenton (2003) argues that '*positivists'* often question the trustworthiness of qualitative research, because their quantitative concepts of validity are unable to be addressed in the same manner. Angen (2000) offers a solution to the subject of validity by an examination of the "*trustworthiness*" of the research. Moustakas (1994, p. 57) defines trustworthiness as *"establishing the truth of things."*

The universal argument appears that the rigorous appliance of a set of previously agreed strategies and procedures will not ascertain the quality or validity of a qualitative research project. I concur with Koch and Harrington (1998) and Sandelowski and Barroso (2002) who argue that the validity of research is revealed in the creation of the research thesis that portrays also the genuine self of the researcher. Sandelowski and Barroso (2002, p. 10) state that readers of qualitative research should "*exercise wise judgement and keen insight in recognizing the nature and merits of a work."* Koch and Harrington (1998) advise researchers to use ongoing self-critique and self-appraisal in their research, including the moral, social and political stance of the researcher. This implies that qualitative research would need to include in the thesis detailed self-reflective and reflexive research in order for quality to be appropriately assessed.

The imperative question regarding the validity of my research is, '*Am I being true to myself and am I able to convey this to the reader*?' I consider that my personal qualities of integrity, courage, honesty, and commitment will assist in validating the research if the reader is able to observe these virtues within the thesis. McLeod (1999, p. 18) concurs with this concept,

> "*A good practitioner research study will provide sufficient information on the personal engagement of the researcher in the study and their heuristic process, for the reader to be able to make a judgement concerning authenticity, ownership and personal integrity".*

The main investigative instrument of heuristic research is the reflexivity of the researcher, their subjective discipline and fidelity to the heuristic research process and methods and the researcher's ability to establish relationships with participants that will encourage expression of accurate data.

When conducting heuristic research (Moustakas, 1990) I repeatedly revisit the data to verify the interpretation of the experience. This enables me to achieve repetitive verification that the explication of the experience and the creative synthesis of essences and meanings actually portray the phenomenon investigated.

> "*Certain visions of the truth, having made their appearance, continue to gain strength both by further reflection and additional evidence. These are the claims which may be accepted as final by the investigator and for which he may assume responsibility by communicating them in print."* (Polanyi, 1969, p. 30).

Creswell (1998) compliments Moustakas (1994) regarding the researcher keeping a balance between subjectivity and objectivity. I recognised my resistance to use heuristic research (Moustakas, 1990) to explore my research area, in case it became a study of my subjective life experiences losing objectivity. After examining Etherington (2004, p. 37) reflexive approach to research. I gained comprehension that would enable me to remain objective but still have elements of subjectivity.

> *"Reflexivity is not the same as subjectivity but rather it opens up a space between subjectivity and objectivity that allows for an exploration and representation of the more blurred genres of our experience."*

I was also influenced by Sela-Smith (2002, p. 59) description of subjectivity in research,

> "*One that invites the conscious, investigating self to surrender to the feelings in an experience, which carries the researcher to unknown aspects of self, and the internal organizational systems, not normally known in waking consciousness."*

Moustakas (1994) said that '*establishing the truth of things'* begins with the researcher's perception and reflection on the meaning of the experience of oneself before then focusing outward, to those being interviewed before establishing '*intersubejctive validity,'* which is the testing out of this understanding with other individuals through backwards and forwards communications and interactions. Moustakas (1994) also stated the researcher could continue the process at this point. I continued the process during the '*immersion'* phase of the heuristic process (Moustakas, 1990) and by the use of triangulation at the later '*explication'* stage of

my heuristic research in which I endeavoured to discover and illuminate themes of emerging data and nuances, via further focus and indwelling.

Triangulation may involve the use of different methods that are consistent with qualitative research principal data collection methods (Denzin, 1970, 1978; Fielding, and Fielding, 1986). Fielding and Fielding (1986) suggested that researchers might use triangulation to increase their deeper understanding of the phenomenon under exploration. McLeod (2013, p. 121) advocates the use of triangulation to inform validity, "T*he qualitative researcher can look for convergence from the data produced from diverse sources, methods and investigators as a check on validity."*

McLeod (2013) states triangulation refers to the practice of utilising different data gathering techniques in the same research study. I compared verbal data obtained from clients during interactions and examined this data in comparison to data obtained from evaluation forms completed at the end of therapy, when both sources of data were in accord this provided triangulation and give me with confidence in the validity of my findings. According to Guba (1981), the use of different methods counterbalances individual research participant's idiosyncrasies, suggesting where possible that other supporting data may be obtained from documents and other means to verify particular details that participants have supplied. I utilised every opportunity to examine any relevant documents or other data in order to facilitate further reflection, and to validate my research findings.

Another form of triangulation that I utilised was involving research participants with different relationships and experiences of the NHS this utilises diverse data sources (Shenton, 2003). Van Maanen (1983) supports the utilisation of triangulation using diverse research participants stating corroboration may take the form of comparing one individuals experience and viewpoint with that of another within an organisation. I made use of research participants from within and external to the NHS, from a variety of positions within the organisation including those delivering service provision and service-users.

Reliability in research is defined as the possibility of obtaining the same results on different occasions with different researchers (Guba, 1981). The concept of reliability originating from a positivist scientific tradition, therefore this measure is arguably of limited relevance to my heuristic research that is qualitative, since the experience of the researcher, and the subjective interpretation of the research is an essential part my research methodology. I concur with Pellissier (2007, p. 12) who stated that, "*In general reliability is low and validity is high in qualitative research whereas in quantitative research reliability is high and validity is low."* I have described my method of research thus believe that another researcher could replicate my research but the results in most probability would be different.

In summary, the validity of my research will be achieved by consistency throughout the research study, and the ability to portray in written format the trustworthiness of my research and the transparency of myself as the researcher. The appropriate use of triangulation will also assist to provide validity to my research. In heuristic research the question of validity is one of meaning arrived at via self-dialogue within the heuristic process of discovery (Moustakas, 1990). I consider the following quotation from Moustakas (1990, p. 32) an accurate synopsis of validity in heuristic research,

> *"The question of validity is one of meaning: does the ultimate depiction of the experience derived from one's own rigorous, exhaustive self-searching and from the explications of others present comprehensively, vividly and accurately the meanings and essences of the experience?"*

1.9 The research questions.

I was mindful of the importance of deciding on the precise research question in order to determine the most appropriate methodology (Hanley et al. 2013) and to focus the research (Maxwell, 2005; Cresswell, 2007) as well as spontaneously facilitating the heuristic process (Sela-Smith, 2002). Sela-Smith (2002, p. 65) advocated, "*If the topic is not adequately clarified, it will be only partially formed; if only partially formed, research will not be able to unfold in heuristic self-inquiry."*

The process of heuristic inquiry starts with a personal problem, issue or theme that the researcher seeks to illuminate or answer. My selected area of research has a significant personal interest to me; consequently, it has encouraged a passionate diligent commitment in me as the researcher to discover thus facilitating additional personal ardent interest in the selected research theme. Deciding on a topic of research with a personal importance is the beginning of the heuristic research process since the research enquiry arises from the researcher's enthusiastic exploration of their individual avid area of research (Moustakas, 1967, 1981, 1990, 1994; Douglass and Moustakas, 1985).

I will now elucidate the development of my personal fervent area of research in order to inform the reader of the underpinning narrative of my heuristic research theme. I identified in the initial stage of my career as a therapist, that organisational influences and culture had the potential to affect the client detrimentally or beneficially within the therapeutic process. I recognised that if I gained an increased conceptualisation of organisational influences and culture, this would inform my therapeutic practice. Consequently, I discovered factors and dynamics external to the therapeutic relationship that did influence clients' experience of therapy. I therefore decided to research this area further.

Gavaghan (2002) consisted of a dissertation involving a counsellor's heuristic exploration of 'self' when counselling within an organisation, British Armed Forces. The experience of conducting MA research was a personal and professional journey I explored the influence of the organisational culture on the development of my 'self' and the effect of the culture on the client and counselling provision within the organisation. Gavaghan (2002) concluded that organisational culture and dynamics intrude overtly and imperceptibly into the therapeutic relationship. Nonetheless, having an understanding of culture and organisational dynamics enhances the communication of Rogers core conditions (Rogers, 1957) especially empathic understanding which when used appropriately constructively informs the therapeutic relationship hence therapy.

My experiences of conducting research (Gavaghan, 2002) created a curiosity and

desire to explore further the phenomenon between the therapeutic relationship and external factors to the therapeutic relationship such as organisational culture. I discovered when examining clients written evaluations of therapy a common emerging theme was my ability as a therapist to have a precise empathic understanding of the client. I agree with Rogers (1957) that the core conditions are crucial in the establishing, developing and sustaining of the therapeutic relationship. I gained an ongoing committed personal interest in external influences that may influence the client and therefore the therapeutic relationship including organisational dynamics. In addition, I obtained an increased comprehension of how understanding these external factors association with the therapeutic relationship enhanced empathy providing an increased understanding from the client's perspective. I thus attained a profound personal and professionally interest in the core condition empathy (Rogers, 1957) and I strived to obtain increased knowledge and awareness of empathy in my undertaken to improve and develop my empathic understanding.

I commenced the Professional Doctorate Programme eager to engage in a similar area of research to Gavaghan, (2002). When considering the topic of my first written assignment this initiated the heuristic investigation as I commenced an '*inward clearing'* an inner searching for deeper awareness and understanding concurrently achieving enhanced self-awareness. The question that emerged from my initial heuristic process (Moustakas, 1990) is linked indisputably with my 'self,' personal experiences and my avid interest in the role of empathy in therapy and in the development of empathic awareness in therapists within an organisational context. The following question transpired "*What external influences have the potential to influence the therapeutic relationship*". Moustakas (1990) '*initial engagement'* is the first stage of heuristic research. Moustakas (1990, p.40) describes the initial process as,

> "*The awakening of such a question comes through an inward clearing, and an intentional readiness and determination to discover a fundamental truth regarding the meaning and essence of one's own experience and that of others."*

I continued the process of '*initial engagement'* by exploring my 'self' and experiences as a counsellor practicing within the culture of NHS Primary Care. I searched inward for tacit awareness and knowledge to clarify the topic and research questions and title according to Moustakas (1990, p. 11) who cited, "*Heuristic research involves self search, self dialogue, and self discovery: the research question and the methodology flow out of inner awareness, meaning and inspiration."* The initial heuristic process facilitated further thorough self-exploration from which further research questions become apparent;

"*How may organisational influences influence the therapeutic relationship?"*

"*What organisational influences have the potential to influence the client and possibly obtrude into the therapeutic relationship?"*

"How the traditional organisational culture of the NHS and the societal perspective of counselling may influence the client and the counselling relationship?"

"How previous experience and perception of the NHS may influence a counselling client?"

"How may conflicting NHS sub-cultures have an influence on the patient / client?"

"Where do counselling and the client fit into the hierarchical organisation culture of the NHS?"

"Is the client and the counselling relationship influenced by the organisational and the societal view of counselling?"

"How might the changing NHS be influencing patients and professional medical relationships?"

"How may the doctor–patient relationships influence the therapeutic relationship?"

“How referrers may influence the therapeutic relationship?”

Maxwell (2005) stated that to initiate research an appropriate question is required. Cresswell (2007) encourages researchers to try to define one overarching question, which can then have a number of sub-questions as in Gavaghan (2009).

At this stage of the Professional Doctorate Programme, I discussed my theme and methodology of research as well as my progress with my supervisors. I did not consider a individual specific assignment would completely capture the essence of my heuristic research (Moustakas, 1990) and as my preferred area of research had similarities to the subject matter included in all of the first three assignments. I requested to combine my research assignments into one single dissertation comprising the three assignments. The supervisors, after deliberation agreed with the rationale of my request. This assignment was entitled;

> *“A counsellor’s experience of practicing in the context of NHS Primary Care: A heuristic exploration of external influences that could influence the therapeutic relationship.”*

Heuristic research, according to Moustakas (1990) consists of six phases of inquiry, which are;
Initial engagement.
Immersion.
Incubation.
Illumination.
Explication.
Creative synthesis.
In order to provide further rationale of my heuristic research process I have described each of the stages of heuristic research in Annex: 1.

1.9 Précis of chapter 1.

I endeavoured to create a written thesis according to Moustakas (1990, p. 13) who said, *"I am creating a story that portrays the qualities, meanings, and essences of*

universally unique experiences." Not just a straightforward summary of what occurred during the heuristic research process but a comprehensive depiction of a human experience in its entirety. A unique comprehensiveness that is not possible to pre-plan or predict but instead emerged from the process of heuristic research and its creation appeared to take on a life of its own. I intended to portray a concise account of my heuristic journey and research process, a creative synthesis born from the heuristic research process that depicted an amalgamated integration of the data, and themes discovered by means of the heuristic research. *"Heuristics is concerned with meanings, not measurements; with essence, not appearance; with quality, not quantity; with experience, not behavior."* (Douglass and Moustakas, 1985, p. 42).

Heuristic inquiry is an incredible qualitative research approach that epitomizes the personal journey of the heuristic researcher towards tacit knowing, understanding and knowledge. The research has challenged me to use flexibility and creativity, introspection and self-exploration, self-reflection and reflexivity and has provided me with a deeper comprehension of the meaning and the essence of significant human experiences.

My heuristic research methodology (Moustakas, 1990) consisted of a disciplined pursuit of the experience of the phenomenon and it required me to commit not just my time but also my mind, heart and soul to the research, which was a challenging process. The heuristic research process was an extensive journey of self-search, which has developed my self-awareness and self-insight enormously as well as beneficially informing my practice as a qualitative researcher and as a psychological therapist. I often felt overwhelmed during the heuristic process and experienced feelings of drowning in the data and heuristic process. Revisiting the data persistently instigated feelings of exhaustion as I relentlessly reviewed the data, painstakingly interviewing co-researchers, and studied any relevant information related to the research questions. There were times when I wanted to give up and forget the heuristic research experience especially when concurrently I encountered several severe difficulties in my personal life.

I gradually appreciated the paradox that structure does exist within an extremely subjective research methodology. Heuristic research methodology may be subjective but it is also a disciplined structured research methodology and if the researcher is able to be diligent, disciplined and motivated to confront the depth of effort required, I reason that the difficulties and challenges are surmountable.

The process of the validation of heuristic research is a demanding process that requires the researcher to engage in an extensive and fatiguing process. I have endeavoured to achieve internal consistency and validation throughout my heuristic research. This is accomplished when a consistent rational is present throughout the heuristic research process, from the philosophical basis through the manner in which the focus of the research is approached, via the selection of research question as well as methods, to the conclusions and written depiction. I have demonstrated fidelity to the methodology of heuristic research (Douglass and Moustakas, 1985; Moustakas, 1967, 1990, 1994, 2001). I also considered the studies of Patton (2002) *"heuristic inquiry"* and Sela-Smith (2002) HSSI and have pursued the heuristic process from initial engagement to completion. Therefore, validation depends upon my thoroughness in researching, authenticity of my conclusions, and clarity of my written communication in the form of a creative synthesis as well as conveying my 'self' as the researcher in the final depiction.

1.11 Development as a researcher and suggestions for further research.

The advantages of completing the MPhil process are numerous especially relating to professional development. I have examined how Gavaghan (2009) has assisted in the development of my knowledge and skills as a researcher. The learning has enabled me to more effective in the workplace not just as a therapist and researcher but my contribution as a professional within the field of therapy has improved. I feel more capable to; present my findings to peers, manage discussions and defend my position and have confidence to put forward my ideas or results to senior management and other professionals.

My research experiences have enabled me to review and understand quantitative as well as qualitative research including evaluating the research, making judgments

about the value of information, and drawing conclusions from the data before advising on appropriate implementation of plans and actions for the IAPT service. Additionally, I have increased confidence to make informed decisions relating to research evidence from which I am able to action for the benefit of my professional therapeutic practice.

Learning from my research has aided me to critically analyse and review published research evaluating knowledge and relating it to the context of the IAPT service. I am also able to critically analyse research data collated from within the service and have communicated the results and information using a variety of methods to varied audiences including; strategic meetings, therapists, other professionals, referrers, and commissioners.

Research experience (Gavaghan, 2002, 2009) and the MPhil has enabled me to support and mentor colleagues and supervisees conducting research including Masters Research (Rogers, 2012; Lough, 2013). I assisted in research conducted by Grega, (Grega et al. 2013; BBC News Health, 2013; University of East Anglia 2013) regarding people with social anxiety interacting in social situations via video capture. These activities have facilitated continued development as a researcher and encouraged further understanding and knowledge of different research methodologies.

I questioned whether my research has contributed to understanding and developing, new and innovative research methodologies and after deliberation concluded that my research had not directly but may contribute to and take its place within innovative pluralistic research methodologies.

An IAPT service has a plethora of data that is available to be utilised for research. The data is of both a qualitative and quantitative nature, the data information searches on electronic databases are almost infinite producing qualitative and qualitative information (see Annex: 2).

I have a desire to complete further research and have considered implications for further research utilising my research experience and available data within the IAPT

service. I am aware of both limitations and strengths of heuristic research (Moustakas 1990) because of Gavaghan (2009) and MPhil process. I have considered the type of available IAPT data and the possibility of using heuristic research. After deliberation I concluded pluralist research methodology would utilise all available data within an IAPT service potentially allowing research methodologies to complement one another increasing validity by confirmation of results by means of different data sources and methodologies, in a manner cited by Denzin (2009, p. 298),

"Each research method implies a different line of action towards reality and hence each will reveal different aspects of it, as much like a kaleidoscope, depending on the angle at which it is held, will reveal different colours and configurations of objects to the viewer. Methods are like the kaleidoscope; depending on how they are approached, held, and acted toward, different observations are revealed."

I have considered pluralistic qualitative methodologies including, bricolage and eclecticism (Denzin and Lincoln, 2000, 2005; Kincheloe, 2001; Onwuegbuzie and Leech, 2005; Todd et al. 2004; Moran-Ellis et al. 2006). Dicks et al. (2006) states all methods are equal and advocates using the most appropriate research methodologies. McLeod (2011) suggests the pluralistic research framework function as a meta-theory in which it is possible to utilise the concepts, strategies and specific interventions from a range of therapeutic orientations. Pluralistic research can also combine quantitative and qualitative research methodologies (Johnson et al. 2007).

I have contemplated areas for ongoing research in pertaining to my interest in external factors that influence the therapeutic relationship. Pluralistic research would enable research in this field to continue to be researched further in an IAPT context, in order to gain increased comprehension of theory and knowledge. Concurrently, informing the provision of therapy and therapeutic practice in organisational contexts.

I have already reviewed my experience completing a PGDip as an academic researcher (section 1.3).

The University of Manchester

Professional Doctorate in Counselling

ASSIGNMENT. Years One – Three.

Comprising Specialist Modules:

Counselling psychotherapy and society. Year One.

Counselling in a specialist setting (Primary Care). Year Two.

A counsellor's experience of practicing in the context of NHS Primary Care: A heuristic exploration of external influences that could influence the therapeutic relationship.

ANDREW GAVAGHAN MA

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Self-reflective practice and explanation of the reflective technique "*Tracking down and tracing back*".

Self-reflection and reluctance to self-reflection.

Reflexivity is closely associated with the profession of counselling with the majority of counsellors from differing therapeutic approaches aware and familiar with the term reflection. Many counsellors endeavour to be self reflective and self aware, developing into reflective practitioners and some into reflective researchers.

Self-reflective practice is not however just restricted to the profession of counselling but encouraged in many other diverse occupations. Schon (1983) studied reflective practitioners and examined self-reflective practice in architects, engineers, managers, planners, as well as psychotherapists. Etherington (2004) explores reflexivity in counselling practice and the transition from reflective practitioners to reflective researchers. She also advocates that aspects of the transformation from reflective practitioners to researchers are applicable in other professions, for instance;

"Medicine, and related disciplines, law, anthropology, sociology, psychology, social work, mental health, education, disability studies, theology, to name a few." (Etherington, 2004, page, 15.)

Self-reflection is not just an activity associated with counselling or indeed a recent concept. Many celebrated philosophers throughout the years have written about the topic of self-reflection. Self-reflection is the capacity of humans to exercise introspection and the willingness to learn more about our fundamental nature, purpose and essence. Samuel Taylor Coleridge (1798) who lived between 1772 and 1834 was an innovative lyrical poet and philosopher he argued that self-reflection was an art that one should master otherwise what is the point of existing. Socrates the Greek philosopher encouraged people to, "*Know thy self*." and argued that an unexamined life is not worth living.

When counselling I am aware that as well as focusing on the clients' verbal and non-verbal communication, I also self-reflect and evaluate on numerous different levels. I recognise that during counselling I self-reflect by simultaneously contemplating my thoughts, feelings, and messages from within me, including attentiveness to my physical responses and what may be happening to my body. As well as reflecting on what is occurring between the counsellor and client, I endeavour to self–reflect in order to increase my awareness of other influences that may have the potential to obtrude imperceptibly or obviously into the counselling process such as organisational and cultural influences, parallel processes, transference and counter transference, as well as the physical environment and context in which I am counselling.

Clients are encouraged to self-reflect by counsellors who promote self-exploration in order to gain increased understanding of "self". Most counsellors initial training, continual professional and personal development involves self-reflection and a willingness to share self-insights, findings and professional experiences with others including; tutors, colleagues, supervisors, clients and especially honestly with their "self".

In spite of the fact that self-refection can be considered a necessity to the profession of counselling the paradox is that resistance to self-reflection exists either in a conscious or concealed manner. As counsellors, we could improve and develop our practice by having an understanding and mindfulness of resistance to self-reflection in both our clients and ourselves. I have revealed that self-reflection is not a modern concept similarly, reluctance to self-reflection and a resistant attitude towards people whom may be interested in their "self" discoveries, is not a recent perception. The following reference relates to the life of Socrates (469 BC – 399 BC) and was produced by Aristophanes a writer in 423BC:

"Something in people resists self-examination: they do not want to answer deep questions about themselves, and they hate those who cajole them." (Encyclopaedia Britannica. 2006, page, 14.)

I suggest that many people including counsellors are often anxious and even fearful

about recognising, acknowledging, accepting and understanding aspects of their "self" and their own self-discoveries. Consequently, to share their self-discoveries and personal and private self-insight, with others could be terrifying whether it is in written form or verbal discourse. The "self" of an individual is entwined and integrated into each counsellor's unique and individual professional practice. It is not therefore surprising why counsellors are often guarded and resistant to disclose private issues regarding their "self" or professional practice or describe the disparities in how they practice, for fear of demonstrating personal and professional vulnerabilities and limitations.

I participated in a professional development group that was formed to discuss professional practice, share experiences, and ideas. The group met for three hours a month for approximately a year. A proficient group analyst who also had vast experience as a psychoanalyst and supervisor facilitated the group. The group consisted of seven experienced counsellors from diverse counselling orientations, some whom were or had been counselling supervisors and trainers. The varied counselling approaches included, cognitive behavioural therapy, (CBT), pure Rogerian person-centred approach, transactional analysis (TA), and gestalt, as well as variations of eclectic and integrative counselling practices. Despite the vast collective experience and knowledge within the group and individuals commitment to participate in the group process, invisible hindering barriers existed the whole time restricting the group process and the purpose of the group.

Considerable time was spent addressing, exploring, and discussing these encumbering and inhibiting obstructions to the process of the group. The factor that constantly kept emerging was the fear and vulnerability of disclosing anything regarding ones "self" and professional practice. Although the group never accomplish its potential and intended purpose, it considerably enhanced the understanding of my "self" and I gained vast self-awareness, knowledge, and understanding of group process and dynamics by provocative self-refection. The following is an extract from my personal Journal (S*eptember 2004)* pertaining to my experiences of participating in the group.

"I noticed that as I drove to the venue I was taking deep breaths, then I became

aware my heart pounding fast and hard - I was sweating - my stomach was churning. Into the lion's den once more I thought! Can't be late again I have run out of excuses but I suppose -- better to be with the lions and part of the pack than to be late thus outside the pack therefore potentially the packs next meal. I imagined the group like lions, waiting to be fed appearing tame but hidden beneath the docile pleasantries and debate the hidden viciousness waiting to devour any one who dares to be different or show weakness. I reflected regretfully on the conflicting feelings of guilt yet relief when the pack turned on someone else and I hated myself for nibbling and eating part of the meal. I wasn't going to be late and provide the lion's with food I imagined them clearly waiting for their meal poised ready to pounce beneath smiles of welcome".

Etherington (2004) acknowledges the feelings of risk and vulnerability;

"I did not take those risks until I had achieved a PhD and reached a stage in my life and career when the risk seemed less important than the value of being known for who I really am." (Etherington, 2004, page, 143.)

I advocate that if counsellors can be courageous expose vulnerabilities, take risks, and be open to the external critical reflections of others, then, additional learning and insight can occur for both the individual as well as for others. Winter et. Al (1996) suggest that critical reflections of other people and analysis can enhance our own understanding by challenging or validating our perspectives. Bolton (2001) believes that issues and findings resulting from self-reflective practice must be challenged and examined by means of frank discussions with counsellors and colleagues from other backgrounds. Bolton (2001) also suggested that concurrently examining texts from different fields of work and perspectives would promote learning by informing self-reflection. Bolton perceives this method of reflecting on professional practice as;

"becoming politically, socially, as well as psychologically useful, rather than a mere quietist navel-gazing exercise." (Bolton, 2001, page, 3)

I personally believe and recognise that critical self-reflection is a necessary element of professional counselling practice because it enhances personal and professional

growth and development as well as assists in the development of counselling provision, practice and services. I constantly encourage internal self-reflection as well as continually evaluating and reflecting on my counselling practice. I persistently endeavour to gain increased awareness of external influences to counselling such as the counselling context, cultural influences, organisational dynamics and the physical environment.

Sharman and Seber (2004) in concurrence with the British Association for Counselling and Psychotherapy (BACP) acknowledge that models exist and are useful to assist the reflective process and provide frameworks for structured analysis and evaluation. I have a personal technique that I have named "*Tracking down and Tracing back"*. I have developed this technique to facilitate my exploration and reflective process and to enhance my understanding and awareness of consequential influences to the counselling relationship.

I use the reflective technique *"tracking down and tracing back"* to supplement my continuous self-reflection and to develop my self-reflective practice by endeavouring to discover influences that may have a bearing on the therapeutic relationship. The knowledge and increased understanding gained from using this reflective technique informs and develops my counselling practice. I call the process *"tracking down and tracing back"* because I intentionally search for information that informs my understanding of my counselling practice and influences that effect the therapeutic relationship, especially those that are external to what occurs during the physical contact between client and counsellor.

"*Track down*" in the Oxford Thesaurus is defined as;

"Track down the necessary information. Hunt down, hunt out, turn up, dig up, ferret out, nose out, bring to light, expose, discover, find out, detect." (Kirkpatrick, 1994, page, 835.)

The previous quotation aptly describes my quest for information; I do my utmost to obtain any relevant information by numerous means. I constantly encourage personal self-reflection, which facilitates my heuristic process and tacit awareness

therefore enabling me to acquire enhanced understanding, and avoid what Bolton (2001) entitles, *"navel gazing".* I also continually reflect on my counselling practice. I utilise the following to facilitate my self-reflection and self-reflective practice;

A persistent quest to obtain increased self-awareness and understanding.

Listening to the opinions and experiences of clients, other professionals and fellow counsellors especially those who have differing therapeutic orientations to that of my self, I also gain insight and knowledge from meetings, supervision, and professional development groups.

Debates discussions, conversations and interviews with clients, counsellors and colleagues from different professional backgrounds and perspectives

Evaluating and reflecting on counselling practice and exploration of the therapeutic process,

Reflective research and the study of counselling literature, academic literature and texts from non-counselling professional practice

Writing, reading and interpretation of personal journals and written reflections and counselling documentation such as referral documentation, letters, client satisfaction questionnaires, clinical outcomes.

Understanding the influence of the context of counselling including organisational dynamics and cultural influences, the influence of the physical environment.

Gaining insight from a client's perspective by placing my self in the position of a client "as if" I were the client.

Observation of people and the physical and environmental aspects that influence counselling. Studying interactions between people.

“Tracking down and Tracing back” correlation with heuristic research.

The technique *“tracking down and tracing back”* is comparable to the concepts and processes of heuristic research according to Moustakas (1990).
Heuristic research is a reflective methodology of self-exploration.

“Heuristic research involves self search, self dialogue, and self discovery: the research question and the methodology flow out of inner awareness, meaning and inspiration.” (Moustakas, 1990, page, 11.)

I believe that data is within me; the challenge is to discover and illuminate its nature. I therefore intend to question myself, and self explore, reaching inward for tacit awareness and knowledge, thus striving to clarify the context from which the questions take form and meaning.

The heuristic inquiry process starts with a problem, issue or theme that the researcher seeks to illuminate or answer. The researcher then perseveres with the process by an inward clearing, self-reflection, and inner searching exploring for deeper awareness by searching inwards to explore intuitive feelings drawing from within for tacit awareness.

Discovering a significant area of research that encourages an enthusiastic commitment of the researcher is the beginning of the heuristic process. I have a passionate interest in the external influences to the therapeutic relationship from which my question has arisen. The following research question initiated my heuristic enquiry;

“*What external influences have the potential to influence the therapeutic relationship?”*

The initial research question that has emerged is linked indisputably with my “self” and has evolved from both my personal and professional counselling experiences. These experiences I am still living thus, as I proceed through the research process,

questions will keep on arising. It is a personal challenge to search for and "*track down*" in order to illuminate answers.

The technique "*tracking down and tracing back*" facilitates my heuristic process. In heuristic research questions flow from inspiration, inner awareness and personal meanings thus further research questions informing the research will continue occurring. As part of the process, I question the answers to these questions rather than answer the questions.

The following are examples of questions that have transpired;

"How may organisational influences influence the therapeutic relationship?"

"*What organisational influences have the potential to influence the client and possibly obtrude into the therapeutic relationship?"*

"How the traditional hieratical organisational culture of the NHS and the societal perspective of counselling may influence the client and the counselling relationship?"

"How previous experience and perception of the NHS may influence a counselling client?"

"How may conflicting NHS sub-cultures have an influence on the patient / client?"

"Where do counselling and the client fit into the hierarchical organisation culture of the NHS?"

"Is the client and the counselling relationship influenced by the organisational and the societal view of counselling?"

"How might the changing NHS be influencing patients and professional medical relationships?"

"How may the doctor–patient relationships influence the therapeutic relationship?"

"How referrers may influence the therapeutic relationship?"

The Concise Oxford Dictionary definition of "trace back" is; *"Trace back, go back over the course of." (Sykes, 1977, page, 1227.)* I do exactly what the definition states, I "*trace back*" both metaphorically and in person literally. This enables me to discover possible influences to the counselling relationship that I may not have been aware of. The technique can be used at any time including prior to the time the counsellor and client meet for the first counselling session. If I acquire understanding and information, I endeavour to remain mindful of these findings throughout the period of counselling.

I make an undertaking to discover what Moustakas (1990) defines as "*identifying with the focus of inquiry*" by self-searching and immersion my "self" in active experience in order to gain understanding of the questions as if I am a part and parcel of the question. Salk (1983) a renowned physician and researcher referred to this identification as *"the inverted perspective"* he attempted to place himself in the position of the object or subject he was interested in or researching.

"I would picture my self as a virus, or as a cancer cell for example and sense what it would be like to be either". (Salk, 1983, page, 7.)

When I "*trace back, "as if", I were a client*, I utilise a comparable concept to Salk (1983) in order to gain enhanced understanding and to facilitate my self-dialogue. Salk (1983) envisages himself *"as if"* he were a virus or cancer cell whilst I envisage my self *"as if"* I were the client.

I gain knowledge and increased insight by literally physically "*tracing back,"* I retrace the clients' route to the place of counselling replicating the clients physical journey "*as if*" I were the client. The Oxford Thesaurus describes, "Tracing" as; *"Follow the traces. Trail, spoor, scent, marks, tracks, prints, imprints, footprints, footmarks, footsteps." (Kirkpatrick, 1994, page, 835.)* As I trace the clients' footprints and trail to the surgery I observe the physical aspects of the environment that may have an effect on the client. Concurrently whilst "*tracing back*" I examine and become aware of my feelings, emotions, and my physical responses. In summary, I reflect on the entire experience of attending counselling "*as if*" I were the client in order to endeavour to obtain an understanding of how clients' perception of counselling

provision may be influenced by external influences and how this may encroach into the counselling relationship.

"Tracking down and tracing back" correlation with health and safety.

I will demonstrate my reflective technique, "*tracking down, and tracing back"* by exploring my counselling within the NHS Primary Care setting. I have selected this context because potentially this context provides more influences and factors that may have consequential effect on the provision of counselling and the therapeutic relationship, than most other settings.

The context in which counselling takes place determines the amount and type of information that is available when reflecting and exploring using the *"tracking down and tracing back*" technique. This is a similar comparison to the amount and type of information that may be obtained when evaluating risk and making risk assessments. The information available and contained in risk assessments will be vastly different for a patient attending for an appointment at a NHS Primary Care surgery or a client attending counselling at a counsellor's home.

I equate the technique of "*tracking down and tracing back*", to a Health and Safety, Risk Assessment. The Health and Safety Executive define a risk assessment as;

"A risk assessment is nothing more than a careful examination of what, in your work, could cause harm to people, so that you can weigh up whether you have taken enough precautions or should do more to prevent harm." (Health and Safety Executive, 2003, page, 2.)

In comparison, the following is how I compare and define "*tracking down and tracing back*";

"Tracking down and tracing back", is nothing more than a careful examination of what, in your work, could influence and potentially harm the counselling relationship, so that you can weigh up whether you have taken enough precautions or should do more to prevent harmful influences to the counselling relationship."

Deliberately comparing the two definitions elucidates the rational informing the technique of *"tracking down and tracing back*" whilst facilitating understanding of the technique. Despite the fact that Health and Safety Risk Assessments examine potential harm to people, conversely risk assessments also aim to promote good health and safety practice. High quality health and safety practice has a positive impact on an organisation and improves the corporate reputation with customers and other people as well as providing a physical and emotionaly heathy environment for employees and service users.

In contrast utilising the "*tracking down and tracing back*" technique will identify possible harmful influences to counselling but also highlight positive aspects of counselling provision and areas for development. The counsellor is therefore continuously reflecting, monitoring, evaluating and striving to improve the quality of counselling, therefore safeguarding high standards and trying to create an environment in which excellence in counselling provision can flourish. This concept is aligned with the NHS policy of clinical governance Department of Health, (1998). Clinical governance is an element of the efficiency agenda of the NHS and is a phrase to encapsulate the array of activities and initiatives to improve the quality of health services, Rosen, (2000).

Health and Safety Risk Assessments today are an integral part of everyday lives especially in the workplace and clinical governance is fundamental and commonplace within the NHS. I believe that techniques such as "*tracking down and tracing back*" that encourage examination of self, endorse reflective practice, and promote the evaluation of counselling provision and clinical outcomes should be a commonplace essential integral part of counselling practice and provision.

<u>Implications for counselling.</u>

The experience of *"tracking down and tracing back*" provides me with subsequent information regarding the provision of counselling in general within a context, as well as my individual counselling practice.

"Tracking down and tracing back" facilitates ongoing development of my counselling by promoting self-awareness and critical reflective practice. The technique also encourages the development of the counselling provision from a practical as well as a clinical perspective. The data obtained may identify areas of concern and development as well as distinguish aspects of quality practice and provision. The technique therefore as well as encouraging reflection to gain additional awareness and understanding also is a means of continually evaluating and validating the counselling service.

The use of the reflective technique enables counsellors to consider and evaluated the counselling experience "*as if*" a client. The physical aspects such as buildings and facilities as well as the referral process can be experienced from a client's viewpoint *"as if*" a client.

I have used the technique of *"tracking down and tracing back*" with success in various settings and contexts to obtain additional awareness and understanding of influences that may effect the counselling provision and therapeutic relationship. The contexts and settings include; private practice, telephone counselling, organisational contexts such as NHS Primary Care, HM Young Offenders Institute, Ministry of Defence (Armed Forces), Employment Assistance Programmes (EAP).

Conclusions.

I am aware that there is more to counselling that what occurs within the therapy room and the therapeutic relationship. I have discovered that numerous factors external to the counselling relationship have the potential to influence the therapeutic relationship.

These influences can be either beneficial or disadvantageous to counselling. I endeavour to explore and examine these influences further because I consider that if a counsellor is aware of these influences it will provide increased understanding of the therapeutic relationship therefore potentially improving personal competences and clinical effectiveness. Conversely, not to be vigilant to the external factors that may influence the counselling relationship and not to have an awareness of the

context in which counselling is taking place, is to ignore the impact that these issues may have on the therapeutic relationship often to the detriment of the counselling.

I therefore reason that counsellors should have an understanding of possible external factors, dynamics and an appreciation of the context in which the counselling is taking place. This knowledge and awareness will assist in gaining an understanding of how issues may influence the counsellor or client individually or collectively thus the therapeutic relationship. I endeavour to discover, understand, and manage these influences, which may be either obvious or obscured. I recognise that many influencing factors often begin transpiring before the first counselling session thus before the client and counsellor have even encountered one another in a therapeutic context.

An exploration of the traditional hieratical organisational culture of the NHS.

Introduction.

"How may organisational influences influence the therapeutic relationship?"

In order to answer this question I realised that I would have to expand my understanding of traditional hieratical organisations by examining the NHS and acquiring an appreciation of the organisations culture. I have employed my reflective technique *"tracking down and tracing back"* to the context of the NHS to encourage exploration of the organisation. When using the technique I thoroughly consider the context that counselling is taking place and endeavour to identify, contemplate, and comprehend the organisational dynamics and the culture of the organisation. I believe that similar to attaining understanding of someone's personality you can gain an impression of the personality of an organisation and an understanding of the dynamics and culture by observing, self-reflection, listening, researching, reading, and other forms of communicating such as interviewing, discussing and debating.

I have tried to obtain increased insight into the personality of the organisation by examining physical aspects of the NHS as well observing people within the organisation. I examine the character of the buildings, the décor, and furnishings, I

also observe people as individuals and in groups noticing what they wear and how they behave and communicate. This reflection enables me to gain increased knowledge and understanding of the organisations culture and dynamics.

In order to attain further understanding I have examined counselling within an organisational context in general relating the organisational context to the NHS setting in particular. I have studied the NHS as an organisation, which has assisted me to understand the NHS organisational influences on society in general, therefore the client and counsellor as members of society.

To attempt to enhance my understanding of the organisational culture and organisational dynamics of the NHS, I have studied definitions of culture and of organisational culture as well as descriptions of the structure and classifications of organisations.

I evaluated my conclusions and considered the implications to counselling by reassessing the question. *"How may organisational influences influence the therapeutic relationship?"*

Counselling in an organisational context.

In any counselling context clients' perspective of counselling will be influenced by many factors including their expectations, assumptions, values, life experience, attitude, intelligence, education, health, and social culture however in the context of counselling within NHS Primary Care other dynamics such as the organisation and its culture may influence the clients opinion of counselling. I believe that the context of counselling within NHS Primary Care has multifaceted and complicated dynamics due to many organisational and cultural influences. Subsequently, many dynamics and influences have the infinite potential to impact on the counselling relationship. Lees (1998) acknowledges the peculiarity of counselling within the context of NHS Primary Care compared with other counselling contexts.

"Indeed it is felt that "clinical counselling in primary care" is a sophisticated and complex clinical activity, quite distinct from "clinical counselling" in other settings."

(Lees, 1999, page, 1.)

In previous research pertaining to counselling within organisations principally the MOD (Army), Gavaghan (2002) I concluded that organisational cultures intrude overtly and imperceptibly into counselling relationships creating an additional dynamic to the counselling relationship. McLeod (1998) Clarkson (1995) recognise the context in which the counselling takes place and how the context can influence the counselling relationship. Carroll and Walton (1997) acknowledge that organisational cultures impact on the counselling process. Organisational culture has the potential to influence both the client and counsellor thus the counselling relationship.

"The upsurge of counselling in organisation settings (medical, educational, industrial and religious) came a realisation that the organisation in which counsellors worked impacted enormously on them and their work." (Carrol, 2006, page, 47.)

I argue that counsellors working within an organisational context should be aware of the additional dynamic that organisational culture creates in their work and how it may have some bearing on both their "self" and their client. I infer that the organisational context impacts directly onto the client, I believe that organisational influences have the possibility to alter clients' attitude to counselling and therefore potentially influence the therapeutic relationship.

<u>The influence of the NHS on society, individuals and counselling.</u>

I have worked as a counsellor within the Primary Care setting of the NHS, since 2003 in several NHS primary Care Trusts (PCT). By utilising the reflective technique "*tracking down and tracking back*" I have discovered that NHS cultural and organisational influences are present even before the first counselling session and that organisational influences have a bearing on the counselling process and the therapeutic relationship.

The NHS is an extremely large organisation employing 1.3 million staff and undertaking approximately 1 million treatments every 36 hours. HM Treasury (2006)

financial budget for 2006 – 2007 was 96 billion. The following reference confirms the magnitude of the NHS;

"The NHS is the 3rd largest organisation in the world, the biggest employer in Europe and employs the largest numbers of science graduates in the UK." (NHS Innovations, 2007.)

The organisational culture of the NHS not only exerts cultural influence over people that are employed within the organisation but also extends its power outside the organisation potentially influencing every person who makes use of NHS health care. The following quotation relating to NHS Primary Care, accentuates this fact in a enumerate manner;

"Ninety-eight per cent of the people in Britain are registered with a practice and 60 per cent of them consult their GP at least once a year, 90 per cent in any two-year period." (East, 1995, page, 122.)

I concur with Seale and Pattison (1994) who argue from a historical approach that medical understanding and views on medicine and health care within the United Kingdom are inseparable from our culture. The culture of the NHS and the culture of the United Kingdom therefore must be interrelated with one another. Nigel Lawson (1993) a former Chancellor of the Exchequer from 1983 –1989, considered that the NHS is the closest thing the British people have to a national religion. Department of Health, (DH), (2008) states, *"Our NHS is the most cherished of British Institutions." (DH, 2008, page, 9.)* The powerful influence of the culture of the NHS continually impacts into our daily occurrences and influences our experiences, learning and self-development in a manner comparable to these quotations;

"For power is the social element in which we exist. It is almost impossible to think of a human experience which is not shaped by power, that does not carry either a positive or negative charge of power." (Smail, 1991, page, 2.)

"Health and healthcare are fundamental to what we can achieve in life. The NHS touches everyone, our families and our friends, from the beginning of our lives to the

end." (DH, 2008, page, 7.)

I believe that the culture of the NHS has the capability of influencing the counselling relationship because it extends its influence to some extent on both the client and counsellor in varied degrees depending on individual circumstances.

I have personal experience of NHS health care provision as a patient therefore I have experienced similar organisational cultural influences and observed and experienced the NHS from a similar perspective to that of my counselling clients. I have gained an understanding of NHS cultural influences and an appreciation of subsequent difficulties encountered by patients from the perspective of a patient. The previously gained information, and understanding achieved as a patient has been enhanced whilst working within the NHS as a counsellor. This opportunity has enabled me to view and examine the NHS and its culture from another perspective enhancing my awareness and knowledge further.

The uniqueness of the client and counsellor are an intricate fundamental part of the counselling relationship however when both are intrinsic to the same organisational cultural this adds another dynamic to the therapeutic relationship. Counsellors and clients may have experienced comparable cultural influences resulting from sharing similar experiences within the NHS as patients, employees, or both. These experiences and influences may encroach into the therapeutic relationship.

I consequently believe that counsellors working within the context of the NHS will improve their clinical practice by gaining an understanding of this dynamic and becoming aware of organisational cultural influences on the client and counsellor thus the therapeutic relationship. I therefore have intentionally studied the culture and dynamics of the NHS and also examined definitions of culture and organisational culture as well as found out about the structure and classification of organisations. This learning and additional knowledge has stimulated my self-exploration as part of my heuristic research process and my quest to "*track down*" to obtain further comprehension and information.

<u>Definitions of culture.</u>

I discovered that various definitions of culture replicate the differing theories for understanding and evaluating human activity. Culture has ancestry as an anthropological and sociological concept denoting how people exist and behave as a consequence of particular mutual beliefs and social practices. Cultural anthropology is the study of culture and social systems from a broad ethnographic sense. Cultural anthropologists are concerned about the concept of social systems of societies. The theory integrates the distinctive human form of adaptation and the distinctive manner in which different human populations arrange and organise their individual cultures, each culture having structure and an array of implicit and explicit protocol, either conscious or unconscious, which people acquire as components of that distinctive cultural group. Keesing (1981) defines culture from an anthropological viewpoint as;

"Systems of shared ideas, systems of concepts and rules and meanings that underlie and are expressed in the ways that humans live" (Keesing, 1981, page, 68.)

The United Nations Educational Scientific and Cultural Organisation (UNESCO) descried culture as;

"Culture should be regarded as the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and that it encompasses, in addition to art and literature, lifestyles, ways of living, together, value systems, traditions and beliefs." (UNESCO, 2002, page, 1.)

These two definitions of culture cover an extensive range of meaning and assist in the clarity when endeavouring to understand the term "culture", however these definitions do not exhaust the numerous usage of the term "culture".

Social scientists from varied disciplines recognise the importance of understanding cultural anthropology in order to inform, enhance, and develop their particular professions. Schein, (2004), (1999), a Professor in Management and whom is considered to be one of the 'founders' of organisational psychology advocates that high-quality managers must work from a more anthropological model and have an

understanding of cultural anthology. Rogers (1951) whom is considered to be the founder of the humanistic approach to psychology and instrumental in the development of non-directive psycotherapy advocates that counsellors' practice would benefit from gaining an understanding of cultural anthropology.

" It seems desirable that the student should have a broad experiential knowledge of the human being in his cultural setting. This may be given, to some extent, by reading or course work in cultural anthropology." (Rogers, 1951, page, 437.)

Culture has been described as,

"The way of life for an entire society." (Jary and Jary, 1991.)

I argue that culture influences everyone's daily existence and behaviour I thus consider that all counsellors, but particularly those practising within organisations will benefit from studying and attaining an understanding of how organisational culture may influence the counsellor, the client, and therefore the therapeutic relationship.

Definitions of organisational culture and sub-cultures.

"*Organisational culture*" is a term that is difficult to articulate distinctively but in a general sense, organisation culture is the personality of an organisation.

The topic of organisational culture has been studied from many varied perspectives and I have discovered that there is no single definition of "*organisational culture*". Definitions exist from various disciplines perspectives including; anthropology, Becker and Geer (1960), sociology, Louise (1980), organisational behaviour, Allaire and Firsirotu (1984), management and leadership, Schein (1988) organisational communication, Trice and Beyer (1984).

In summary, the definitions of "*organisational culture*" fall into two general categories the anthropology and sociology viewpoint opposed to the organisational behaviour, management, and organisational communication perspective. Sociology and anthropology view organisational culture as implicit in social life and believe

organisational culture naturally transpires as individuals transform themselves into social groups. The organisational behaviour, management, and organisational communication, standpoint is that organisational culture is an explicit social creation arising from social interactions as a consequence of behaviour. For instance organisational culture is comprised of observable appearances such as, methods of working and problem solving, ceremonies, design of physical environment, customs, and language that the group creates through social interactions to challenge the broader social context.

Having studied literature pertaining to the culture of organisations, I have interpreted that cultural researchers are frequently at variance with regard to the definition of "*organisational culture*". Numerous, often contradicting, definitions of organisational culture exist, influenced by many factors including the researcher's philosophy, chosen approach to research, and personal bias. (Martin 1992) recognises the discord amid cultural researchers and endeavours to consolidate the diverse theoretical and empirical studies into an analytic structure of "*organisational culture*" that both clarifies as well as challenges hypotheses from differing studies relating to "*organisational culture*".

Martin states, *"Generalist research examines a wide range of cultural manifestations". (Martin, 1992, page, 41.)* I consider a definition of organisational culture from a generalist research perspective to be a generic definition because the generalist approach has an all-encompassing perspective examining varied interpretations of "*organisational culture*" including the relationship with other themes of organisational theory. Martin (1992) refers to the following citation by Sergiovanni and Corbally (1984) suggesting it is the; *"Clearest representation of a generalist approach". (Martin, 1992, page, 53.)*

"A standard definition of culture would include the system of values, symbols, and shared meanings of a group including the embodiment of these values, symbols, and meanings into material objects and ritualised practices. The "stuff" of cultures includes customs and traditions, historical accounts be they mythical or actual, tacit understandings, habits, norms and expectations, common meanings associated with fixed objects and established rites, shared assumptions, and intersubjective

meanings." (Sergiovanni and Corbally, 1984, page, viii.)

The following quotation referring in a frivolous yet accurate manner defines the organisational culture of the NHS, which is comparable to the previous generic definition of organisational culture, Sergiovanni and Corbally (1984);

"The medical world can be linked to a tribal society. The ubiquitous visitor from Mars might discover a culture with a rich recorded history in addition to its folklore which has a complex system of values and beliefs and an established educational system rooted in science but also responsive to sponsorship and patronage by the elders who offer funds for research. Outsiders are excluded. There are strange rituals and ceremonial dress, peculiar rites of passage, apprenticeships and initiation tests, oaths of fealty and loyalty, both formal and informal codes of behaviour and rules of punishment and excommunication." (Lees, 1999, page, 26.)

During the Government's instigated independent inquiry into children's heart surgery at the Bristol Royal Infirmary Bristol Royal Infirmary (2000) a seminar discussion took place to explore professional and managerial cultures and their impact on the quality of service. The seminar recognised that the NHS has an established "*organisational culture*". The seminar defined "*organisational culture*" as a culture that has a mutually shared set of ideas, behaviours, understandings, norms, conventions, and values that are embodied in symbolic systems such as ceremonies, rituals, jargon language and linguistic shorthand with conditions based on membership of the culture.

Large societies or organisations often have sub-culture, which are groups of people with distinct sets of behaviours and beliefs that distinguish them from the larger group that they are a part of. Sub-cultures can be based on identification with union membership or membership of professional associations, professional roles, education and training and occupational or professional skills or by geographical location. Sub-cultures have specific characteristics and a sense of identification yet concurrently they remain united with the ideologies and values of the organisations overall culture.

The Bristol Royal Infirmary Inquiry (2000) acknowledged the influence of several dominant sub-cultures within the organisational culture of the NHS. The following quotation reflects the sub-cultures within NHS Primary Care Trusts and therefore the difficulties of classifying organisations such as NHS Primary Care Trusts into a structured category of classification;

"The primary care sector as a whole consists of a differentiated variety of sub-cultures, probably numbering as many as there are surgeries." Lees, 1999, page, 1.)

I have providing counselling provision for two NHS Primary Care Trusts (PCT) in ten different surgeries. The surgeries are demographically and geographically diverse according to Reilly and Eynon, (2003) as they are located in areas representing some of the 10% most social and materially deprived arrears of England as well as those ranked as the most affluent. The number of patients registered with surgeries varied from 5,000 to 19,000. The geographical areas that the surgeries provide provision for vary from densely populated urban areas covering only several square miles to sparsely inhabited rural countryside. For instance one surgery in a town has a patient catchment area of only several square miles whereas a rural surgery comprises an area of over approximately 400 square miles.

I was initially aware that each individual surgery had a differing sub-culture. I concluded that this was due to the diverse geographical and demographical influences that had an obvious bearing on the culture of individual surgeries. After further reflection and investigation, I discovered that even surgeries sharing similar demographic and geographical localities with comparable populations of registered patients had noticeable different sub-cultures. I therefore determined that every surgery is a unique sub-culture of the NHS with further sub-cultures existing within each surgery.

"*Organisational culture*" is intricate, multifaceted, and very complex especially the "*organisational culture*" within a large organisation like the NHS. Hall, (1959); Gitternam and Miller, (1989); Trompenaars, (1993); have acknowledge the complexities of "*organisational culture*". When gaining an enhanced understanding

of an organisations culture one must not just observe the manner in which an organisation formally undertakes its business. To accurately comprehend one should focus on the less obvious more implicit and informal characteristics that influence how decisions are made and how people's behaviour is influenced by the organisation. I consider that by examining an organisation culture from different points of view and from a sociological perspective in particular one can augment and enlighten understanding of the complexity of that organisation.

"Applying sociological perspective and looking at each organisation as a unique living entity in itself, one that has its own history, traditions, character and patterns of internal dynamics; one that has a "culture" of its own." (Carroll and Walton, 1997, page, 92.)

I suggest that by observing an organisation as a culture and attaining increased understanding of the nature of the culture and sub-cultures encourages counsellors to examine beyond the façade of the organisation. The gaining of deeper understanding of the organisational culture facilitates comprehension of how organisational culture imparts influence on the client and counsellor thus the counselling provision provided and the therapeutic relationship.

<u>The classification of organisations and structure of organisations.</u>

I am aware that organisations may be labelled and classified into categories however I believe that this is a difficult undertaking. McKelvey (1975) stated that the study of classification of organisations is at such an early phase that conformity cannot be even made about general terminology. He also puts forward that existing classifications are not comprehensive enough to classify organisations into scientific groupings and that no standard theory of classification has been agreed. The Office for National Statistics (2007) has classified organisations in the National Accounts by how the organisation engages in transactions involving goods, services, and financial assets. This manner of classification is materialistic and fails to consider the influence of the organisations culture, which is more complex and complicated to accomplish.

Organisational structures refer to who has authority, how decisions are made, and who relates to whom. Chandler (1988) claims that the first organisational structure "chart" designed to resolve uneconomical and ineffective organisational management was created in 1854. The organisational chart designed by the General Superintendent of the New York and Erie Railroad illustrated a line of authority depicting responsibilities of people and their accountability to their direct supervisors. The chart enabled everyone to understanding, which people had authority and who each person was to associate with and work with as well as how decisions were made.

Classification of organisations.

I have discovered attempts have been made to classify organisations by the type of culture present in the organisation, Harrison (1972), Pheysey (1993), Summerfield and Van Oudtshoorn (1995), Critchley and Casey (1989). This classification allows organisations to be compared and contrasted with one another in a universal manner. A limitation of the compartmentalisation of organisations is that organisations can be generalised without considering that culture within organisations can vary in intensity, and many varieties of differing sub-cultures exist within an organisations culture. I argue that organisations may be similar but each one is unique and different, in a similar way to people, we may be similar but we are all unique and different individuals.

As a consequence of *"tracking down"* information relating to cultural categories and relating the findings to my heuristic understanding and experience, I consider that the NHS could be categorised as a power culture, Harrison (1972), Pheysey (1993) Carrol (1996). The following is a definition of a power culture;

"The power culture is one where dominance rules, where strength and control are cherished values, and where individuals know their place in the pecking order. Usually hierarchical leaders are seen as making key decisions, without feeling, and keeping clear and tight control on what happens." (Carroll, 1996, page, 77.)

The Bristol Royal Infirmary Inquiry seminar discussion on culture revealed that the culture of the NHS is founded on power;

"Medical culture has traditionally been based on power." (Bristol Royal Infirmary Inquiry, 2000, page, 3.)

The Bristol Royal Infirmary Inquiry (2000) cited examples of cultural expectations of medical Doctors that compare precisely with Carroll (1996) definition of a power culture, these include; *not to show emotion, to be tough and not to complain, to be self managing and self sustaining, not to draw on peers for help, and not to criticise other Doctors*. The Inquiry concluded that the cultural expectations of medical Doctors are regulated by the existence of subconscious and implicit power generated from the organisations culture.

"Such expectations are neither explicit nor openly discussed, but those whom defy them may encounter difficulties in their careers." (Bristol Royal Infirmary Inquiry, 2000, page, 3.)

Medical Doctors are perceived to hold powerful status and cultural influence within the hieratical organisational culture of the NHS. The following citation confirms the NHS as a hieratical power organisation and corroborates the medical Doctors position within the organisation;

"The hierarchical structures of the personnel are reinforced by the building itself. In this spatial metaphor for the status of the staff the doctors and nursing staff work on the top floor, normally accessed by a lift, the counsellors on the floor below and ancillary and support services on the ground floor." (East, 1999, page, 110.)

I have observed the hieratical status of GP's and experienced their powerful influence within PCT surgeries as well as noticed their influence on the culture and sub-cultures. The hieratical position of medical Doctors I have detected in the physical aspects of surgeries such as; separate car-parking facilities closer to the surgery entrance, a different doorway to the surgery than other staff and patients, superlative rooms with contemporary furnishings, their own rest rooms with cups and

sauces and fresh coffee. This is in comparison to other staff having to experience limited car parking or having to pay for parking, allocation of whatever room is available and sharing a dishevelled assortment of mugs and cheap instant coffee.

As a consequence of the Doctors eminent hieratical position within the organisation, I argue that if the aforementioned cultural expectations of medical Doctors stated in the Bristol Royal Infirmary Inquiry (2000) are actually present these unconscious expectations must be replicated throughout the entire organisational culture of the NHS. I subsequently consider that individuals throughout the organisations culture must be influenced by cultural influences such as; *to be tough and not to complain or show emotion, to be self managing and self sustaining, and not to draw on peers for help.* I concur with this deduction because I have noticed these perceptible cultural constructed qualities in individuals when examining interactions with NHS employees and myself and also whilst observing communications between NHS employees as well as exchanges involving NHS employees and patients.

Structure of organisations.

Organisational structure relates to the allotment of work and tasks. Traditionally structures focus on the purposes of subdivisions of the organisation and individuals that are performing various tasks according to the organisation's standard bureaucratic procedures and culture. I have discovered that organisations may be systematised into cultural categories, but within the organisation, dissimilar organisational structures exist.

Since groups and individual people are often in different locations executing different tasks and having different responsibilities but working toward a common organisational objective a plan showing how the work will be structured and organised ought to be in existence. The plan for the efficient arrangement of work is the "*organisation structure".* The following is a definition of "*organisational structure*".

"Organisation structure is comprised of functions, relationships, responsibilities, authorities, and communications of individuals within each department" (Sexton, 1970, page, 23).

The structure of an organisation is created by organisational design. An organisational design known as classic bureaucracy was developed from the traditional hierarchical organisational systems such as the Armed Forces, by a German sociologist Max Weber (1947). This design is comparable to the hierarchical organisation of the present day NHS in that management is marked by hierarchical authority among numerous offices and by fixed procedures.

I have personal experience of working and also residing within a hierarchical organisation. This was gained from over twenty-three years service within the Armed Forces. I have become aware of apparent similarities between the culture and organisational structure of the NHS and the Military. The following quotation from the investigation into the Bristol Royal Infirmary refers retrospectively, however current evidence including my heuristic findings suggests that similar perspectives are still evident within the NHS.

"The almost military organisation of nursing was exemplified in the past by the marking of incremental progress through the ranks by such symbols as gaining a new belt." " (Bristol Royal Infirmary Inquiry, 2000, page, 4.)

Martin (1968) recognised the work of Robert Michels a student of Webber. Michels developed Webbers ideas in particular those pertaining to organisational classic bureaucracy design. He believed that any large organisation, when faced with problems of coordination could only solve these problems by creating a bureaucracy. A bureaucracy, by design, is hierarchically organised to achieve efficiency because many decisions have to be made daily which cannot efficiently be made by large numbers of people. The effective functioning of an organisation therefore requires the concentration of much power in the hands of a few with a hierarchical structure.

I believe that the descriptions of classic bureaucracy design are comparable to the structure of the NHS despite the fact that the NHS is transforming and has been forced to facilitate consultation with patients and the public. The involvement of the general public in the transformation of the NHS is in compliance with the Act of Parliament (2001) specifically the, *"Health and Social Care Act, Chapter 15, Section 11"* which states that the NHS have a legal duty to involve and consult patients and

the public in regard to service planning, operation, and provision as well as in the development of proposals for change and improvement.

Acquiring an appreciative of the structure of organisations in particular the NHS has assisted me to understand the dynamics of the organisation and how the organisation functions. This knowledge enables me to consider how the organisational structure may have an impact on counselling.

Implications for counselling.

By means of using the technique of *"tracking down and tracing back*", to discover "*How may organisational influences influence the therapeutic relationship?"* I have uncovered essential information that has enabled me to acquire an increased understanding of the organisational dynamics and culture of the NHS. I have endeavoured to use this information to gain awareness and understanding of how organisational factors may influence the counselling relationship.

I contend that counsellors employed within an organisational context should be aware of the additional dynamics that the organisational context creates.
I suggest that by studying an organisation as a culture and obtaining increased understanding of the nature of the culture and sub-cultures as well as the dynamics of the organisation encourages counsellors to examine beyond the façade of the organisation. This enhanced understanding enables counsellors to understand how organisational influences may influence the client, counsellor, and therapeutic relationship.

I consequently believe that counsellors working within the context of the NHS or other organisation will improve their clinical practice by gaining an understanding of organisational cultural influences and organisational dynamics.

Conclusions.

I have intentionally examined counselling within organisations and discovered that organisational influences do have an effect on client's perspectives of counselling

consequently also the therapeutic relationship. The NHS in particular exerts its powerful influence on society in general including individuals such as the client and counsellor therefore the counselling relationship.

The purpose of exploring the theory and definitions of culture as well as the definitions of organisational cultures and sub-cultures has informed my understanding of the organisational culture of the NHS. This information has enabled me to gain increased awareness and knowledge of the organisations culture and dynamics in particular how the profession of counselling may be influenced. Examining the NHS from a sociological perspective, I deem that the NHS undeniably has a distinct culture with myriad complex sub-cultures and that the hierarchical organisational culture of the NHS can also be identified with the definitions of culture from anthropology, and organisational perspectives.

Having studied the classifications of organisations and the structure of organisations if I were endeavouring to categorise the traditional hierarchical organisational culture of the NHS I would suggest the culture of the NHS to be a power culture with a structure created by a classic bureaucracy design. This comprehension assists me to appreciate how the NHS functions and therefore how organisational influences and organisational politics may impact on counselling.

<u>An exploration of how the traditional hieratical organisational culture of the NHS may influence the client and the counselling relationship.</u>

<u>Introduction.</u>

"*What organisational influences have the potential to influence the client and possibly obtrude into the therapeutic relationship?"*

If I were to ask the same question when exploring my private practice minimum organisational influences would be present, conversely, if exploring counselling within an organisational context such as the context of the NHS the additional dynamic of organisational influences I would anticipate more apparent.

Hitherto I have gained an enhanced understanding of cultural influences and organisational dynamics, I subsequently have considered how these influences might affect clients' attitude towards the NHS, and the services provided by the NHS such as counselling provision. I decided to focus primarily on possible organisational influences on the client however I acknowledge that organisational influences also affect the counsellor. Initially I intended exploring organisational influences that may have a bearing on the counsellor and client as well as the counselling relationship however discovered the magnitude of this undertaking therefore decided to enforce self-imposed restraints focusing on the client and counselling relationship. I am therefore attentive to endeavour to attain understanding of how clients' perception of counselling provision may be influenced by external influences and how these may impinge into the counselling relationship.

In order to explore how the traditional hieratical organisational culture of the NHS may influence the client and the counselling relationship I contemplated the following question;

"How the traditional hieratical organisational culture of the NHS and the societal perspective of counselling may influence the client and the counselling relationship?"

I considered the influence of clients' personal experiences of the NHS and that of the media to discover if these factors may have a consequential effect on the counselling client by influencing their attitude in either a detrimental or productive manner.

I studied the contrast between some NHS sub-cultures and explored how the influence of conflicting NHS sub-cultures may influence patients and counselling clients. I examined two examples, *appointment systems* and the *imposed limit of counselling sessions* to illustrate how conflicting sub-cultures may influence patients, clients, counsellors and the therapeutic relationship.

I have explored counselling's position within the hierarchical structure of the NHS and the societal perspective of counselling to discover possible influences to the client and consequently the counselling relationship.

Throughout I have been mindful to try and acquire a perception of how clients' view of counselling may be prejudiced by external influences and how these factors may intrude into the counselling relationship.

In conclusion I re-evaluated the initial title, *"An exploration of how the traditional hieratical organisational culture of the NHS and the societal perspective of counselling may influence the client and the counselling relationship?"* I considered my findings I had discovered and considered the implications to counselling.

<u>How previous experience and perception of the NHS may influence a counselling client?</u>

Similar to many counsellors I am self-employed and not employed directly by the NHS, however from my experience clients still deem myself to be an employee and the counselling service an integral part of the NHS. This perception is understandable since NHS staff instigate referrals and counselling takes place in NHS premises with my name on the door of the counselling room.

When I examined the influence of the NHS on society I concluded that the organisational culture of the NHS exerts cultural influence on those within the organisation as well as on almost every person who has utilised NHS health care. I therefore considered the following question;

"How previous experience and perception of the NHS may influence a counselling client?"

I believe that previous experiences of the NHS and individuals perspectives and considered opinions of the NHS may affect viewpoints and attitudes towards counselling. This is because counselling is understood to be an integral part of the organisation. This pre-conceived judgment has the power to intrude into the therapeutic relationship in either a hindering or advantageous manner.

The client's perception of the NHS is based on their own and others previous experiences as well as the influence of the media. The media has a strong social and cultural impact upon society as it has the ability to communicate strong influential messages to an extensive audience using many means including radio, television, newspapers, and other publications as well as the Internet.

I am have been aware of detrimental media coverage of the NHS for some time. When I was offered counselling work within the NHS in 2003 I did consider the negative exposure by the media whilst making an informed decision. Individually we rely on information to make choices and to inform our opinion. The media however are able to decide which topics and issues are given broadcasting time or publishing space and which aspects and facts are presented or concealed. Media therefore have the ability to influence public opinion and those controlling the media are capable of altering the nature of discourse in their desired direction. The following two quotations by, Richard Salent, former president, of CBS News and Richard Cohen, Senior Producer of CBS political news confirms this fact.

"Our job is to give people not what they want, but what we decide they ought to have." (Mass media influence on society, 2008.)

"We are going to impose our agenda on the coverage by dealing with issues and subjects that we choose to deal with." (Mass media influence on society, 2008.)

Despite promoting and driving comprehensive reforms to improve and develop the NHS the NHS experiences negative media coverage. The following quotations emphasises this perspective;

"If the aims of the NHS Plan are so well founded and supported by reforms, why have we seen so much negative media coverage portraying the NHS in crisis." (Robinson, 2006, page, 8.)

"National media reports portray it as an organisation at boiling point due to the extent, speed and pressure of change. This pressure is real, but across the board

there is also a wealth of opportunity and grounds for optimism about what the reforms will enable the NHS to deliver." (Robinson, 2006, page, 9.)

A Google alert is a service offered by Internet search engine Google, I have utilised Google alerts for some time to monitor and keep updated on issues relating to the NHS. On the day that an article is printed in a media publication I am sent an email with the contents of the article contained within. I have become aware of a continuing trend of detrimental publicity directed towards the NHS. A typical example is that between the 01 April and the 21 April 2008 I received emails containing news relating to the NHS on 19 days and on only one occasion did the news not contain disparaging publicity.

During counselling clients regularly mention adverse articles concerning the NHS highlighted in the media however these articles rarely epitomise clients' unfavourable experience of the NHS even so the clients perspective of the NHS is influenced detrimentally. I do not want to test or question the credibility of media reporting of the NHS however I argue that frequent detrimental reporting impacts on patients consequently influencing their perspective of the NHS in a negative manner.

I consider that a client would have a positive proactive attitude towards counselling if the person believed that the NHS provided a quality service. This considered opinion would be based on previous positive experiences of the NHS and the high standard of the provision provided by the organisation. Conversely, a client who held negative unimpressed beliefs regarding the service provision of the NHS due to having encountered detrimental experiences would be apt to have a pessimistic perspective of the NHS and a similar view and attitude towards counselling within the context of the NHS.

If the counselling client determined that they were either satisfied or dissatisfied with the physical aspects and environment as well as the atmosphere and manner in which the surgery was managed this predetermined opinion has the influence to effect individuals' attitude towards counselling which is located within that surgery. This judgement potentially may influence the counselling in either a disadvantageous

or constructive manner. I intend to explore the influence of the physical and environmental aspects of surgeries in greater detail.

Crandell and Allen (1982) and Carroll and Walton (1997) suggest a "*parallel process*" in which clients experiences, opinions and feelings relating to the organisation and the organisational culture will transpire concurrently with their presenting issues into the counselling process.

"Some issues that are brought to the counsellor will be owned by the individual clients whereas others may well be a reflection of wider issues of the organisation itself." (Carroll and Walton, 1997, page, 134.)

The following is an extract from a written Client Satisfaction Questionnaire (CSQ) completed at the conclusion of counselling;

"I was pissed off with the NHS. No one listened or cared. What's the point of doing all them stupid questionnaires when no one gives a shit. I was totally dissatisfied with everything to do with the NHS. Months waiting for appointments then to be cancelled, re-arranged - with link workers, psychologists, psychiatric people, then back to see you in the same room that it all started the GP's room. I was pissed off with you and I am sorry for been rude I was just so annoyed with the system. You had the patience of a saint and somehow understood my circumstances. I was so angry that I convinced my self that I wasn't going to let this counselling work."

The comments from the client highlight how a client's previous experience and opinion of the NHS had intruded into the counselling relationship detrimentally.

Alternatively previous positive experiences of the NHS and holding the NHS in a high status can have an effect on counselling clients in an optimistic manner. I have had affluent people choose NHS counselling service provision before a private referral due to their positive assumed view of the NHS. I have discovered people in a quandary over what counsellor to choose mainly due to having little comprehension regarding different therapeutic approaches and what therapy would be beneficial or their choice. Prospective clients have believed that, as I was a NHS counsellor I

would have the appropriate personal and professional credentials to be able to provide them with a perceived exceptional service. I have been propositioned in the inaugural session to provide private counselling rather than NHS counselling at an exceedingly higher monetary rate. I have declined these proposals and offered to continue working with them via the NHS. I have however become aware of clients who have had a positive view of the NHS also have a pro-active and constructive perspective towards counselling.

I suggest that clients' previous experience of the NHS definitely has an influence on clients in either a beneficial or detrimental manner to their therapy. I argue that counsellors ought to be aware of this dynamic especially when establishing and maintaining a therapeutic relationship.

The influence of conflicting NHS sub-cultures on patients / clients.

Having an enhanced understanding of the organisational culture of the NHS and an awareness of sub-cultures within the organisation has enabled me to explore the dissimilarities between sub-cultures. I have observed, experienced, encountered and become aware of conflict between sub-cultures within the NHS. I contemplated if this inter-cultural discord might have a bearing on the client or counselling provision. I asked my self the following question;

"How may conflicting NHS sub-cultures have an influence on the patient / client?"

I considered this question and discovered that the tensions and conflicts that exist between the sub-cultures of the NHS have the power to influence the clients' care and treatment with the client having little or no control to influence organisational policy regarding their individual treatment.

The overall objective of the NHS could be identified as, *"to maximise the quality of patient care"*, and the intention of the DH (2000) NHS Plan is to provide a health service designed around the patient.

"At the heart of the Plan is the aim of ensuring these resources are used effectively to provide a health service "designed around the patient"." (University of York, Centre for Health Economics, 2001, page, 1.)

With common objectives it could be assumed that the different elements of the NHS would have the same mutual aspirations to providing a quality service for the patient including similar courses of action in executing and achieving these objectives. Nonetheless, dominant sub-cultures within the NHS with similar nevertheless dissimilar structures of bureaucracy design often have different and contradictory understanding of how to provide health service provision. Medical professionals for instance may concentrate on providing the optimum care for individual patients whilst managers most likely will focus on patients collectively.

I contend that clinical based NHS sub-cultures may be in conflict with sub-cultures who set value on fiscal policies rather than health care and health promotion. The Bristol Royal Infirmary Inquiry (2000) identified the tension between different NHS sub-cultures;

"Tensions between managers and clinicians may be heightened where politically determined objectives on patients collectively, are thought to have a detrimental impact on a certain individual patient." (Bristol Royal Infirmary Inquiry, 2000, page, 3.)

Smith and Norton, (1999) explore, identify, and describe the sub-cultures that influence the NHS designating the upper echelons of the organisational hierarchy as supra-cultures and the sub-cultures within multidisciplinary medical teams as sub-teams. Miller (1989) declares that tensions between sub-cultures in clinical teams have detrimental influence on staff moral, which results in sickness, absenteeism, and malingering. This discord between the sub-cultures within the organisation is likely to effect the functioning of a team and also clinicians individually. Consequently variance between sub-cultures has the potential indirectly to degenerate patients' health care.

I concur with Smith and Norton (1999) and Miller (1989) and argue that whatever part of the hierarchical organisational continuum a sub-culture is positioned that sub-culture has the potential to influence both the patient and counselling client either directly or circuitously. The following quotation confirms that cultural discord between sub-cultures is able to detrimentally impact on service users;

"Complications at either level can feed up or down the hierarchy of systems and so affect the functioning of the team or the clinical transaction." (Smith and Norton, 1999, page, 107.)

Conflicts between sub-cultures may also impact on counsellors therefore indirectly influencing the counselling relationship. Direct cultural influences caused by tensions between sub-cultures that do not understand the ethos and culture of counselling or are governed by monetary matters impact on counselling provision and individual counsellors. For instance the precincts to service provision such as the limit of counselling sessions allocated to each surgery and the amount of sessions permitted for each individual client can impact directly onto the counselling relationship as well as influence the client and counsellor individually.

<u>Example of how conflicting sub-cultures influence patients / clients: Appointment systems.</u>

An example of contradicting attitudes between sub-cultures in the NHS that pervades to patients is the appointment system in some primary care surgeries. In order to minimise "did not attend" (DNA) rates many surgeries operate a book an appointment on the day policy. People responsible for financial budgets and the optimum use of resources have initiated this strategy for patients collectively rather than individual patients care. I am aware of disgruntlement from both medical professionals and patients alike regarding this policy.

NHS (2007) explains that since January 2006 the NHS has instigated a patient "*choose and book*" system for hospital appointments allowing the patient to choose the date and time of their appointment from at least four hospitals or clinics. Nonetheless patients' still experience difficulties gaining access to appointments in

NHS primary care surgeries. A Patient and Public Involvement Forum sought the opinions of approximately 1,000 people and discovered that;

"The major cause of anxiety expressed by patients was in attempting to telephone practices to arrange appointments". (Darlington Patient and Public Involvement Forum, 2007, page, 1.)

I concur with this finding because numerous counselling clients relate their unpleasant experiences regarding this appointment procedure during counselling which detrimentally influences therapy as it distracts from the focus of addressing their primary presenting issues.

The surgeries that utilise this type of DNA strategy may reduce DNA's however the policy also has the potential to cause needless distress and inconvenience to some patients.

The following is an example of an elderly lady who revealed her experience during counselling;

She had "Obsessive Compulsive Disorder" (OCD) as well as arthritis and other physical conditions effecting mobility, as a result she found it almost impossible to leave her home in the morning. She described the anguish she experienced when in winter suffering from an infection she endeavoured to organise an appointment with her GP. For four succeeding mornings she endured her medical conditions and severe winter conditions to walk to the closest public telephone in order to stand for thirty minutes repeatedly calling the engaged appointment line to the surgery, to be eventually informed that no appointments for that day were available and to try again the following day.

I am able to relate to patients dilemma as the surgery that I was registered operated a telephone on the day for an appointment policy. I have used the technique "*tracing back*" to gain further understanding from a patient's perspective. The inconvenience of the appointment system caused personal distress to me and persuaded me to persevere with medical condition instead of trying to procure an appointment with a

GP. If I endeavoured to obtain an appointment I would have to cancel appointments with counselling clients for the entire day because I could not be certain of a definite appointment time. I would not even be guaranteed an appointment so would have to persevere again the following day with the same quandaries for my self and my clients, if unable to attain an appointment. This appointment system causes distress to my self, including loss of earnings, non-fulfilment of contracts and consequently complications and difficulties for my clients.

At the end of initial counselling sessions I have observed clients' literally cry with relief when we arranged their subsequent appointment. The obvious relief and satisfaction of my counselling clients when I collaborate with them in the arranging of their ensuing appointments emphasises the value that people place on having control of their own health care including their appointments. If I am able to arrange the first appointment personally by telephone I do so by listening to the client and mutually agreeing a convenient date and time. I notice clients' sincere displays of satisfaction to this method of setting appointments. Sometimes administrative and support staff arrange my appointments and confirm the overall satisfaction of clients when arranging their counselling appointments. Support staff and clients have stated that this approval is due to the client having choice and autonomy.

<u>Examples of how conflicting sub-cultures influence clients and counsellors: Imposed limit of counselling sessions.</u>

I have encountered disagreeing perspectives between counsellors and those responsible for the management of counselling services. I am aware many counsellors working within the NHS or EAP settings including my self would like to have more flexibility and have professional autonomy in the amount of sessions we can provide to clients, however people interested in budgets such as those involved in the management of services often limit the sessions rigidly. The restraints placed on counselling provision has an effect on both the counsellor and client therefore has the potential to influence the therapeutic relationship.

On occasion several additional counselling sessions over the agreed allocation could proactively prevent the clients' condition deteriorating and avoid the client having to

re-refer at a later date for superfluous counselling appointments. The freedom for the counsellor to decide on further additional sessions would potentially save money by reducing the number of sessions overall. For instance, 8 initial contracted appointments plus several additional sessions are less than a future re-referral of 8 sessions. The following extract describing the procedures for the quantity of counselling appointments, I consider this to be an example of a flexible, positive, proactive approach to counselling provision.

"The service offers up to 8 appointments with the provision to extend if the referrer and counsellor agree that there is potential for significant improvement". (Newbould, 2007, page, 1.)

This illustration Newbould (2007) respects the counsellors' professional judgement and also may optimise a more cost effective service. In addition this example of practice precludes the client from experiencing further distress by ending counselling at an inappropriate time as well as promoting clients well-being and respecting their autonomy, therefore abiding by the ethical principles of counselling and psychotherapy according to the BACP Ethical Framework for good practice, BACP (2002).

Frequently on written client satisfaction questioners completed at the end of therapy clients express dissatisfaction with the number of counselling sessions available. Clients regularly comment during the contractual part of the initial session on the constraints of counselling sessions. The following are examples of clients' remarks;

"What's the point I wont even be scrapping the surface by session six."

"Six just six I was in therapy for two years. We wont even know one another before we are saying good byes."

"I have waited three times longer for counselling than the weeks I am going to be able to have appointments."

If the client has a negative attitude towards therapy instigated by the restriction of sessions this will impact directly on the counselling. Additional demands are placed on the counsellor to establish and maintain a therapeutic relationship and to "socialise", and promote therapy. This is even more difficult if the counselling is in agreement with the client regarding the constraints to counselling because destructive pessimistic collusion and parallel processes may develop to the detriment of the counselling.

I endeavour to convey my congruence to the client. If appropriate to refer to the issue and if I deem that more than the allotted limit of sessions would be advantageous I state this fact. If I consider that even limited appointments would benefit the client I communicate my opinion. My clients' verbal responses and written satisfaction questionnaires confirm that clients still gain from counselling even when strict restrictions are implied to the amount of sessions I am able to provide. My clinical data relating to my practice collated using Clinical Outcomes for Routine Evaluation (CORE), Grey, and Mellor-Clark, (2007), Core IMS (2008), a method of measuring outcome, evaluation and performance management, suggests that my counselling clients benefit significantly from counselling even when the amount of appointments offered is imposed.

I find that even if the client is sceptical regarding counselling due to the limit of sessions by conveying Rogers (1961) core conditions especially empathy and congruence assists in establishing a trusting productive therapeutic relationship. This quotation empathises the importance of the core conditions in establishing trust and facilitating counselling process;

"Like empathy and unconditional positive regard, congruence makes it easier for the client to trust the counsellor and the counselling process." (Means and Thorne, 1988, page, 86.)

I involve clients in any decision relating to their therapy including the option of additional sessions or the restricted limit of appointments. I believe that this process encourages client autonomy and facilitates the client to experience feelings of becoming valued, understood, and listened to, which has the potential to enhance

the therapeutic relationship positively as the person becomes acquainted with their changed role as an autonomous counselling client rather than a patient expecting and waiting for expert advice.

I call the transition that a person makes from a patient in any type of clinical relationship to that of a client in a counselling relationship, *"from patient to client".* I believe that in all types of counselling but especially in time limited therapy with a person–centred nature, someone will gain the most benefits the sooner that they are able to assume the role of a client willing to participate and collaborate in therapy as an autonomous individual, rather than as a patient awaiting guidance from a perceived expert the more benefit.

<u>The influence on clients due to counselling's position within the hierarchical structure of the NHS and the societal perspective of counselling.</u>

During my research so far I have gained increased knowledge and understanding of organisations and organisational cultures and sub-cultures. I have discovered that the NHS is a hierarchical organisation with many sub-cultures sometimes in conflict with one another.

I intend to use this information and my enhanced awareness to explore counselling in the organisational context of the hierarchical NHS to endeavour to discover if counselling's perceived position may influence the client and or the counselling relationship.

I propose to explore societal perspective of counselling in order to establish if this perception may influence clients and counselling.

I consider that it is important for counsellors to understand the dynamics of the organisational culture in which they practice and how these dynamics may influence counselling.

<u>Counselling's position within the hierarchical structure of the NHS.</u>

I recognise the existence of many powerful sub-cultures within the NHS for example within the Primary Care Trusts each surgery is a unique sub-culture. Within the surgery more sub-cultures exist these include; the medical sub-culture comprising of medical doctors, nursing, specialist nursing other sub- cultures include administrative and support, mental health, and health promotion. On reflection counselling does not appear to belong to any of the aforementioned sub-cultures.

As a self-employed counsellor working within the NHS I encounter difficulties gaining acceptance by the cultural organisational groups. This dilemma encouraged me to ponder;

"Where do counselling and the client fit into the hierarchical organisation culture of the NHS?"

I endeavour to explore this question from a client's perspective and the position of counselling as a profession utilising the technique of *"tracking down and tracing back"*.

Membership of organisational cultural groups is defined by the ability to be accepted by the cultural group. Counselling as a profession has still not been perceived as a valid organisational member of the NHS organisational hierarchical culture. For a prolonged period of time the profession of counselling has encountered almost constant conflict with the medical orientated cultures and therefore the NHS and its sub-cultures.

"*Because of its ambiguous epistemological status (is it a psychological or medical treatment?) as far as ownership is concerned, psychotherapy has been at the centre of important boundary disputes and conflicts between professional groups inside the mental health service over the last twenty years." (Pilgrim, 1990, page, 12.)*

As an individual, in a similar manner that is reflective of counselling as a profession I have experienced difficulties gaining membership and acceptance into the organisational cultural of the NHS. As a self-employed counsellor I am perceived by

many not to be part of the NHS organisational culture due to my self-employed status and also due to my profession of counselling.

I meet some of the criteria of membership such as having an awareness and understanding of the customs, traditions, and language but I have no individual history within the organisation and I am difficult to place within the hierarchical structure which is in discord to the established rites, tacit understanding, and shared assumptions of the organisations culture. To be approved by the cultural group one must be able to conform by acting, behaving, and relating in a manner that is accepted within the organisational, as well as understand the culture including the customs, traditions, language, historical influences, tacit understandings, habits, norms, expectations, behaviours, common meanings, established rites, and shared assumptions.

I am regularly engaged in conversations where I sense individual members of the NHS's cultural group are endeavouring to establish where I fit into the hierarchical structure. I note their confusion as they; try to recognise me, look for an identifiable NHS identity card, and strive to guess by my dress and demeanour, "*What my professional position may be*?" Uncertainty is often followed by leading questions that probe for my professional position in the hierarchical organisation, such as;

"Hi, who are you and what do you do?"
"Where are you going to be graded with the agenda for change?"
"Where did you train?"
"Where did you qualify?"
"We have not met. What do you do?"
"I am a "g" grade what grade are you."

I often feel that concurrently people are attempting to assert their perceived hierarchical position and professed self-importance in the pecking order of the organisation whilst investigating my position, I cite the following as examples;

"I am an employed psychotherapist working in secondary care, you must only be a counsellor working in primary care".

“I am a psychologist you have to be a counsellor or I would know you.”

People frequently introduce their self by title and position rather than a name and await my response and reaction.
“I am the matron and who are you”.
“Hi, I am the lead nurse practitioner, what are you doing?”
“I am the senior clinical lead, what do you do?”

The following example draws attention to how NHS employees place importance on their place within the hierarchy of the NHS. Peter Walters (2004) had been a senior NHS manager before becoming a member of a team that provided counselling to NHS staff. He recognised reluctance to use the counselling service by employees who deemed the position of counselling within the NHS hierarchy lower than their perceived ranking. In order to overcome this problematic issue attempts were made to disguise his position within the hierarchical organisation.

“My specific grade and pay point must remain a complete secret from all.” (Walton, 2004, page, 26.)

If, the NHS employs me albeit on a self-employed basis and I experience difficulties gaining acceptance as an equivalent member of the organisational culture, what hope has the client of attaining equal membership and acceptance by the organisational culture. Particularly when the client is not in the employment of the NHS and is generally unaware of the dynamics of the organisations sub-cultures and the customs, traditions, language, historical influences, tacit understandings, habits, norms, expectations, behaviours, common meanings, established rites, and shared assumptions of the culture.

The patient is not employed by the NHS but is a crucial and fundamental part of the organisation and culture as without patients the NHS would not exist.
Paradoxically, the NHS strives to provide a quality service to patients but I believe places them at the bottom of the hierarchical structure. Penny Grey a managing editor of the Journal of the Faculty of Healthcare Counsellors and Psychotherapists (FHCP) a division of the British Association for Counselling and Psychotherapy

(BACP) concurs with my view;

"There still is a hierarchy in medicine, with the client at the bottom" (Grey, 2006, page, 7.)

I regularly observe professionals within the NHS consign patients in general at the bottom of the organisational hierarchical structure, I also notice that mental health patients are placed even lower in the hierarchy in comparison to other NHS medical patients, with counselling clients given an even lower-ranking position. The following quotation is an example of the position of counsellors within the hierarchy of the NHS;

"The marginalized position of most counsellors, who are part time and low in the medical or management hierarchy." (Lees, 1999, page, 103.)

During a discussion with a Primary Care Mental Health Link Worker in relation to my counselling provision, after hearing about my experience and use of therapeutic approaches stated,

"*You are a really skilled and experienced professional what are you doing only working as a counsellor in primary care, you are far better suited to work in secondary care psychotherapy rather than just primary care".*

I mentioned my interaction with the Link Worker in a meeting attended by counsellors employed in a NHS primary care setting and my experience was collaborated by colleague counsellors who stated that they had encountered similar experiences with other mental health link workers. The contrary point of view highlighted counselling's perceived position in the hierarchy of mental health. Link Workers are considered to be expert advisers regarding mental health matters within Primary Care as confirmed in the following statement;

"The Primary Care Link Worker is a specialist experienced mental health practitioner who works alongside your GP providing information, advice and support". (Norfolk and Waveney, Mental Health NHS Foundation Trust, 2008, page, 2.)

The negative perspective of mental health is partially due to the stigma that is attached to mental health and the subsequent treatments that are not considered medical. The "talking therapies" such as counselling are thought to be abstract and considered vague in comparison to concrete measured treatments like medication and surgery.

The perception of how counselling as a profession is regarded within the NHS organisational hierarchical structure I believe influences how other professionals view counselling as a profession, counsellors as individuals and counselling clients. I consider that counsellors should have sufficient self-awareness and cultural awareness to recognise when cultural dynamics can threaten their relationship with other professional colleagues as this could indirectly be to the detriment of the service provision provided to counselling clients. I concur with Seaburn et al. (1996) whom argue that medical professionals who are able to work collaboratively and establish good relationships with one another will consequently provide an improved service to patients. I relentlessly endeavour to promote my self as a professional and advocate for the profession of counselling.

I constantly hear comments from different professional people representative of the different NHS sub-groups that are derogatory to counselling clients. The following is an extract from referral forms from GP's highlighting how NHS professionals often perceive counselling clients;

"I refer the patient to you because I have tried every possible medical intervention to diagnose and discover an prognosis and treatment. Nothing medically is wrong with this person. It is in his imagination he is just apathetic and wasting my time as well as others. Wish you luck!"

"This patient will not heed my medical advice. In fact no advice from anyone drinks to excess, takes risks with sex, and life style. Lives in deprived area with no motivation to do anything with life. Depression, perhaps lazy more likely."

Colleagues whom are NHS professionals have made the following comments

regarding my counselling clients;

"He bleats on and on wont work, wont wash, wont loose weight wont stop drinking wont stop taking illegal chemicals and drugs wont accept that nothing is wrong with him. People like him are the lowest of the low and you always seem to get these stars." Practice Nurse.

"He is just here to whinge, play the system, and get attention. You must have the patients of Jobe listening to that sort of person whine and moan all day." Receptionist.

"My room stinks. She can't even be bothered to wash and look after her self typically one of your type of patients. Do you have to carry air freshener or are you trained to talk while holding your breath." Nurse Practitioner.

I reason that counselling's position as a profession within the hierarchy of the NHS and how other professionals perceive counselling provision will have an influence on the client because either directly or circuitously these negative detrimental influences will have potential consequences on how the client perceives their self and the therapy offered by the NHS.

I have discovered that if the client is detrimentally influenced by their perceived position within the hierarchy of the NHS demonstrating appropriate congruence by sharing my experiences and feelings relating to the position of counselling within the NHS and in particular my personal experiences as a counsellor enhances the therapeutic relationship because these shared experiences promote empathy from a mutual perspective.

During counselling clients recurrently comment that they feel a burden to the NHS, their family and friends, their self, society and my self as their therapist. They perceive themselves in a disapproving manner believing that they are at the bottom of the hierarchical organisational structure even below that of other patients presenting for medical treatment. I argue that a contributing factor to this attitude in

clients is due to counselling's position within the NHS and the stigma that is still associated to mental health and related therapeutic interventions.

Societal perspective of counselling.

There is a commonly held cultural stigma about getting assistance for something that is non-physical or not medical as a result unfortunately attending for counselling is often misunderstood as a sign of weakness or failure. Williams and Davis (2002) and Carrol (1996) acknowledge that there has long been a stigma to counselling and that this attitude still prevails based on the assumption that people should be able to cope and get on with their emotional problems without professional assistance. East (1995) recognises a similar perspective relating to the stigmatisation of mental illness stating that people feel the need to explain mental illness as a physical condition as it is more acceptable.

I am aware of the stigma linked to mental health but have explored the following question to gain an insight and to discover if the societal and NHS organisational view of counselling may have a consequence on the client and the counselling relationship;

"Is the client and the counselling relationship influenced by the organisational and the societal view of counselling?"

The Department of Health (DH) has recognised for some time that stigma and discrimination exists towards mental health.

The DH *(2001)* instigated a national campaign called *"Mind Out for Mental Health*," from 2001 until 2004. It was aimed at tackling the stigma and discrimination faced by people with mental health problems and supporting their social inclusion. The initiative focused on young people, employers, the media and the general public. DH (2004) initiated a five-year anti-stigma strategy "*From Here to Equality"* that focuses on partnership working between the NHS and voluntary and private sectors to reduce stigma and discrimination on mental health grounds. This initiative was

implemented by the National Institute for Mental Heath in England (NIMHE) and the Disability Rights Commission.

The DH (2006) recognised that mental health and related therapeutic interventions are perceived with a negative stigma. On "*world mental health day*" on 10 October 2006 the DH produced a document entitled, *"Action on stigma: Promoting mental health, ending discrimination at work"* to assist organisations improve the way they deal with mental health issues.

Research by the Shaw Trust, which is a UK national charity that supports disabled and disadvantaged people, has discovered that mental health and treatments such as counselling still have a negative stigma.

"The research highlights a lack of understanding about mental health in the workplace and that even in today's more enlightened society there is still a stigma attached to mental health problems". (Shaw Trust, 2006, Page, 1.)

The Healthcare Counselling and Psychotherapy Journal (HCPJ) (2007) reported that mental health charities such as, Mind, Rethink, and Mental Health Media and the Institute of Psychiatry collectively commenced the largest ever promotion to address the stigma of mental health in England. The Lottery Fund and Comic Relief contributed to the campaign.

A similar promotion in Scotland was launched in October 2002 called "*See me*" preceded the England campaign. A *"See me"* survey (2004) (www.seemescotland.org.uk.) discovered that; 57% people concealed their mental health history for fear of loosing their job. 43% of people had not applied for promotion or a job because of trepidation of how their mental health record may have been perceived. 20% stated that they had been denied promotion because of previous mental ill health. 43% of people said that they had been encouraged to leave work or not to return back to work after absence resulting from mental ill health

The negative stigma towards mental health and counselling is reflected in clients' attitudes. This is corroborated by remarks made by clients during counselling. The

subsequent statement by a client is the most common recurring theme I have noticed from clients;

"*I wish that I had a broken leg or arm so everyone could see that I am not well. I am ill this is worse than a broken leg and arm combined and times by 100 but to everyone I am a waster the lowest of the low because nothing is visible." C*lient with depression.

Moore and Garland (2003) have observed similar beliefs in clients;

"Although great strides have been made in reducing the amount of social stigma attached to psychiatric illness, such stigma is still prevalent in many sectors of society. As many patients observe, it seems to be more socially acceptable to have an illness such as cancer than to receive a diagnosis of depression." (Moore and Garland, 2003, page, 120.)

The following are further comments from clients;

"I feel guilty asking the Doctor for help and wasting valuable time that should be for people with genuine medical problems."

"I am taking up your time surely other people have worse problems than me, I don't deserve your help."

"This is the last chance saloon don't think you can help. No one else has."

The external influences relating to the societal negative attitude and stigma towards counselling and counsel lings position within the hieratical structure of the NHS, I argue must have an internal detrimental effect on the self-concept of the clients and how they perceive counselling as a therapeutic intervention.

<u>Implications for counselling.</u>

I have observed that NHS clients often present with a negative self-concept and an

unenthusiastic perspective of counselling. I advocate that the client's previous experience of the NHS as well as their perception of the NHS and of counselling's perceived position within the hierarchical structure of the NHS impinge on how clients present for counselling within the NHS. The detrimental stigmatised societal perspective of counselling also influences clients' perspective of themselves and counselling as a therapy.
The following reference accentuates how societal, cultural attitudes as well as the NHS may influence a client;

"An individuals understanding of an illness will be to some extent shaped by ideas predominant in their culture, which in western society is the medical model. This model posits a biological / genetic basis to both physical and psychological illnesses." (Moore and Garland, 2003, page, 120.)

"*Tracking down and tracing back"* enables me to gain increased understanding of clients' perspectives and associated feelings therefore facilitating my communication of accurate empathy to the client. Empathic interactions encourage clients to feel understood, valued and significant, as well as encouraging trust and candidness within the therapeutic relationship.

I am nevertheless diligent to avoid becoming complacent, narrow-minded and opinionated and inaccurate in my empathic understanding and subsequent communication with the client. This could occur if when encountering recurring clients with similar organisational influences and then imprecisely deducing that the organisational influence on each client is comparable. My reflective practice and continual personal self-refection develops self-awareness which prevents me from correlating previous clients with present clients when communicating empathy and congruence, in a manner described in this quotation;

"Experience can tempt the practitioner to become lazy in his thinking, or too sure. And it is often tempting to use short-cuts to insight, based upon what has already made sense with other patients." (Casement, 1990, page, 19.)

If aware of influences initiated by the organisational culture of the NHS and the societal perspective of counselling having a detrimental bearing on the client, I am especially attentive in endeavouring to establish a trusting mutual therapeutic relationship. Simultaneously, I involve the client as soon as possible as a mutual participant in counselling. I try to accomplish a therapeutic relationship by communicating the core conditions according to Rogers (1951) (1961) and by encouraging trust and collaboration by involving the client in the counselling process. This process encourages exploration of how their self-concept may have been shaped by society in general and in particular the NHS.
The use of the technique "*tracking down and tracing back*" relative to how the organisational culture of the NHS and the societal perspective of counselling assists me to gain increased empathic understanding from a clients perspective as well as increased awareness of external factors that may influence the counselling client. This enhanced awareness and understanding assists me to empathise clients' perception of their self-concept and how they may be feeling in regard to participating in counselling.

I have discovered that clients often feel apprehensive and threatened by the cultural power of the NHS and consequently the counselling provision provided within the organisation. I am constantly attentive to the aspect of power imbalance between the client and myself and the possible consequences to counselling.

"In the counselling relationship this implies an ever-watchful attentiveness to any imbalance between counsellor and client and a constant seeking to equalise power through any procedures, whether verbal or otherwise, which can remedy such imbalance." (Mearns and Thorne, 1988, page, 18.)

The sharing of power in the counselling relationship empowers the client, which is cognate to the philosophy of humanistic counselling. I endeavour to promote a therapeutic relationship that is mutually trusting with a balance of power between the client and myself. Dryden (1992) acknowledges the issue of power and the importance of empowering the client, I concur with Dryden and attempt to empower the client by encouraging the client to become autonomous and to facilitate a mutual balance of power within the counselling relationship.

"Is concerned with creating a relationship which is empowering for my client." (Dryden, 1992, page, 80.)

I am conscious not to use any purported status and knowledge in the relationship to acquire power and mystify the therapeutic process. I oppose any notion that I am an aloof professional, instead I endeavour to be natural, genuine and respectful when relating to clients.

Frequently recorded in client satisfaction questionnaires are quotes reminiscent of the following;

"I imagined that you would be one of those people who would use big jargonisitic type words and complicate everything like a mad professor type. How wrong could I have been? You have been like a best friend and more."

"I could really relate to you, you are normal. I was put off because I thought that you would talk down to me."

"I expected you to be a sandal, bead-wearing weirdo with a dodgy goatee beard and tank top but I wasn't disappointed to find you sound and not some patronising do-gooder".

In a counselling relationship it is not just two individuals that encounter one another but two different expectations, assumptions, values, social worlds and often cultures as well as influences such as the organisational culture of the NHS and society. I determine that the issue of power is intrinsic to counselling however the technique of *"tracking down and tracing back"* assists in gaining understanding and awareness of this dynamic which then enables a counsellor to pro-actively address the issue within their practice.

By explaining, promoting and socialising my therapeutic approach including the clients' position and function within therapy, facilitates client participation and encourages clients to challenge pre-conceived perceptions and comprehensions of

counselling. Gaining an understanding of their roll within the therapeutic relationship and by beginning the quest of self-awareness and understanding via self-exploration informs the process I call, *"from patient to client".* I name the process, *"from patient to client"* because the person adjusts their role from that of a traditional patient to that of a counselling client. I contend that the client will gain the optimum benefits from counselling the sooner the client makes the transition, "*from patient to client,"* especially when therapy is time-limited.

I deem that the initial counselling session is imperative as it has the prospective to form a foundation for therapy and underpin the therapeutic relationship especially if the client has a pessimistic view of counselling and a negative self-concept.

Conclusions.

An exploration of how the traditional hieratical organisational culture of the NHS and the societal perspective of counselling may influence the client and the counselling relationship has enabled me to gain a greater understanding of the organisational dynamics and of the context in which my counselling occurs. I have particularly increased my awareness of how organisational influences have an effect on clients' attitudes towards counselling in either a detrimental or constructive manner. I am more sensitive to clients' potential anxieties and concerns and conscious that organisational issues may have a damaging impact on the dynamics of a counselling relationship.

I have gained an increased awareness of where the client is supposed to fit within the harsh regularly conflicting environment of the hierarchical organisational culture. I believe that the client is positioned at the bottom of the hieratical organisational structure of the NHS.

I argue that the NHS organisational and societal perspective of counselling influences the counselling client sometimes derogatively. These external influences therefore must affect the therapeutic relationship and consequently therapy.

An exploration of how the transition of the NHS may have a bearing on patients, clinicians and their professional relationship?
and
"How the professional medical relationship and the referrer may influence counselling?

Introduction.

I have maintained an overview that I am endeavouring to obtain an understanding of how clients' perception of counselling provision may be influenced by external influences and how this may encroach into the counselling relationship.

I have examined the transition that is occurring within the NHS especially the changing position of the patient and considered how this might impact on professional medical relationships especially from the perspective of the patient by considering the following question;

"How might the changing NHS be influencing patients and professional medical relationships?"

I have appraised the process that I have referred to as, "*from patient to client"* and considered how professional relationships influence the adjustment from a person's traditional role of a patient to that of a counselling client by ascertaining information and understanding relating to this question;

"How may the doctor–patient relationships influence the therapeutic relationship?"

I have explored various types of professional relationships within the NHS and the situation and role of the patient and referrer within these relationships and contemplated the following;

"How referrers may influence the therapeutic relationship?"

I intend to evaluate my findings and consider how these may influence the client in particular their transition from “patient to client” and their locus of evaluation, Rogers (1961). I will also consider any implications for counselling by relating my conclusions with counselling practice.

In conclusion, I will reconsider the questions that I have explored and summarise my deductions.

The transformation of the NHS and the patients’ changing status.

My previous findings place the counselling client at the bottom of the hierarchical organisational structure of the NHS. Similar perceptions of the NHS patient have been recognised by the NHS and the DH therefore plans have been implemented to address this issue. The following is an extract from the Queens Speech at the opening of Parliament recognising the needs of patients and the public and endorsing that the Government are keen to facilitate change in the NHS;

“My Government will continue its reform of the National Health Service, offering more information, power and choice to patients.” (Queens speech, 2004, page,1.)

As part of the reformation of the NHS the organisation are keen to facilitate consultation with patients and the public. Since January 2003 in compliance with the Act of Parliament (2001) specifically the, “*Health and Social Care Act, Chapter 15, Section 11”* all NHS bodies have had a legal duty to involve and consult patients and the public in regard to service planning, operation, and provision as well as in the development of proposals for change and improvement. A commission for Patient and Public Involvement in Health was established in 2003 to ensure that the public is involved in decision making about health services.

The DH, (2000) *NHS Plan, A plan for investment, a plan for reform*, states that the NHS must be reformed in order to be patient centred. Patient involvement is now a priority on the DH’s agenda, as corroborated in the following publications;

"NHS Plan, A plan for investment, and a plan for reform" (2000),
"Shifting the balance of power within the NHS - securing delivery," (2001); "*Shifting the balance of power - the next steps,"* (2002).
Patient and public involvement. A brief overview. (2004).
Our health, our care, our say. (2006a).
Our NHS our future, NHS next stage review leading local change. (2008)

The strategy for implementing the NHS Plan is a blend of reforms, guidelines, and targets. The strategy is initiated from the top of the hierarchical structure with service development and commissioning implemented further down the organisational structure. The DH "*Our health, our care, our say,"* (2006a) recommended reform towards a health service that is designed around the patient rather than the needs of the patient been forced to fit around the services all ready provided. The paper advocates a more holistic perspective of peoples needs suggesting that individuals' health, well-being, and social needs should be considered.

The prevailing transformation in cultural change is focused on individual patients becoming responsible for their own health and having individual rights and expectations of health care. Medical professionals such as, Fraser (1999) Smith and Norton (1999) and Summerton (2007), acknowledge the change in society and recognise the advantages of patient-centred medical practice.

"Change in society's expectations and increased patient autonomy are emphasising the importance of explicitly involving the patient in deciding on a particular course of action or inaction. (Summerton, 2007, page, 32.)

This is contrary to the traditional medical model that advocates doctor-centred relations with patients. The traditional role of patient is changing and the patient is becoming a consumer whilst the organisational structures and culture is transforming to accommodate this change. Nettleton (1995) defined consumerism within health services as;

- *Maximisation of patients' choice.*

- *The provision of adequate information.*
- *Raising standards of health care.*
- *Shorter waiting times for treatment.*
- *Seeking and taking into account patients views on services.*
- *Ensuring satisfaction and encouraging patients to complain if not satisfied.*
  (Nettleton, 1995, page, 249.)

Despite the transformation of the NHS and the patients' changing status *I have discovered that many people feel powerless in their role as NHS patients both collectively and as individuals. I have gained this insight by gaining an awareness of the point of view of others including that of my counselling clients. I have also augmented my understanding by reflecting on my own experiences.*

I can recall my own personal feelings of powerlessness, annoyance, and frustration, when an appointment for me to undergo surgery was cancelled at short notice without a reason and with no follow up alternative appointment offered. I had been waiting for some considerable time, prepared my self emotionally and physically, arranged childcare, re-arranged work commitments and holidays, organised transport, and made a host of other arrangements and considerations. The feelings of helplessness were compounded when I was unable to speak to anyone to gain any information regarding the situation or to complain and vent my dissatisfaction.

I am aware that many people express distrust and hold disapproving attitudes regarding the dominant influence of the organisational culture of the NHS, and feel ineffectual in regard to their own health care. This finding is a contradiction to the DH (2000) NHS Plan, which endeavours to provide a health service that is patient-centred and designed around the patient.

Patient involvement and obtaining patients' perceptions is accepted as fundamental to delivering the commitments stated in the DH (2000) NHS Plan;

"The NHS Plan requires each NHS Trust in England to obtain feedback from patients about their experiences of care." (NHS Trusts Patient Surveys, 2007, page, 1.)

Patient user groups, satisfaction surveys, interviews, suggestion boxes, random surveys, patient public involvement forums are all methods to acquire data from the public and NHS patients and are an integral element of the DH (2000) NHS Plan. In spite of the consultation with NHS service users and the public in general I constantly hear from clients during counselling that they feel frustrated and disillusioned with the management and policies of the NHS because they believe that they are not listened too and have little influence over the control of their individual heath care. Generally individuals believe that once patients and the public have provided information, employees of the NHS whom have an organisational agenda collate the data, it is then commonly understood that professionals not lay people determine the policy decisions, strategies, and action plans. It is a debatable common belief that NHS decisions and agendas are decided prior to any public / patient consultation people consequently lack motivation to participate in consultations that they believe will not be considered and hence ineffectual in promoting change.

This apathy concerning the NHS often obtrudes into the counselling relationship, as clients perceive counselling as an integral part of the NHS whom in comparison they feel powerless. This viewpoint is in contrast to the humanistic relationship that encourages equality between client and counsellor. The process, *"from patient to client"* is also detrimentally affected.

The Bristol Royal Infirmary Inquiry recognised that patients were ineffective in exerting influence on the culture of the NHS;

"The Panel heard that, historically, users collectively have not exerted a strong influence on health care culture, and that the agenda for care is set by professionals rather than by patients and users." (Bristol Royal Infirmary Inquiry, 2000, page, 5.)

The Government, DH, and NHS are endeavouring to implement change to the health service but acknowledge that innovative policies and change in structures are not sufficient to execute change independently but a concurrent cultural change is also required.

“Patient and public involvement is not just about structures – its cultural change.” (DH, 2004, page, 1.)

The culture of the NHS is multifaceted consisting of complex organisational values, beliefs, behaviours that have gradually developed over a considerable period of time therefore many have become implicit. Many established beliefs are inconsistent with the new organisational reform. These traditional implicit beliefs, values, and behaviours, I argue, have to be made explicit in order for the organisation and individuals to focus on, address and to facilitate effective organisational and individual change.

I believe that the NHS has an organisational structure defined by Webber (1968) as classic bureaucracy design. Efficient organisational functioning is dependent on a hierarchical structure with few holding power achieving efficiency by making decisions rather than consulting large numbers of people. This is in contrast to the changing contemporary NHS, the clash of ideologies potentially hinders and impedes organisational change.

The restructuring of PCT’s from 303 to 152 in October 2006, DH, (2007) has resulted in extensive reorganisation of individuals within the hierarchy of the NHS impeding cultural and organisational change and the implementation of policies affecting the patient. I have experienced difficulties within this organisational disorder with its ambivalent chain of command for instance; my invoices have not been paid on other occasions I have received remittance twice for the same work. I wasted extensive frustrating periods of time trying to ascertain whom to address the issue with and how to rectify the dilemma.

The culture of the NHS is intangible and well established therefore any change is slow and arduous. The NHS is an extremely large organisation hence cultural change will be difficult and slow comparing the organisation to the metaphor of a very large ocean liner, to alter speed and adjust direction the vessel will react obstinately and sluggish. On large liners change in speed or direction is rarely noticed by the passenger apart from a inconvenient shaking of the liners

substructure, correspondingly NHS patient's state that they experience symbolic juddering and inconvenience due to the change within the NHS but encounter no change in a new alternative positive direction. For positive change to be noticed by NHS patients I therefore perceive cultural change to be almost a continuous process of listening, evaluating, developing, and promoting effective action and change to continually strive to improve the patients' quality of care.

The traditional medical model doctor–centred relationship and the traditional doctor's transition.

The medical model has been the principal model of medicine since the mid-nineteenth century I therefore argue that it has influenced the culture of the medical profession and consequently the present-day NHS. The NHS consecutively exerts influences on sub cultures and individuals employed within the organisational cultural environment as well as users of the service.

The perspective of the doctor-patient relationship of the traditional medical model, is that the GP has an authoritarian and controlling position in which GP's are dominant, expert, and make decisions they believe are in the patients' interest. In (1992) a working party from the Royal College of General Practitioners examined counselling in General Practice including the difference between counselling and the consultation techniques used by GP's in the doctor-patient interaction. The following is a finding from the working party defining a doctor's responsibility from a doctor-centred perspective;

"A doctors job is to listen to the patient, attempt to diagnose any disorder, and to prescribe treatment to ease or cure. He or she is seen as an authoritative helper who defines and resolves the problem, directs the course of treatment and gives advice and support." (Sheldon, 1992, page, 6.)

The traditional medical model concentrates on the physical processes such as pathology and the physiology of a disease predominately focussing on diagnosis and treatment. The GP for example is perceived as a specialist with expertise and knowledge that is not generally available to the patient, the GP's aim is to diagnose

ill health then resolve the problem by prescribing treatment to ease or cure, whilst concurrently directing and giving advice. Friedson (1970) documented the apparent power of the medical doctor stating that the doctors' prerogative was to diagnose and forecast illness and then use that information as a means of control. Illich (1976) and Kennedy (1981) alleged that the medical profession were subjugating those in poor health.

My counselling clients when evaluating the counselling process frequently compare the counselling relationship to that of the traditional doctor-patient relationship. They frequently affirm that in their experience GPs are ineffective listeners. This one sided means of communication with patients is associated with the doctor-centred approach to clinical transactions. I have discovered by exploring and reflecting on interactions between medical doctors and myself and also whilst observing communication between GP's and others both in groups and individually that in general GP's are not good listeners. Smith and Norton (1999) concur that studies have repeatedly shown that doctors are inadequate at listening. Wilkinson (1989) in research pertaining to doctors listening skills revealed that the average listening time for doctors before interrupting the patient was only 18 seconds. In (1993) the General Medical Counsel recognised the problematic issue of doctors' communication and recommended that medical students should be trained in effective communication.

In the course of my practice as a counsellor I have discovered that clients who are more familiar with doctor-centred relationships, in general experience difficulties adapting to and understanding their role as a client in the counselling therapeutic relationship. Accordingly their progression from *"patient to client"* is protracted.

The traditional doctor's transition.

The emphasis of focusing on the patient and their importance in the doctor-patient relationship was instigated prior to the DH, (2000) *NHS Plan, A plan for investment, a plan for reform.* The DH, (1991) *Patients Charter,* placed the contemporary emphasis on the patient as a consumer. Innovative medical practitioners such as Balint and Norell (1973) advocated for clinical transactions to be patient centred rather than doctor guided. Korsch and Negrete (1972) argued that the friendliness of

the doctor in transactions with patients correlates with satisfaction and successful clinical outcomes. Long et al. (1976) advocated that GP's should encourage patients' participation in a collaborative doctor-patient approach. Smith and Norton (1999) promoted the establishing of a trusting mutual relationship between doctor and patient arguing that evidence suggested that a relationship based on the GP's ability to successfully empathise with the patient and their predicament improves the outcome of clinical goals. Fraser (1999) stated;

"Good communication also helps to establish a relationship between the doctor and patient which has an important and beneficial effect on the outcome of the consultation" (Fraser, 1999, page, 92).

Despite evidence promoting a patient-centred doctor-patient relationship and the considerable period of time that this concept has been deliberated, I have discovered that many traditionalists are still disinclined to change their clinical approach. This awareness regarding some GP's attitudes and resistance towards change to the person-centred model has originated from my observations, personal experience, conversations with GP's, their family and friends and other NHS staff, as well as verbal statements made by counselling clients during counselling

I am aware that many traditional GPs using a doctor-centred approach experience difficulties adjusting to the patient-centred method of interacting with patients in clinical interactions. Byrne and Long (1976) discovered that doctors with doctor-centred styles were resistant to change in their clinical transactions with patients and omitted any interaction that required collaboration with the patient.

When considering the ongoing enforced organisational transformation and the conflict between the traditional doctor-centred medical model and the patient-centred contemporary model, as well as the influence of innovative diagnostic technologies that are influencing the manner of providing services to patients, one can understand the difficulties and resistance to change from both an organisational and individual basis.

I believe that if resistant GPs were to become attentive to cultural influences and were able to identify and understand their own implicit cultural beliefs, values, and behaviours then change would be less problematic even if their ingrained organisational cultural values were contradictory to the latest NHS cultural reform.

The attitude of the GP regarding transformation within the NHS and change to their clinical professional practice may influence the clients' perspective of the changing NHS. Any resistance to change by the GP may be conveyed to the client therefore affecting their perspective of the NHS consequently counselling, detrimentally.

The patient-centred doctor–patient relationship and the patients' transition.

The traditional medical model and the doctor-centred approach to doctor-patient relationships are opposite to the patient-centred perspective of involving and empowering patients to participate in their own clinical decision-making. The patient-centred model is compatible with many counselling approaches especially those that are humanistic.

Engel (1977) maintains the medical model takes little account of the "person", society, and other factors when reaching a decision regarding the cause, diagnosis, and the treatment. Summerton (2007) describes a comparable perspective;

"Patients do not represent an empty vessel into which a symptom or sign appears; they also bring into the encounter values and expectations derived from their social and psychological state." (Summerton, 2007, page, 20.)

Barker (2003) defines patient-centred care as the doctor focussing on the patient as a person rather than the pathology. The Royal College of General Practitioners working party (1992) concluded that a more collaborative person-centred doctor patient relationship would be beneficial to patients clinical care;

"Exploring the patients beliefs, emotions and concerns, in addition to specifying the nature and history of the presenting problem, has been shown to facilitate diagnostic

skills and to increase patient co-operation in following advice, leading to improved patient care." (Sheldon, 1992, page, 5.)

My experience suggests that since patient-centred models are similar to humanistic counselling approaches, patients whom are familiar with this doctor-patient type relationship usually adapt sooner to their role within the therapeutic relationship and the transition from a *"patient to a client"* is less problematic.

The patients' transition.
Patients are generally embracing their changing status within the NHS, and adapting to their new role in the contemporary doctor-patient relationship. Towle (1998) writing in the British Medical Journal maintained that doctors should be prepared for patients to question their judgement and advice as patients become better educated and adopt to their changing role within the doctor-patient relationship. I concur with the following statement as I personally research issues pertaining to my health via the Internet and I am aware that this is common practice for many people.

"The public has greater access to inform on health matters through the media and the internet". (Fraser, 1999, page, 80.)

The following extract is from a publication known as the indispensable guide for GP's, almost every GP and nurse practitioner that I am acquainted with processes a copy. The publication advises GP's on the subject of answering questions from patients;

"Unless you become patient-centred your patient may never be fully satisfied with you, or fully cooperative." (Longmore, et al. 2004, page, 4.)

I have however noticed that some patients are indisposed to change or experience difficulties assuming the autonomy required in their new position within the clinical transaction and the doctor-patient relationship. Many patients encounter problems adjusting from the traditional role of patient to that of an autonomous service user within the doctor-patient relationship. This observable fact is confirmed in the following quotation;

"Not all patients, however are capable or willing to assume the autonomy and control implicit in the change from the traditional patient roll to the new role of customer" (Smith and Norton, 1999, page, 81.)

Whatever the doctor's approach may be, NHS patients are more familiar with the clinical relationship than the counselling therapeutic relationship. Due to the vast differences between these professional relationships counselling clients frequently struggle to understand the differences between the professional relationships of doctor/patient and counsellor/client and the changing role of the patient/client within these relationships.

Counselling clients often comment that counselling feels unfamiliar in comparison to previous professional relationships as a patient within the context of the NHS. When evaluating the counselling process clients often state how strange it feels that I converse with them as a person and maintain eye to eye contact rather than interacting whilst looking into the screen of a computer, taking notes, or in between talking to a Dictaphone.

I have discovered through my experience as a counsellor that clients who have encountered previous doctor-patient relationships that are patient-centred adapt more easily to the role of a client in the counselling therapeutic relationship therefore facilitating the process, *"from patient to client."*

<u>The diagnostic examination and transition to patient-centred diagnosis.</u>

Summerton (2007) argues that instead of considering medical diagnostic interventions such as referrals to radiology, biochemical testing, magnetic resonance imaging (MRI) or other diagnostic services, GP's should place prominence on the patient as a person as opposed to the disease. He states that the traditional clinical transaction has changed but with advances in technology less attention is given to the patient as a person and with more focus directed to modern technical investigations.

I recall a consultation as a patient with my GP in 2002. I remember the feelings clearly as I reflect and re-visit my personal journal, I was unheard, ineffectual, and frustrated as I was hurried through a clinical consultation. I was trying to articulate and describe how I was feeling whilst the GP focused on, blood pressure readings, urine tests, whilst arranging blood tests, and a liver scan. The GP sounded similar to a vehicle mechanic describing diagnostic tests made to an engine management system of a modern car rather than a Doctor communicating with their patient. It was as if I did not matter as a person and I felt as if my autonomy and control had been handed over to the GP.

I concur with Summerton (2007) and believe that with the ongoing development of new diagnostic technologies the primary care doctor-patient relationship has become even more complex with even less time available to focus on the patient as a person. My observations, conversations with NHS service users, and also NHS staff including GP's, as well as comments from my counselling clients, confirm that diagnostic procedures are becoming accepted practice in the doctor patient relationship to the detriment of communication.

Summerton advocates what he refers to as person-centred diagnosis;

"The patient can provide much of the diagnostic input and they have the potential to provide the majority of the information leading to a solution rather than simply be seen as presenting the problem." (Summerton, 2007, page, 18.)

I concur with Summerton (2007) and believe that patients often have essential relevant information required to assist the GP in diagnosing illness. Many of my clients present with extreme low self-esteem and self-confidence, and consequently often experience difficulties articulating especially with people they perceive to have authority and power for instance the GP. Nevertheless, I consider that even patients who may experience difficulties communicating and expressing still have a plethora of knowledge about their own health if only they were encouraged to converse in a patient centred relationship.

<u>How the referrer may influence the therapeutic relationship.</u>

I contend that from the commencement of the referral process the procedures start having an impression on the clients' perspective of counselling therefore consequently the therapeutic relationship. The correct referral procedures therefore are paramount in order to lay down a constructive foundation to the therapeutic relationship. The British Association for Counselling and Psychotherapy (BACP), (2004) recognise the importance of the referral process as stated in the following quotation;

"The efficiency of counselling often depends on good referral systems. A carefully considered referral system makes for a good counselling service. The referral method can greatly affect the counselling relationship." (Sharman and Seber 2004, page, 26.)

The nature of the referral, and the referrers' attitude to counselling can influence the clients' expectations, understanding, and viewpoint of the counsellor and the counselling process. The clients' expectations, understanding, and attitude to counselling subsequently will have a bearing on the counselling relationship.

If I explore the clients understanding and expectations of counselling the referrer's influence is often apparent. I have discovered that the referrers' attitude towards counselling does influence clients' expectations of counselling. Whines (1999) recognises how GP's influence the client;

"The GP's own orientation towards counselling can clearly help to establish the client's expectations." (Whines, 1999, page, 81.)

The referrer's, belief, and confidence in the positive outcomes and benefits of counselling are frequently conveyed to the client. Conversely any disapproval, sceptism and negativity regarding counselling will be transmitted to the client. The referrers' opinion towards counselling therefore will have a bearing on the clients' attitude towards counselling in either a detrimental or beneficial manner.

Balint (1957) (1973) wrote intensively about the relationship between GPs and

patients. He suggested that GP's engaging with patients on a meaningful and emotional level may gain more insight to patients presenting problems and consequently patients may respond more encouragingly within the doctor - patient relationship. Balint (1993) proposes that the attitude of the referrer influences the success of treatments. These can be either what the GP administers in person or those that are provided by other health care or medical professional after a referral from the GP. I believe that this is also relevant to referrals for counselling.

"Balint and many others have pointed out how important the attitude of the Doctor is in the success of a treatment. Such an attitude must transmit itself to patients." (Keithley, Bond and Marsh, 2002, page, 89.)

Balint (1964) relates to the fact that doctors and patients are also people, with personal lives, feelings, and preoccupations these may not be relevant to the professional medical consultation but nonetheless have the potential to influence the medical consultation profoundly.

A referrers' subjective biases and perspectives that concur with their own individual belief system and personal values influence the referrer when deciding whom to refer to counselling. I noticed a tendency for GP's to refer particular types of clients or clients experiencing specific presenting issues. A GP who had a professional clinical interest in research into the treatment of depression referred all patients who were diagnosed as depressed. A female GP who had experienced cancer referred all of her patients who were either directly or indirectly implicated with cancer. The following quotation demonstrates GP's subjective attitude in referring patients to counselling.

"In my experience a doctors referral of a patient usually represents a referral of part of himself / herself to the psychodynamic counsellor. This notion co-exists with the doctors conscious, and optimally appropriate, assessment of the patient for counselling and needs to remain unconscious to preserve the professionalism of the doctor / counsellor relationship" (Lees, 1999, page, 103.)

The enthusiasm that naturally emerges from a referrers personal interest in a

presenting issue may well be conveyed to the client in a passionate encouraging manner therefore influencing the clients' attitude towards their own presenting issue and counselling. I have additionally observed imperceptible influences to the referrer that are then imparted to the client inadvertently, nevertheless still consequently impacting on the therapeutic relationship.

I recall a GP who insisted that every one of their patients who had encountered a recent bereavement be referred to counselling even if the patient did not have a desire to participate in counselling. I noticed this trend when these particular clients DNA their first appointment, did not opt-in to counselling, left messages stating that counselling was no longer required, and when offered appointments by telephone said that counselling was the GP's suggestion and they considered themselves to be able to manage without counselling. Clients also arrived for their first appointment because the GP had recommended counselling but said they did not want to participate in subsequent sessions. I sensitively addressed the issue with the GP who realised through self-reflection that her own feelings regarding her personal life was obtruding into the clinical doctor-patient relationship and influencing her judgement. She disclosed that her mother whom she was very close to had recently died. The GP was experiencing what Shutz (1967) refers to as a "projective theory of empathy";

"For here we are reading our own lived experiences into the other person's mind and therefore are only discovering our own experiences." (Shutz, 1967, page 114.)

<u>Examples of referrers' subjectivity present in referral documents:</u>
<u>Referral examples.</u>

The degree of the referrers' interest, understanding of, and belief in counselling is often reflected in the manner in which the referral is written
When I read a referral form, I consider the information from a counsellor's perspective as well as reflecting how the written referral if shared with the client or discussed verbally may influence the client's attitude towards counselling.

The referral documents that I have experience using have all been designed in a

constructive manner after careful consideration involving counsellors as well as deliberation with referrers and NHS management. Even if counselling referral forms have been standardised I observe that the information contained in written referral varies considerably between different referrers. The variation is due to referrers' individual subjective bias.

The following are examples extracted from referral forms. The examples highlight the dissimilar manner of which referrals are wrote and the different quantity of information provided as well as how they may influence the client therefore the counselling relationship.

Referral example 1.

The client arrived at the first session without having an understanding of counselling whatsoever. He stated*, "I don't know why I am here the Doctor told me to come so I am here".*

The subsequent paragraph is an extract from a referral:

"Her father died a while ago. She is struggling to cope but trying unsuccessfully to come to terms with the death. Your input I hope will assist her to get over it and move on. She struggles constantly without success with most things in her life – her children - always in debt – different relationships – weight - stress."

The client arrived for counselling with the expectation that I would be able to solve all her issues, she stated, *"The Doctor said that you would sort me out as you are the best!"*

Referral example 2.

"Many issues of bereavement, father and mother last year. Recent miscarriage. Suggest client a candidate for CBT needs to think more positive. Recommend that you address miscarriage first as most recent bereavement".

The client stated, *"Dr. H said that CBT would help me and that you will help me alter my negative thinking then I will feel better and come to terms with all this death. He also said that you need to fix the miscarriage first".*

Referral example 3.

"I would be grateful if you would see this 45 year old lady. Her mother whom she was very close to died recently of natural causes. Since the death up until recently she has been drinking 4 cans extra strong lager a night and I have discussed the need for her to stop this explaining to her the adverse effects it be having on her physical and emotional health. She does have symptoms of depression but no thoughts of self-harm. Her husband is both understanding and supportive. I have agreed to see her in two weeks if she has managed to reduce or stop her drinking at that time and her mood is dipping further we may start an antidepressant. She is quite keen to have some counselling which we have discussed in detail. She is keen to talk and explore how she is feeling and gain some increased self insight relating to her presenting issues as well as explore coping strategies."

The client arrived at the initial session with a proactive attitude towards counselling and an understanding of her part in the counselling process and the counselling process in general. The client stated, *"I know that you haven't got a magic wand and can't make things better. I will have to address my problems myself with your help and support."*

How referrers and patients may perceive a referral to counselling services and the possible consequential bearing on the therapeutic relationship.

Counselling is sometimes perceived in a similar manner as a referral to a medical specialist or diagnostic testing service by referring GP's and subsequently by clients. The following is an example of this perspective extracted from a GP referral to counselling;

"This patient presents with pain however after extensive diagnostic testing and referral to several consultants no medical or physiological explanation can be ascertained. I therefore request that you arrange to see this patient at your earliest convenience, to determine the psychosomatic aspect. Both she and I await and look forward to your assessment. I thank you for your assistance in this matter and readily await your diagnosis."

NHS patients are accustomed to clinical diagnostic testing, and referrals to secondary care or other specialists, if the GP requires confirmation or more expert opinion to establish if a patient has an abnormality and if so a subsequent diagnosis, treatment and prognosis. My counselling clients are familiar with this process and are often of the opinion that counsellors are expert specialists who have a function to diagnose and then treat their condition. Clients often enquire if I have various diagnostic test results available to discuss with them or if I require "bloods" (the universal term for diagnostic blood tests) or blood pressure or cholesterol readings. If this is the clients concept of referral to counselling this perspective may hinder their transformation from "*patient to client*" because they place the counsellor in a position of power rather than of equality which is the orientation of person-centred humanistic counselling approaches.

In the publication *"Choosing talking therapies"* (DH, 2001,b.) the responsibility of the GP is depicted as referral only. The literature lists the following as recommended professionals to be referred to; community psychiatric nurses, psychologists, psychiatrists, social workers, occupational therapists and counsellors. All the listed professionals with the exception of the counsellor (non-directive) perceive themselves as experts and specialist giving directive advice and making diagnosis. This may suggest to the patient that a counsellor has a similar approach and role to that of the other professionals when in fact these medical based approaches are contrary to that of non-directive counselling. This may cause clients to become confused in regard to their individual role as well as the professionals responsibility and undertaking, this may hinder clients' transformation from "*patient to client*".

Locus of evaluations correlation with *"patient to client"* and implications to counselling.

Rogers (1977) recognises that person-centred counselling is at variance to modern western society that thrives on efficiency, the role of the expert, and a minority hierarchy having control over the majority of people. I consider that this definition of modern western society has a similarity to the traditional hierarchical system of the NHS that has a disproportionate few people holding the power and authority of

experts whilst the individual people specifically the patients are reduced to the level of objects.

Clients who have encountered traditional medical model doctor-patient relationships with the doctor perceived as an expert guiding the clinical transaction, in my experience, are more likely to find difficulties adjusting to their unfamiliar newfound autonomous person centred role within the counselling relationship. This is in view of the fact that they are familiar and comfortable with other person in the professional relationship in the role of the expert, directing, and holding authority.

I familiarise my clients to my counselling approach so they recognise that my type of counselling relationship is based on equality, mutuality, with a non-directive character in which the client feels listened to in a non-judgemental, empathic manner. This is in contrast to the doctor-patient relationship in which my clients often state that they feel judged, patronised, dominated and not heard or understood.

The therapeutic relationship is paramount in my theoretical approach to counselling I therefore aim to establish then develop the counselling relationship. I believe that it is imperative to reassure the client and to endeavour to convey congruence, offer unconditional positive regard and impart empathetic understanding in both oral and non-verbal communication in order to establish a therapeutic relationship. These core conditions are the foundation of person-centred counselling and essential when endeavouring to establish a therapeutic relationship that will provide a facilitative environment of growth for the client. I believe reluctant clients may only need to find genuineness, reassurance, acceptance and empathy from a counsellor in order to create a safe, trusting encouraging relationship that will facilitate therapeutic change. The following quotation emphasises the importance of establishing a therapeutic relationship;

"I was asking the question. How can I treat, or cure, or change this person? Now I would phrase the question in this way: How can I provide a relationship which this person may use for his own personal growth." (Rogers, 1961, page, 32.)

My intent is to create a therapeutic relationship by displaying my natural self via the communication of the core conditions both orally and non-verbally, thus revealing my genuine, accepting, understanding self.

"___a relationship characterized by a high degree of congruence or genuiness in the therapist; by a sensitive and accurate empathy on the part of the therapist; by a high degree of regard, respect, liking for the client by the therapist; and by an absence of conditionality in this regard, will have a high probability of being an effective therapeutic relationship." (Rogers, 1961, page, 265.)

I advocate to the following statement by Ashley Montagu a well renowned anthropologist;

"Clinical medicine should be regarded neither as an art or science in itself, but as a special kind of relationship between two persons, a doctor and a patient". (Montagu, 1963, page, 577.)

Fraser (1999) promoted autonomy in a patient in a clinical transaction describing the ideal doctor–patient relationship in a Rogerian manner;

"At, best the doctor – patient relationship should be one of trust, mutual respect and empathy." (Fraser, 1999, page, 72.)

I have noticed that clients who are referred from GP's who are patient-centred and collaborative in their clinical transactions adapt far more quickly to my style of counselling deep-rooted in Rogerian values and philosophy because they are familiar with professional relationships based on mutuality and respect and promptly the "*patient becomes a client"*.

I believe that in all types of counselling but especially in time limited therapy of a person–centred non-directive nature, someone will gain more from counselling the sooner that they are able to assume the role of a client willing to participate and collaborate in therapy as an autonomous individual, rather than as a patient awaiting guidance from a perceived expert. I call the transition that a person makes from a

patient in any type of clinical doctor-patient relationship to that of a client in a counselling relationship, *"from patient to client".* The change, *"from patient to client"* is comparable to what Rogers (1961) calls the transformation during counselling of a client's locus of evaluation from an external locus to that of an internal locus of evaluation.

I concur with Mearns (1994) who maintained that at the start of counselling many clients' have a locus of evaluation that is external which means that they look for direction, guidance, and advice from the therapist. This is similar to a patient placing the GP or other medical professional in a position of expertise and authority and placing the responsibility for promoting positive change with that professional. I have discovered that client expectations when initially attending for counselling are often comparable to what they would expect from other medical professionals. They place the counsellor in the position of the expert and specialist anticipating that they will gain an understanding of their presenting issues and abnormality and consequently receive a diagnosis, treatment, and prognosis and if appropriate advice on prevention. This expectation may benefit more directive approaches to counselling but is detrimental to non-directive humanistic approaches as this concept hinders the transition "*from patient to client"* and the change from an external to internal locus of evaluation.

Thorne, (1992) correlated an external locus of evaluation to criterion for psychological disturbance;

"In many ways the level of dependence on an external locus of evaluation is a reliable criterion for determining the presence of psychological disturbance. Disturbed people constantly betray the lack of an internal locus of evaluation and turn desperately to external authorities or find themselves trapped in a paralysis of indecision." (Thorne, 1992, page, 33.)

I acknowledge that many people find it very problematic to accept responsibility for their self and would rather place the responsibility on to others especially someone that they perceive to be the expert. The subsequent quotation concurs with Smith

and Norton, (1999) whom acknowledge that many people are unwilling to undertake responsibility for their own autonomy and take personal control of their "self".

"It gives ample scope to those who seem only too willing to hand over responsibility for their lives to others, whether out of fear or because of apathy." (Mearns and Thorne, 1989, Page 5.)

I am conscious to establish a counselling relationship in which I don't evaluate or judge the client but accept the clients' thoughts, feelings, and behaviours in a non-judgemental manner. I encourage clients to develop their own internal locus of evaluation, Rogers (1961) and to possess personal power according to Rogers (1977) therefore encouraging clients to recognise that responsibility and choice are within themselves. Rogers (1977) considered personal power the opposite to external authority and power, expressing personal power as a person developing an individual set of values and manner of relating, drawn from within rather than from external influences, stating that;

"These new persons have a trust in their own experience and a profound distrust of all external power." (Rogers, 1977, page, 274.)

Rogers's theory locus of evaluation (1961) and his perspective of personal power (1977) are comparable to what I describe as *"from patient to client"* in which I endeavour to encourage the patient to participate in therapy with autonomy, recognising, understanding and trusting the realisation that they have individual choice and personal power. My counselling approach and *"patient to client"* is related to the person-centred approach to counselling as demonstrated in the following quotation;

"The person-centred point of view, however, places high value on the experience of the individual human being and on the importance of his or her subjective reality. It also challenges each person to accept responsibility for his or her own life and to trust in the inner resources which are available to all those who are prepared to set out along the path of self-awareness and self-acceptance." (Mearns and Thorne, 1989, Page 5.)

The majority of my clients eventual convert to an internal locus of evaluation developing and trusting their own set of internal values, ideas, and beliefs that integrate and are congruent with their self. I have discovered that the sooner this change occurs and the patient becomes a client the more beneficial the client will experience their therapy. This fact is confirmed by qualitative data taken from written evaluation forms completed at the end of counselling and from clients' verbal communication as well as confirmed by measured outcomes using Core evaluation.

Rogers (1961) describes the shift to an internal locus of evaluation in the following quotation;

"The individual increasingly comes to feel that this locus of evaluation lies within himself. Less and less does he look to others for approval or disapproval; for standards to live by; for decisions and choices. He recognises that it rests within himself to choose; that the only question, which matters, is, "Am I living in a way which is deeply satisfying to me and which truly expresses me." (Rogers, 1961, page, 119.)

I encounter clients who are frequently anxiety ridden reluctant and apprehensive towards counselling often influenced detrimentally by external influences to the counselling relationship. Nevertheless, I have discovered that even defensive, vulnerable, and sometimes aggressive clients require the safety of a therapeutic relationship based on empathy, congruence and unconditional positive regard in order to discover from within themselves their inner potential that may have been lost to their consciousness for some considerable period of time. This transformation is based on a change in locus of evaluation, personal power and the change from "patient to client".

<u>Implications for counselling.</u>

I suggest that counsellors working within the context of the NHS would inform their therapeutic practice by acquiring an understanding of how the NHS is transforming culturally and from an organisational perspective in particular how the patients'

status is changing within the NHS. This comprehension is important because the knowledge will enable counsellors to be acquainted with the changing organisational dynamics of the NHS and how this may influence counselling clients and counselling. This enhanced understanding will enable counsellors to be more perceptive of clients and therefore facilitate increased accurate empathy within the counselling relationship.

I reason that the composition of the doctor-patient relationship is strongly influenced by the attitude of the GP and their style of clinical transaction. I suggest that clients' experience of doctor-patient relationships has an effect on the clients' capacity to appreciate and adapt to, as well as contribute to the therapeutic relationship in either a constructive or detrimental manner. Clients' perspective of counselling is informed by the attitude of their referring GP. My experience deduces that clients who have a comprehension of and have encountered person-centred doctor-patient relationships become acquainted more rapidly to the role of a client in a therapeutic relationship. I believe the clients' ability to participate, understand, and actively engage in the therapeutic relationship is directly linked to optimum personal benefits from counselling for the client, and also successful clinical outcomes especially in time limited counselling.

I endeavour to become acquainted with referrers' attitude towards counselling as well as their underpinning knowledge, understanding and belief in counselling. I also ascertain the referrer's style of referring for example the manner in which they write the referral and to what extent they discuss counselling with their patient. This awareness assists me to understand how the attitude of the referrer may influence a client's attitude, expectations, preconceptions, and perceptions towards counselling.

I maintain that counsellors who acquire an awareness of referrers' views of counselling and obtain understanding of the types and styles of professional relationships will gain an enhanced comprehension of how clients' experience of previous professional medical relationships may influence their attitude towards counselling therefore the therapeutic relationship. This knowledge and appreciation will enable the counsellor to be more au fait to clients' perspectives therefore more effective in understanding clients and conveying accurate empathy. This empathic

understanding will enhance and facilitate the establishing and maintaining of the therapeutic relationship.

Conclusions.

I have examined and explored the enforced transformation of the NHS and of the changing significance of the patient within the NHS. This has enhanced my insight and understanding of the NHS changing organisational dynamics and how these may influence the client therefore the counselling relationship.

Having explored the question, *"How may the doctor–patient relationships influence the therapeutic relationship?"* I argue that previous experiences of medical relationships do influence the clients' attitude towards counselling and their change from "patient to client". I have discovered that patients who encounter difficulties assuming the role of an autonomous patient within the doctor-patient relationship or are familiar with this type of relationship are also likely to experience a dilemma adapting to the role of client within the counselling relationship. Conversely clients who have accepted their responsibility, as patients in a collaborative doctor-patient relationship are more adaptable to the transformation from "patient to client" subsequently encouraging positive change to their locus of evaluation, and personal power.

I conclude that the referral process is capable of influencing the client in either a beneficial or unfavourable way since clients' opinions and attitudes to counselling are prejudiced by the behaviour of the referrer and the referral procedures. I therefore consider the referral process to be a vital component in the establishing of a therapeutic relationship and in the transition of a person makes from a "patient to client".

CHAPTER 3. CONCLUSION.

3.1. Introduction to Chapter 3.

3.1.1. Overview of the chapter.

I have critically deliberated how the MPhil process has had an informative influence on my personal development, professional practice and continual development as a therapist and researcher. I unequivocally agree with Orlinsky and Rønnestad (2005) and Boyd-Franklin et al. (2013) who support therapist's commitment to lifelong learning and continual professional development. Orlinsky and Rønnestad (2005) study into the multifaceted nature of psychotherapeutic work concluded that the most effective therapists are those that embraced continual professional development.

I re-examined Gavaghan (2009) and considered how the thesis has contributed to theory and knowledge in my area of specialism, therapy within an organisational context. Also how the process has assisted in gaining enhanced knowledge and understanding of relevant theory informing my professional practice. Since Gavaghan (2009) relates directly to professional practice within an organisational context I explored how theory and knowledge gained from the MPhil thesis contributed to the development and improvement of an IAPT service including my professional practice within that context.

3.1.2. My experience of the IAPT programme.

Gavaghan (2009) using heuristic research (Moustakas, 1990) explored counselling within the organisational context of the NHS. In order to evaluate how the thesis has contributed to theory and knowledge in the organisational context field of therapy I evaluated Gavaghan (2009) influence on my experience in an IAPT service.

I have experience of employment within an IAPT service in clinical, strategic, managerial and training positions. These roles have enabled me from diverse

perspectives to gain further insight of how Gavaghan (2009) has contributed to the knowledge and theory of therapy in an organisational context and has influenced professional practice.

Experiences within an IAPT service assisted me to instigate a productive secondary heuristic process initiated by reviewing and evaluating Gavaghan (2009) as part of the MPhil process. Further heuristic exploration reconfirmed as well as enhanced my appreciation of how external factors such as organisational culture and dynamics influence the therapeutic relationship. I concur with (McLeod, 2001, p. 94) regarding my secondary heuristic process, *"Such research is likely to have considerable heuristic value, in generating new understandings, grounded in everyday experience that can inform both practice and research."*

(Annex: 2. contains further information regarding IAPT services).

3.2. How exploration of the traditional hieratical organisational culture of the NHS Gavaghan (2009) has influenced professional practice within an organisational context and how theory and knowledge from Gavaghan (2009) has contributed to the development of an IAPT service.

3.2.1 How Gavaghan (2009) has contributed to theory and knowledge related to understanding the traditional hieratical organisational culture of the NHS.

I examined questions that transpired during the heuristic process (Moustakas, 1990) to achieve a comprehensive understanding of the traditional hieratical organisational culture of the NHS.

"*How may organisational influences influence the therapeutic relationship?"*

"What organisational influences have the potential to influence the client and possibly obtrude into the therapeutic relationship?"

In order to facilitate the heuristic process when completing Gavaghan (2009) I explored the organisational theory, classifications, structure and culture from various

disciplines and perspectives enhancing my understanding of the complex organisational culture of the NHS, (Hall, 1959; Becker and Geer, 1960; Sexton, 1970; Louise, 1980; Keesing, 1981; Trice and Beyer, 1984; Allaire and Firsirotu, 1984; Sergiovanni and Corbally, 1984; Schein,1988; Gitternam and Miller, 1989; Jary and Jary, 1991; Martin, 1992; Trompenaars, 1993; Carroll and Walton, 1997; Lees, 1999; Schein, 1999). When evaluating Gavaghan (2009) I explored additional research regarding organisational theory, classifications, structure and culture (Ravasi and Schultz, 2006; Schein, 2004, 2009, 2010; Ybema et al. 2011; Child, 2012) that confirmed Gavaghan (2009) conclusion that organisational culture is multifaceted and complex and the NHS hierarchical organisational culture indisputably has a distinct culture with myriad complex fluctuating sub-cultures. Gavaghan (2009) discovered that the context of therapy, organisational cultures and dynamics, influence the therapeutic relationship and the process of therapy (Clarkson, 1995; Carroll and Walton, 1997; McLeod, 1998; Lees, 1999) research by Stein (2010) and Cait (2011) corroborated findings (Gavaghan, 2009).

Gavaghan (2009) concluded that no single definition of '*organisational culture'* exists but organisational culture is a set of shared psychological assumptions that influence and guide elucidation in organisations by defining appropriate behaviour for various situations. Gavaghan (2009) substantiated that organisations often have contradictory conflicting structures, classifications and cultures that co-exist and that subcultures develop and subsist within organisations and that organisational cultures and sub-cultures have both negative and positive aspects that influence the therapeutic relationship.

Gavaghan (2009) suggests therapists employed within an organisational context would improve their clinical practice by gaining an understanding of organisational cultural influences and having an awareness of the additional dynamics that the organisational context produces. This enhanced understanding would enable therapists to understand proactively how organisational influences have potential influence on the client and therapist thus the therapeutic relationship. Gavaghan (2009) advocated that if therapists understood organisational influences and dynamics from a clients perspective this would augment their ability to convey the core conditions particularly empathy (Rogers, 1957, 1975).

An enhanced awareness and knowledge of the classifications of organisations, structures of organisations and organisational culture and dynamics (Gavaghan, 2009) has enabled me to have a greater appreciation of how the NHS functions and therefore how the organisational influences affect the profession of talking therapies and the therapeutic relationship. I utilised the knowledge obtained from Gavaghan (2009) contributing this to the theory of therapy within an organisational context in particular an IAPT context.

3.2.2. How exploration of the traditional hieratical organisational culture of the NHS (Gavaghan, 2009) has influenced professional practice within an organisational context, IAPT service.

I asserted that training on the development of organisational culture and sub-cultures (Gavaghan, 2009) and the development and process of group and cultural dynamics (Gavaghan, 2009; Tuckman, 1965, 1977, 2011, Brown, 2000; Hogg et al. 2001;) would be beneficial to IAPT staff on 'induction training'. The appraisals by attendees at induction training confirmed that Gavaghan (2009) contributed to theory and knowledge regarding therapy in organisational contexts. Documented statements concerning the induction training informed by learning from Gavaghan (2009) are contained in Annex: 3. A summary of how Gavaghan (2009) influenced the development of organisational culture and ethos of the IAPT service is in recorded format entitled "*The MHCO Vision"* (MHCO, 2012a; YouTube, 2013a). In general, staff stated that prior to attending 'induction training' they had minimum understanding of organisational influences to therapy.

The process of establishing and developing a new IAPT Service was a difficult and complex transition and producing extreme levels of stress collectively and individually. An entirely new workforce emerged with individual dissimilar prior experiences of organisational cultures, alongside disparate therapeutic modalities and individual expectations and ideas pertaining to the service's operational methods. Concurrently, the majority of staff had the supplementary pressure of attending mandatory university based psychological therapy training. Therapists delivered therapeutic interventions on a metaphorical 'blank canvas' of a developing

service with embryonic ever-changing procedures and protocols. Groups formed based on shared identities but were fluid, and transient, which added to the difficult complex developing organisational dynamics. (See Annex: 4). A staff survey (MHCO, 2010) regarding retention and managing stress within the service identified common emerging themes that could be related to the distribution of knowledge and theory related to Gavaghan (2009). (See Annex: 4).

Colleagues stated that learning from the 'induction training' including increased awareness of organisational cultures and dynamics assisted them to "*normalise*" the stress relating to the process of group dynamics according to Tuckman (1965, 1977, 2011). '*Normalise'* in this instance is a coping strategy used to preemptively depathologise problems and the persons view of the problems *"as ordinary difficulties of life,"* (O'Hanlon and Weiner-Davis, 1989, p. 93).

Increased learning concerning the traditional hieratical organisational culture of the NHS and how organisations influence the client and therapeutic relationship (Gavaghan, 2009) has enabled me to contribute to the establishing and development of an IAPT service by conveying theory and knowledge to IAPT staff. The increased awareness of organisational issues encouraged staff to reflect on their individual contribution to the establishing and development of a new service and interrelated developing culture, thus supporting the evaluation of a preferred organisational culture and willingness to address potential difficulties, and impeding factors to the development of this culture. The enhanced appreciation of various organisational dynamics outside of the therapeutic relationship enabled therapists to improve their clinical practice by gaining awareness of how organisational influences can affect the client, therapist and therapeutic relationship, thus gaining greater understanding of the influence of the delivery of therapy within the organisational context, and additionally facilitating empathic development in therapists Rogers, 1957, 1975). Therapists frequently commented on their increased attentiveness in endeavouring not to allow any negative detriment influences of the organisational culture and dynamics to impede into the therapeutic relationship.

Accompanying information is contained in Annex: 4, relating to how (Gavaghan, 2009) influenced professional practice within an organisational context and contributed to the development of an IAPT service.

3.3. How exploration of the traditional hieratical organisational culture of the NHS and the societal perspective of counselling (Gavaghan, 2009) may influence the client and the counselling relationship.

I explored the hieratical organisational culture of the NHS (Gavaghan, 2009) I then considered what organisational influences have the potential to affect the client and therefore influence therapy by intruding into the therapeutic relationship. Subsequently, questions immerged from the heuristic research process. "*What organisational influences have the potential to influence the client and possibly obtrude into the therapeutic relationship?"*

The research questions that emerged from the heuristic process related to the influence of organisational culture and the societal perspective of counselling to the client and therapeutic relationship. I will address the immerging questions in turn.

3.3.1 What organisational influences have the potential to influence the client and possibly obtrude into the therapeutic relationship?

I considered what influences might affect clients' attitude towards the NHS, and during the MPhil process explored statutory services such as IAPT services. I examined how the client's perception of the provision of therapy is influenced by external influences such as organisational culture and how these dynamics may impinge into the therapeutic relationship.

Gavaghan (2009) highlighted the magnitude of the NHS as an organisation stating it is the third largest employer in the world and the largest employer in Europe. Since 2009, the NHS has continued to expand employing more staff (NHS Choices, 2013).

The consequential powerful organisational influences of the NHS affect clients and the therapeutic relationship according to Gavaghan (2009).

Gavaghan (2009) claimed that due to the enormity of the NHS as an organisation, and the percentage of people registered with a General Practitioner (GP) and considering the status of the NHS within the nation, this determines that the NHS is inseparable from the national culture of the United Kingdom (UK) (Seale and Pattison 1994; Lawson, 1993; Department of Health, 2008). The publication of the NHS Constitution (2013) confirms the NHS is an integral part of the UK and embedded in the national culture and law. Gavaghan (2009) suggested that the powerful influence of the culture of the NHS continually affects our daily existence and influences our experiences therefore must have influence on the client and the therapeutic relationship.

Gavaghan (2009) concluded that the media as an organisation have a strong social and cultural impact upon society because of the professions ability to communicate influential messages to an extensive audience using countless resources and means of communication. Gavaghan (2009) discovered that the media in general influenced peoples' perspective of the NHS unfavourably. Research by Perse (2008) produced findings similar to the conclusions from Gavaghan (2009) that the media are able to decide which issues to communicate, by what method and from which perspective to influence the public's view towards the NHS.

Gavaghan (2009) researched the influence of the NHS on society and concluded that the organisational culture of the NHS exerts cultural influence on those within the organisation as well as on almost every person who has utilised NHS healthcare or is acquainted with someone having had experience of the NHS. Gavaghan (2009) suggested that the NHS exerts its powerful influence on society in general therefore also individuals such as the clients therefore also the therapeutic relationship. Gavaghan (2009) subsequently explored the following question; "*How previous experience and perception of the NHS may influence a counselling client?"*

3.3.2 How previous experience and perception of the NHS may influence a counselling client?

Gavaghan (2009) revealed that previous experiences of the NHS affected people's perspectives and attitudes towards counselling because people considered counselling in Primary Care Services to be an integral part of the NHS. Gavaghan (2009) advocated that pre-conceived judgments or judgements based on previous experiences have the power to intrude into the therapeutic relationship in either a hindering or an advantageous manner similar to '*parallel processes,* (Crandell and Allen, 1982; Carroll and Walton, 1997; Davies, 1997; McLeod and Machin, 1998). Gavaghan (2009) determined that if someone had positive NHS experiences or believed that the NHS provided a quality service in probability they would have a positive proactive attitude towards therapy within a NHS context. Conversely, a client with a pessimistic perspective of the NHS who had encountered detrimental experiences would have a similar parallel view and attitude towards counselling within the NHS context (Gavaghan, 2009). Gavaghan (2009) refers to organisational influences as a "*parallel process*" in which clients experiences, opinions and feelings relating to the organisation and the organisational culture transpire concurrently with their presenting issues into the therapeutic process.

Gavaghan (2009) promotes the awareness and understanding of organisational influences. This awareness would assist in the identification of organisational parallel processes (Davies, 1997; Stevenson, 2010; Reeves, 2013) for the benefit of therapy. Davies (1997) states a parallel process is a valuable resource for the therapist but only if the therapist is sufficiently aware of the parallel process and is able to identify and verbalise accurately and congruently in therapy. Stevenson (2010) claimed that parallel processes may not always be noticeable but if the therapist has an awareness of the possibility of the dynamic influencing therapy and is able to identify the organisational parallel process, the therapist can introduce the newfound information into therapy providing additional useful insight for the client. Reeves (2013) correlates with Gavaghan (2009) and acknowledges the dynamic of parallel process in the therapeutic relationship caused by the influence of the organisation, *"Good management and supervision of psychotherapists in the workplace facilitate the recognition of parallel process and bring it into the awareness of the therapists."* (Reeves, 2013, p. 126).

Gavaghan (2009) proposes clients perceptions of the NHS have an influence on clients either beneficially or detrimentally regarding their therapy, therefore suggests that therapists ought to be aware of this dynamic and organisational parallel processes especially when establishing and maintaining a therapeutic relationship within an organisational context. This conceptualisation has benefitted my professional practice immensely.

Gavaghan (2009) enhanced my understanding of organisational cultures particularly in the NHS including an awareness of sub-cultures within the organisation and the dissimilarities and occasional conflict between sub-cultures. I therefore contemplated if this inter-cultural discord might have a bearing on the client or counselling provision. I hence explored the following question, "*How may conflicting NHS sub-cultures have an influence on the patient / client?"*

3.3.3 How may conflicting NHS sub-cultures have an influence on the patient / client?

Gavaghan (2009) discovered tensions exist between the sub-cultures of the NHS and have the power to influence client's care and treatment with the client having little control to change organisational policy concerning their individual treatment.

A generic objective of the NHS is to provide a quality service for the patient that is responsive to their needs and preferences. Nonetheless, Gavaghan (2009) identified dominant sub-cultures within the NHS with similar nevertheless dissimilar structures of bureaucracy design and diversity in their fundamental beliefs and assumptions and often having contradictory understanding of how to provide a quality service for the patient. Healthcare professionals concentrated on providing the optimum care for individual patients whilst managers focused on patients collectively. Clinical based sub-cultures may be in conflict with sub-cultures who set value on fiscal policies rather than healthcare. I discovered that organisational sub-cultural discord exists in IAPT services and emulates the NHS. Davies and Mannion (2013, p. 3) citation correlates with the results of Gavaghan (2009), *"Our healthcare organisations, then, are better viewed as multiple (often competing) subcultures, stratified by hierarchy".*

Francis (2010, 2013) conducted an Independent Inquiry into serious failings in NHS care citing cultural deficiencies in the NHS and recommend fundamental cultural change. Francis (2010) identified conflicting sub-cultures especially between sub-cultures with fiscal and financial priorities to those focusing on healthcare. Francis (2010, 2013) confirms that NHS sub-cultural conflicts exist correlating with Gavaghan (2009). McLeod (2009) cited that production of results desired by organisations rather than the therapist and client, is an example of competing expectations between therapy and organisational culture, I have experienced this same sub-cultural disparity in IAPT services and the NHS.

Gavaghan (2009) suggested clients attending for therapy are often aware of tensions between sub-cultures for example limitations on the amount of therapy sessions and procedures for discharging clients for missing appointments. Gavaghan (2009) discovered clients do not feel valued due to restriction of sessions therefore often have negative attitudes towards therapy. This client response may directly affect the therapeutic relationship with the therapist experiencing additional difficulties developing a therapeutic relationship and facilitating client's motivation towards therapy. My self-awareness has been raised due to the process of completing Gavaghan (2009) and I have discovered that if I am in agreement with the client regarding issues like restrictions to counselling, transactions may become complex because destructive pessimistic collusion and parallel processes may develop to the detriment of the therapy. My increased self-awareness assists to prevent potential detrimental influence to therapy. Konteh et al. (2011) substantiated Gavaghan (2009) by confirming that views and perceptions of professionals and patients regarding organisational culture and sub-cultures are remarkably similar.

Annex: 3c, is an example from a Client Satisfaction Questionnaire (CSQ) relating to previous NHS treatment influenced by conflicting sub-cultures. PEQ, IAPT (2013a, 2013b) correlate with Gavaghan (2009) confirming clients have an appreciation of organisational culture and sub-cultures and perceptions and attitudes towards the NHS are informed by societal influences like the media and past NHS experiences. (See Annex: 3f).

Gavaghan (2009) identified that tensions between sub-cultures have detrimental influence on staff moral, sickness, absenteeism, and affects the functioning of a team and clinicians individually (Miller, 1989; Smith and Norton, 1999). Francis (2010) discovered similar evidence to Gavaghan (2009) within the culture and sub-cultures of the NHS. Gavaghan (2009) suggested that variance between sub-cultures has potential to have detriment impact on the functioning of a team and individuals also indirectly, to degenerate patients healthcare and whatever part of the hierarchical organisational continuum a sub-culture is positioned that specific sub-culture has the potential to influence the service-user either directly or circuitously.

Davies and Mannion (2013) when analysing the investigation and recommendations by Francis (2010, 2013) concurred with the conclusions of Gavaghan (2009) that the NHS is a hierarchical organisation with many sub-cultures sometimes in conflict with one another to the detriment of the client or patient. Davies and Mannion (2013, p.2) state, *"Organisational cultures in healthcare are manifold, complex, and dynamic. Healthcare organisations are better seen as multiple coexisting subcultures rather than as uniform cultural monoliths."*

Gavaghan (2009) increased my knowledge and understanding of organisations, organisational cultures, sub-cultures, and organisational dynamics and how these may influence therapy. The client's perception of the NHS has an influence on their perception of therapy thus influencing the therapeutic relationship (Gavaghan, 2009). My increased comprehension of external influences to the therapeutic relationship benefit therapy by assisting me to gain increased understanding of clients' perspectives and associated feelings therefore facilitating my communication of accurate empathy to the client (Rogers, 1957, 1975,). Empathic interactions encourage clients to feel understood, valued and significant, as well as encouraging trust and candidness within the therapeutic relationship. Since completing Gavaghan (2009) I am more sensitive to clients' potential anxieties and concerns and conscious that organisational issues may have a damaging impact on the dynamics of a therapeutic relationship.

Gavaghan (2009) recognised the existence of many powerful sub-cultures within the NHS. Nevertheless counselling as a profession did not appear to belong to any sub-

cultures. I therefore examined the position of counselling provision within the hierarchy of the NHS to gain appreciation if this may have an influence on the client the therapeutic relationship or the societal perspective of counselling. I personally had encountered difficulties gaining acceptance as a counsellor by NHS cultural organisational groups. The following research question became apparent, ***"****Where do counselling and the client fit into the hierarchical organisation culture of the NHS?"*

3.3.4 Where do counselling and the client fit into the hierarchical organisation culture of the NHS?

Counselling.

Gavaghan (2009) suggested that counselling as a profession, is not accepted as a valid organisational member of the NHS organisational hierarchical culture and has encountered conflict with the medical orientated NHS culture. Gavaghan (2009) concurred with Pilgrim (1990) who suggests the ambiguous epistemology of counselling was a factor that made the profession difficult to place within an NHS sub-group. The '*talking therapies'* are considered abstract and vague in comparison to concrete qualitative evidence measured treatments like medicine and pharmacology. Gavaghan (2009) concluded that the counselling profession does not have the status for consideration as an individual sub-group and has encountered conflict with medical orientated cultures and sub-cultures.

Gavaghan (2009) described personal difficulties gaining acceptance into the organisational cultural of the NHS. As a counsellor he was able to meet some of the criteria for membership of the NHS culture but was difficult to place within the hierarchical structure except in an insignificant position, low in the NHS hierarchy. Lees (1999) findings corresponded with Gavaghan (2009). Walton (2004) published evidence of the reluctance of NHS staff to use staff counselling services because they deemed the position of counselling inferior than their perceived NHS ranking in the NHS hierarchy which correlated with Gavaghan (2009).

Gavaghan (2009) stated that counselling, as a profession was considered by other sub-cultures within the NHS to have an ambiguous epistemology therefore not

professionally credible. Clark and Turpin (2008) research correlated with Gavaghan (2009) but also stated that counselling has acquired a position within NHS interrelated services such as IAPT but only if counselling continues to compromise the epistemological position embracing the medial model. Conversely, I have witnessed resistance to compromise to the medical model derived from concerns of stigmatisation via labelling clients as well as losing professional identity as counsellors and not having fidelity to Rogerian values. I concur that counselling has gained gradual acceptance by IAPT services because of adaptation to the organisational cultures by compromising epistemology models. Nonetheless, I maintain that compromising denotes being flexible to the organisational culture whilst remaining true to individual therapeutic modalities philosophy and epistemological stance. I suggest that counsellors and talking therapists using Rogerian modalities can embrace the suggestion of Edley (2001) who argued that epistemological conflicts keep debates radical and contribute to knowledge and understanding thus accomplishing change, according to Chwalisz (2003, p. 515) "*be able to effect changes in the system consistent with our values-from the inside*." MA research (Gavaghan, 2002) concluded that therapists would have to have an understanding of an organisations culture to enhance proficient communication with the organisation in order to be accepted professionally. I suggest these conclusions (Gavaghan, 2002) should be considered as an additional training need for therapists employed in organisations because these conclusions remain as relevant today. I have conveyed my knowledge (Gavaghan, 2009) to person-centred therapists, enabling them to adjust to the organisation culture and dynamics of the IAPT service and use of the medical model without compromising Rogerian philosophies. (See Annex: 4).

Douglas (2010, p. 24) acknowledged that counselling as a profession is gradually gaining acceptance in statutory organisations, such as IAPT, however an important consideration is,

> "H*ow to retain a humanistic value base within a framework dominated by a medical model of distress in which treatment guidelines focus on disorder, within such a framework, therapies and their research bases, are premised on the notion of disorder and its classification."*

My experiences in an IAPT service since 2009 correlates with Douglas (2010) and the original findings (Gavaghan, 2009). (See Annex: 5).

After re-evaluating Gavaghan (2009) and considering more recent research, I determine that Gavaghan (2009) conclusions are still valid in that counselling is still perceived to have a low ranking within organisations including the NHS and IAPT. The following quotation is as relevant as ever in these organisations, *"The marginalized position of most counsellors, who are part time and low in the medical or management hierarchy."* (Lees, 1999, p. 103).

Patient / Client.

The patient although not employed by the NHS is a crucial and fundamental part of the organisation as without patients the NHS would not exist. Paradoxically, the NHS strives to provide a quality service responsive to their needs but places them low in the hierarchical structure (Gavaghan, 2009). Professionals within the NHS consign patients to the bottom of the organisational hierarchical structure with mental health patients placed even lower in the hierarchy and counselling clients given an even lower-ranking position compared to those receiving other psychological therapeutic interventions (Gavaghan, 2009). Grey (2006, p. 7) states *"There still is a hierarchy in medicine, with the client at the bottom."*

Gavaghan (2009) discovered that counselling clients often perceive themselves in a disapproving manner believing that they are below other patients in the hierarchical organisational structure. A contributing factor to clients attitudes are due to the position of counselling within the NHS, and the stigma that is still associated to mental health (Lees, 1999; Walton, 2004). Stigma towards counselling is long-standing (Carrol, 1996; Williams and Davis, 2002). East (1995) and Gavaghan (2009) state that due to the stigmatisation of mental illness, people feel the need to explain mental illness as a physical condition because it is more acceptable. The negative perspective of mental health within the NHS is partially due to the stigma attributed to mental health in general but also due to treatments for psychological health such as counselling are not considered medical when compared with

evidence-based treatments like medicine and quantitative evidence based therapeutic modalities like Cognitive Behavioural Therapy *(*CBT).

How the profession of counselling is regarded within the NHS influences how professionals judge; counselling as a profession, counsellors as individuals and counselling clients. Gavaghan (2009) cited that if counsellors had a cultural awareness of these organisational perceptions and were able to recognise when cultural dynamics could threaten relationships with other professional colleagues to the detriment of the counselling provision, they would then be able to be pro-active by working collaboratively and establishing good relationships with other professionals, consequently providing an improved service for their clients and concurrently, promoting themselves and counselling as a professional accomplished profession (Gavaghan, 2009).

Gavaghan (2009) reasoned that the position of counselling as a profession within the hierarchy of the NHS has an influence on the client because either directly or circuitously these negative detrimental influences will have potential consequences on how the client perceives their 'self' and their therapy within the organisation. Gavaghan (2009) increased my personal awareness of the stigma linked to mental health and the unfavourable organisational view of counselling within the NHS. I therefore decided to gain an increased insight into the societal perspective of counselling and consequences to the client and the therapeutic relationship by the following question, *"Is the client and the counselling relationship influenced by the organisational and the societal view of counselling?"*

3.3.5 Is the client and the counselling relationship influenced by the organisational and the societal view of counselling?

DH (2001, 2004, 2006) the Shaw Trust (2006) and Gavaghan (2009) acknowledge that stigma and discrimination exists towards mental health. Gavaghan (2009) revealed that a negative stigma to counselling exists based on the assumption that people should be able to cope and resolve their emotional problems without professional assistance and that a commonly held cultural stigma is present about seeking assistance for something that is non-physical or not medical. Evidence from

clients suggested due to stigmatisation and mental health perceived as a sign of weakness or failure, people would rather describe their mental illness as a physical condition (East, 1995; Moore and Garland, 2003; Gavaghan 2009), (Annex: 3e. for clients statements). Moore and Garland, (2003, p. 120) observed similar attitudes,

> *"Although great strides have been made in reducing the amount of social stigma attached to psychiatric illness, such stigma is still prevalent in many sectors of society. As many patients observe, it seems to be more socially acceptable to have an illness such as cancer than to receive a diagnosis of depression."*

A former Minister of State for the DH made a statement (Burstow, 2013), that correlates with the findings of Gavaghan (2009).

> "*It's a radical idea: that there should be parity of esteem between mental and physical health. The interdependence of mental and physical health should mean that we are pushing on an open door. But somehow the NHS default remains stubbornly biased towards physical health. A terrible false economy at the expense of people's lives."*

Gavaghan (2009) highlighted inadequate understanding about mental health in the workplace and despite changing attitudes of a more enlightened society stigma is still prevalent in many sectors of society. Gavaghan (2009) acknowledged some progress made in reducing the amount of social stigma attached to psychological illness (Time to Change, 2008). Time to Change, (2008) was the largest programme in England designed to reduce stigma against people with mental health. Development of Time to Change, (2008) programme is addressed in further detail in Annex: 6.

Henderson and Thornicroft (2013) evaluated the Time to Change (2008) programme suggesting that mental health professionals still had a pessimistic attitude and behaviour towards mental health patients. Their findings correlate with Gavaghan (2009) that negative patients experiences with health professionals will deter people from seeking further help, including therapy and also influence the therapeutic

relationship.

After re-evaluation Gavaghan (2009) I conclude that external influences relating to the societal negative attitude and stigma towards counselling and the position of counselling within the hierarchical structure of the NHS, all have a detrimental effect on the self-concept of clients and influence how they perceive counselling as a therapeutic intervention, thus encroaching into the therapeutic relationship detrimentally.

3.3.6. The importance of developing a productive societal perspective in an organisation.

Gavaghan (2009) accentuated the importance of having an awareness of the societal perspective of therapy including how the media influence the societal perspective of an organisation because societal influences are an external factor that influences the client thus the therapeutic relationship either beneficially or detrimentally depending on the societal perspective of the organisation.

When the IAPT service was developing a publicity initiative, I communicated findings from Gavaghan (2009) suggesting that the societal perspective has a bearing on therapy, which then became an important consideration when implementing media and promotional incentives. Further information is contained in Annex: 7. regarding a positive societal perspective. The outcomes of Gavaghan (2009) were taken into consideration when developing an organisational website (MHCO, 2012b). Examples of clients comments of how the website (MHCO, 2012b) was influential are included in Annex: 3. "*The MHCO Vision"* (MHCO, 2012a; YouTube, 2013a) in video format and other resources such as MHCO (2012a, 2012b, 2013a) were informed by the conclusions of Gavaghan (2009).

Gavaghan (2009) encouraged therapists to gain understanding of external factors that have potential to inform the therapeutic relationship including influences prior to therapy such as the societal perspective and referral systems. How to promote the potential client to the socialisation of therapy (Roos and Wearden, 2009; Neenan and Dryden, 2011) and initiating the transition from "*patient to client*" (Gavaghan,

2009) via media were considered with the rationale of influencing the therapeutic relationship positively prior to therapy (MHCO, 2012a, 2012b; YouTube, 2013a)

3.3.7. Influence of the medical model.

Gavaghan (2009) concurred with Moore and Garland (2003) who stated the medical model has biases towards biological and genetic posits and has influenced the culture of the UK. The traditional medical model of medicine has influenced the development of the NHS (Gavaghan, 2009) having had dominance in western medical science, including psychiatric clinical practice (Engel, 1977; Cohen, 1993; Barney, 1994; Kazarian and Evans, 2001; Gavaghan, 2009). Laing (1971) described the medical model as dictated procedures that all doctors train to conform too. Clare, (1980) suggested that the medical model is a scientific process involving observation, description and differentiation, which moves from recognising and treating symptoms to identifying disease aetiologies and developing specific treatments.

Siebers (2008, p. 3) argued that, "*The Medical Model reduces disabled people to their bodily impairment and defines disability as an individual's defect lodged in the person, a defect that must be cured or eliminated if the person is to achieve full capacity as human being."* I agree with Odegaard (1986) and Engel (1977) who challenged the medical model for oversimplifying the illness and focusing only on the physical compliant, "*It leaves no room within its framework for the social, psychological, and behavioural dimensions of illness."* (Engell, 1977, p. 130). Shah and Mountain (2007), suggest a refinement of the medical model to reflect the contemporary practice of medicine, proposing that the, *"Medical model is a process whereby, informed by the best available evidence, doctors advise on, coordinate or deliver interventions for health improvement."* (p. 375). Shah and Mountain (2007) in their contemporary definition of the medical model, I argue still have no consideration for the holistic person and propose an evidence-based model that will still require medical model procedures (Laing, 1971; Clare, 1980).

Gavaghan (2009) endorses the dominance of the medical model and the predisposition to focus on biological, genetic and physical diagnosis rather than non-

physical, social and psychological factors to illness and has detrimental impact on people who experience non-physical disorders, such as clients referred for psychological therapies. Gavaghan (2009) proposes the mental health system is based on the medical model of psychiatric practice and is oppressive and controlling, principally due to the importance placed upon diagnosis, subsequent treatment and prognosis, (Clare, 1980), in fact detrimentally stigmatising and '*labelling'* the client (Engel, 1977; Odegaard, 1986; Johnstone, 2000, 2008; Bentall, 2003, 2009; Laurance, 2003; Siebers, 2008 Gavaghan, 2009).

Venner (2009) James (2010) and Cole (2013) alternatively refer to non-diagnostic, non-medical philosophy and non-labelling that can be a proven substitute to the medical model in mental healthcare thus reducing stigma and discrimination experienced by those with mental health disorders. I concur with the propositions of Venner (2009) and James (2010) regarding non-diagnostic and non-medical philosophy because the models are patient-centred rather than based on the medical model therefore advantageous to the patients transition from "*patient to client*" (Gavaghan, 2009). I additionally agree with Rogers, (1951, p. 223) who believed that, *"A diagnosis of the psychological dynamics is not only unnecessary but in some ways is detrimental or unwise."*

The NHS, NICE, BABCP and IAPT are biased towards the medical model. CBT utilises some of the procedures of the medical model (Laing, 1971; Clare, 1980). Beck Institute (2013), in video format argue the importance of diagnosis in effective CBT. In my CBT training, I was taught the importance of diagnosis influenced by the medical model and the use of "*Structured Clinical Interviewing" (* Fitz, et al. 2002), to establish a diagnosis to inform treatment protocols. I had difficulties accepting the rationale of using diagnosis in my therapy as it conflicted with my person-centred philosophies and my conveyance of Rogers core conditions (Rogers, 1957, 1959). Principally unconditional positive regard because I was judging someone subjectively and congruence, as I was performing an undertaking that I did not agree with.

3.3.8 Précis of the section and how Gavaghan (2009) has contributed to theory and knowledge related to understanding the traditional hieratical

organisational culture of the NHS and therapy within an organisational context.

Gavaghan (2009) increased my comprehension of how the medical model has influenced the organisational culture of the NHS and the societal perspective of counselling and consequently the client. I discovered that client's previous experiences and view of the NHS as well their perception of counselling provision are factors that affect how clients present for counselling within an organisational context. Gavaghan (2009) argued that the stigmatised societal perspective of mental health influences clients perspective of themselves and counselling as a therapy. I discovered that counselling clients within the NHS often present with a negative self-concept and pessimistic perspective of therapy due to the detrimental influence of the hieratical organisational culture of the NHS towards counselling and the negative societal perspective of counselling (Gavaghan, 2009). This has the potential to affect adversely the client's attitude towards therapy hence influence the therapeutic relationship.

I have greater understanding of how external factors influence the therapeutic relationship especially the influence of the organisational context such as organisations cultural influences as well as the societal perspective towards therapy (Gavaghan, 2009). I am therefore more sensitive to clients' potential anxieties and concerns and conscious that organisational issues may have a damaging impact on the dynamics of the therapeutic relationship. This enhanced understanding of external factors to the therapeutic relationship enhances my ability to convey Rogers core conditions especially empathy accurately (Rogers, 1957, 1959, 1975, 1989) therefore has positively influenced my professional practice.

3.4. How the research (Gavaghan, 2009) has contributed to theory and knowledge related to how the transition of the NHS may have a bearing on patients, clinicians and their professional relationships?

Gavaghan (2009) examined the transition occurring within the NHS at the time of the research especially the significance of the changing patient within the hierarchical

culture of the NHS. Gavaghan (2009) considered how the enforced change might have a bearing on the professional medical relationships in particular from the perspective of the patient by considering. *"How might the changing NHS be influencing patients and professional medical relationships?"*

3.4.1 How might the changing NHS be influencing patients and professional medical relationships?

The strategy of transforming the NHS was initiated from the highest level of the hierarchical structure, the Secretary of State for Health. Queens Speech (2004, pg. 1) authenticated that the reforming of the NHS had support from the uppermost level of Government, *"My Government will continue its reform of the National Health Service, offering more information, power and choice to patients."* The strategy for implementing the reformation of the NHS (DH. 1991, 1998, 2000, 2001, 2002, 2004, 2006, 2006a, 2007a, 2008a, 2008b; NHS Trusts Patient Surveys, 2007; NHS Patients and Public, 2007) consist primarily of publications describing the plans for restructuring and transformation the organisational culture and structure. The NHS reformation aimed to transfer the balance of power from the organisation to the patient (DH, 2000, 2001, 2002, 2004, 2006a, 2008, 2008a).

The NHS facilitated consultation with patients as part of the reformation. Terminology appeared such as, '*patient-centred'* and '*patient-involvement'*. Gavaghan (2009) studied different perspectives of "*patient-centeredness.*" Barker and Buchanan-Barker (2003) defined patient-centred care as the doctor focussing on the patient as a person rather than the pathology. McWhinney and Freeman (1997) describe the patient-centred approach as focusing on the primacy of the person rather than the disease and they suggested committing to the person rather than to a particular body of knowledge. Stewart (2001, p. 445) defined patient-centred as, *"Patient-centred actually means taking into account the patient's desire for information and for sharing decision making and responding appropriately."* I consider that the patient-centred approach to clinical consultation *(*Little et al. 2001, Stewart, 2001; Barker and Buchanan-Barker, 2003; McWhinney and Freeman, 1997, 2009) has correlation with the beliefs of Rogers (1951) '*client-centred therapy'* and Balint (1957) '*person-centred medicine'* as well as Fraser (1999) who promoted

patient autonomy during a clinical transaction. Stewart (2003, p. 10), description of the person-centred approach has similarities with the philosophies of Rogers (1951, 1957, 1961) therefore correlating the link between the patient-centred approach and Rogerian psychological therapies, *"A person-centred approach is more than just a way of acting: it is a way of thinking. It means always seeing the patient as a unique person in a unique context and taking into account patient preferences and expectations at every step in a patient-centred consultation."*

Little et al, (2001) concluded that NHS patients prefer a patient-centred approach, with communication from an approachable GP with a partnership-approach. Research literature including Gavaghan (2009) acknowledges the advantages of patient-centred medical practice (Rogers 1951; Balint, 1957, 1964; Balint and Balint, 1961; Balint, et al. 1966; Balint and Norell, 1973; Fraser, 1999; Smith and Norton, 1999; Stewart et al. 2000, 2001, 2003, 2006; Summerton, 2007; Miles, 2009, 2011). Stewart, et al. (2000, pg. 804) argued "*Patient-centered practice was associated with improved health status."* Balint (1993) proposed the attitude of the referrer influences the success of treatments and Kiethly et al, (2002, p. 89) "*many others have pointed out how important the attitude of the Doctor is in the success of a treatment. Such an attitude must transmit itself to patients."*

Conversely, Mead and Bower (2002) reviewed research that investigated the relationship between patient-centred clinical relationships and outcomes of treatment concluding that due to existing evidence of methodological inadequacies the correlation is not definitive.

The DH (1991, 1998, 2000, 2001, 2002, 2004, 2006, 2006a, 2007a, 2008b, 2011c, 2013a, 2013b, 2013c, 2013d) focused on a change of ethos and culture for the NHS relating to reforming a health service designed around the patient rather than the needs of the patient being forced to fit around the services provided. The reformation advocated a holistic approach suggesting that patients' health, well-being and social needs need to be taking into consideration. The transformation in cultural change focused on patients becoming responsible for their own health with individual rights and expectations of healthcare. The transformation of the NHS is contrary to the medical model (Laing, 1971; Clare, 1980) that advocated a doctor-

centred relationship that hitherto had influenced the organisational culture of the NHS. Gavaghan (2009) recognised the altering traditional role of a patient, patients becoming autonomous consumers with choice of treatments, access to information, and ability to articulate opinions, complain and provide feedback pertaining to their healthcare. The organisational culture and structures of the organisation experienced enforced transition to accommodate this reformation.

Gavaghan (2009) explored the transformation of the NHS and discovered people still experienced feelings of powerlessness in their changing role as patients, many having distrusting attitudes regarding the dominant influence of the organisational culture, feeling ineffectual rather than having autonomy. The evidence from Gavaghan, 2009 is a contradiction to the DH policies of NHS transition that endeavoured to provide a health service that is patient-centred shifting the balance of power to the patient. Gavaghan (2009) evidence suggested that people believed that they were not listened too and had diminutive influence over the control of their individual healthcare and regardless of any consultation process decisions are decided. This produced patient lethargy, and a lack of motivation to participate in consultation believing their opinions would be ineffectual in promoting change.

(See Annex: 3c. evidence client's pessimistic attitude towards the NHS). Gavaghan (2009) discovered that client apathy concerning the NHS often intruded into the therapeutic relationship, as clients perceived counselling an integral part of the NHS, an organisation they considered powerful in comparison to themselves.

Since Gavaghan (2009), having the benefit of retrospection I therefore judge that the NHS has continued to evolve and develop to the benefit of the patient. (See Annex: 8. continued transition of the NHS since 2009).

3.4.2 Précis of the section and impact of research (Gavaghan, 2009) on professional practice and contribution to theory and knowledge related to therapy in an organisational context.

Gavaghan (2009) and further evaluation (MPhil) confirmed the culture of the NHS is multifaceted consisting of complex organisational values, beliefs, behaviours that

gradually developed over time, therefore many have become implicit and are inconsistent with the recent transformation of the NHS organisational culture. The traditionally functioning of the NHS related to the top of the hierarchical structure achieving efficiency by making autonomous decisions rather than using consultation. This is in contrast to the changing contemporary NHS who embraces and encourages consultation and patient involvement. This clash of ideologies potentially hinders and impedes organisational change (Gavaghan, 2009). The culture of the NHS is intangible, well established therefore change will be slow and arduous and due to the size of the organisation, may not be obvious to everyone. Gavaghan (2009) consequently suggested that for positive cultural change to occur and be observed by NHS patients it has to be a continuous process of consulting, developing, evaluating, and promoting effective action change to continually strive to improve patients' quality of healthcare.

Gavaghan (2002, 2009) emphasised that therapists should understand the importance of the context of therapy especially when providing therapy in an organisational context as organisational culture and dynamics has potential to influence the therapeutic relationship. Gavaghan (2002, 2009) recommended that to improve and inform therapeutic practice therapists should understand organisational culture and dynamics as well as how these external influences to therapy may affect the client and accordingly the therapeutic relationship.

3.5. How the professional medical relationship and the referral may influence counselling?

Gavaghan (2009) considered how the client's relationships with NHS professionals influenced the adjustment from a client's traditional role as a patient to that of a pro-active client in therapy by exploring the research question, *"How may the doctor–patient relationships influence the therapeutic relationship?"*

3.5.1 How may the doctor–patient relationships influence the therapeutic relationship?

The process of a client's transition from a traditional role as a patient to that of a collaborative client in therapy I refer to as, *"from patient to client" (*Gavaghan, 2009).

Gavaghan (2009) research suggested the GP's attitude and style of clinical transaction directly influences the type of doctor-patient relationship. Client's experiences of doctor-patient relationships influence the client's capacity to adapt to and contribute to the therapeutic relationship (Gavaghan, 2009).

The doctor-patient relationship originated from the medical model, (Laing, 1971; Clare, 1980; Bynum, 2008) because the medical model influenced the development of the NHS organisational culture. Sheldon (1992) described the GP in the doctor-centred relationship as a controlling, authoritarian in a dominant position making decisions for the patient in what they believe are in the patient's interest. This description correlates with the medical model (See section 3.3.7). Haslam (2006, p. 231) describes the doctor-centred relationship in a detrimental manner,

> "*It used to be so much simpler. Doctors were the experts and told patients what to do. Patients listened and occasionally took notice. Doctors were criticised as behaving as if they were God, and medicine was something that was done to people. All too often, the doctor-patient relationship, in transactional terms, was parent-child and it wasn't healthy".*

Gavaghan (2009) discovered that GPs associated with the doctor-centred relationship generally communicated in a didactic one-way manner. The conclusion was obtained via the heuristic research process (Moustakas, 1990). In the '*immersion'* phase, I attained data from patients and professionals experiences including my experiences as a patient and a professional. I integrated accompanying data acquired through experiences assessing GP proficiencies for appraisals (GP 360 Appraisal System, Doctor 360°, 2013). Appropriate literature (Wilkinson, 1989; Smith and Norton, 1999; GMC, 1993) also facilitated the '*immersion'* phase and triangulation (Fielding and Fielding 1986). Killaspy et al. (2000) concluded that poor communication from the referring GP increases non-attendance at initial appointments. Wilkinson (1989) stated that research revealed the average listening time for doctors before interrupting the patient was 18 seconds.

GMC (1993) recognised the problematic issue of GP communication and recommended medical students have training in effective communication. Studies by Balint referred to the inadequate communication skills of doctors (Balint, 1957, 1964; Balint and Balint, 1961, Balint, et al. 1966). GMC, (2006) cited that it expected Doctors to be effective communicators to enhance the doctor–patient relationship, which has evolved from a paternal to a partnership model suggesting Doctors communicate in partnership with patients. Research since 2009 emphasised the GMC priority to improve communication within the patient-doctor relationship (GMC, 2009, 2013, 2013a).

The transformation of the NHS (see section 3.4.1) places an emphasis on the importance of the patient in the doctor-patient relationship encouraging participation in a collaborative relationship. Gavaghan (2009) advocated that the affability and genuineness of the doctor and the GP's ability to convey empathy with the patient and their predicament correlates with patient satisfaction (Balint, 1957, 1964; Balint and Norell, 1973; Fraser, 1999; Smith and Norton, 1999; Summerton, 2007; Stewart et al. 2000, 2001; Miles, 2009, 2011).

Despite the DH and GMC promoting patient-centred clinical relationships, Gavaghan (2009) revealed that many GP's were disinclined to change their clinical approach, and experienced difficulties adjusting to the patient-centred method. Gavaghan (2009) recognised some GPs resistance to numerous simultaneous ongoing enforced transitions although predominantly organisational transformation and the conflict between the doctor-centred medical model and the patient-centred partnership model of clinical consultations was the most problematic. I suggested that if resistant GPs were to become attentive to cultural influences and identified and understand their own implicit cultural beliefs and behaviours then change would be less challenging even if their ingrained organisational cultural values were contradictory to the latest NHS cultural reforms (Gavaghan, 2009). If GPs resistance to transformation are conveyed to the client this potentially influences the client's perspective of the NHS and affects their perspective of NHS counselling provision detrimentally (Gavaghan, 2009)

The medical model (see section, 3.3.7) is contradictory to the patient-centred perspective. The patient-centred approach to clinical consultation involves empowering patients in their own clinical decision-making, which is compatible with Rogerian psychological therapy modalities. Stewart (2003, p. 10) description of the patient-centred approach to clinical consultation is comparable with the philosophies of Rogers (1951, 1957, 1961, 1977).

> *"A person-centred approach is more than just a way of acting: it is a way of thinking. It means always seeing the patient as a unique person in a unique context and taking into account patient preferences and expectations at every step in a patient-centred consultation."*

Fraser (1999 p. 72) promoted patient autonomy during clinical transactions in a Rogerian manner (Rogers, 1951, 1957) *"At best the doctor – patient relationship should be one of trust, mutual respect and empathy."* Montagu (1963, p. 577) stated, what is now described as a patient-centred approach, "*Clinical medicine should be regarded neither as an art or science in itself, but as a special kind of relationship between two persons, a doctor and patient."* Stewart (2001, p. 444) states, *"Patient-centredness is becoming a widely used, but poorly understood, concept in medical practice. It may be most commonly understood for what it is not, technology-centred, doctor-centred, hospital-centred, disease-centred."*

Gavaghan (2009) suggested that since '*patient-centred'* clinical relationships are similar to Rogerian therapeutic approaches (Rogers, 1951, 1957, 1961) patients familiar with the '*patient-centred'* relationship usually adapt sooner to their role within the therapeutic relationship and the transition from a *"patient to a client"* is less problematic. Alternatively, Gavaghan (2009) discovered that client's familiar with the '*doctor-centred'* relationship, experienced difficulties adapting to and understanding their role as a '*client*'. Gavaghan (2009) advocated that as soon as the '*patient"* is able to engage with the therapist as an autonomous, collaborative '*client'*, the sooner the therapeutic relationship is established to the benefit of the client's experience of therapy, especially in time-limited therapy. Gavaghan (2009) advocated that clients' ability to conceptualise the rationale and actively engage in the therapeutic

relationship is directly connected to optimum improvements especially in time-limited therapy.

Gavaghan (2009) identified patients indisposed to change preferring the doctor-centred relationship or experiencing difficulties assuming the autonomy required in the patient-centred relationship. This behaviour is often replicated in the therapeutic relationship, *"It gives ample scope to those who seem only too willing to hand over responsibility for their lives to others, whether out of fear or because of apathy." (*Mearns and Thorne, 1989, p. 5). Shah and Mountain (2007) state that some patients when feeling vulnerable and powerless react with behaviours influenced by experiences of life and decide not to engage in treatment therefore displaying power and choice albeit not constructive to medical treatment or therapy. Nunes et al. (2009, p. 1) researched medication adherence and stated, *"Adherence shifts the balance between professional and patient."* The balance of power is passed to the client however many clients are unable to accept the responsibility for their own treatment and personal power (Rogers, 1977, 1978) becoming dependent on the opinions and guidance of others including therapists. This is an external locus of evaluation (Rogers, 1951, 1961; Raskin, 2004a, 2004b; Mearns and Thorne, 1988, 1999, 2000; Mearns et al. 2000, 2013; Mearns and Cooper, 2005). An external locus of evaluation is a person that listens to others opinions and judgements rather than their own and is influenced strongly by external factors to the therapeutic relationship (Gavaghan, 2009).

The client who experiences difficulties changing from the traditional role of patient to an autonomous service-user within the patient-centred relationship often present with an external locus of evaluation and may use resistance as a defence thus influencing therapy. Nevertheless, I concur with Rogers who stated, "*The individual has within himself or herself the vast resources for self understanding, for altering his or her self concept, attitudes, and self directing behaviour."* (Kirshenbaum and Henderson, 1990, p. 135). I therefore focus on establishing, developing and maintaining the therapeutic relationship by communicating Rogers core conditions (Rogers, 1951, 1957, 1959) as well as involving the client in the sharing of power, which empowers the client, and is associated with the values of person-centred therapy (Rogers, 1951, 1977, 1978). This process facilitates the transition from

"patient to client" (Gavaghan, 2009).

3.5.2 How referrers and the referral process may influence the therapeutic relationship?

Gavaghan (2009) proposed that the referral process and the attitude of the referrer are capable of influencing the client's opinions and attitudes to therapy (Wilder, *et al.* 1997; Lacy et al. 2004). The referral process is a vital component in establishing a therapeutic relationship and in the transition from a *"patient to client"*. Gavaghan (2009) correlates with Horton (2006, p. 118) who suggested, "*Many practitioners believe that the actual therapeutic relationship actually begins before any face to face contact with the client."* Gavaghan (2009) emphasises that from the commencement of the referral the process will have an impression on the client's perspective of therapy therefore is an external factor that will have a bearing on the therapeutic relationship. The referrer and referral process influences the client's expectations, understanding, viewpoint of therapy, as well as opinions of the therapist (Gavaghan, 2009).

The appropriate referral procedures are paramount to lay down a constructive foundation to the therapeutic relationship,

> ***"****The efficiency of counselling often depends on good referral systems. A carefully considered referral system makes for a good counselling service. The referral method can greatly affect the counselling relationship."* (Sharman and Seber, 2004, p. 26),

Gavaghan (2009) suggests that high-quality professional referral protocols have positive influence on clients' motivation and attitude regarding therapy thus impact on the therapeutic relationship (Wilder et al. 1977; Farid and Alapont, 1993; Leigh, 1998; Killaspy *et al.* 2000; Lacy et al. 2004; Johansson and Eklund, 2006). Evaluating Gavaghan (2009) activated a secondary heuristic process (Moustakas, 1990) I now reason that any interaction with staff during the referral process has potential to influence the client's attitude towards therapy.

Whines (1999, p. 81) concluded that GP's influence clients *"The GP's own orientation towards counselling can clearly help to establish the client's expectations."* Farid and Alapont (1993) found an association between clients' non-attendance and referrers who were sceptical about psychological therapies. Gavaghan (2009) revealed that client's attitudes towards therapy often portray the referrer's direct influence.

Gavaghan (2009) findings were consistent with Balint (1964) recognising that GPs / referrers personal lives and subjectivity have the potential to influence the clinical consultation thus client. The referrer's subjective biases relate to their own individual belief system, personal values and experiences and influence the referrer's judgement when referring therapy clients. I also identified GP's referring clients based on professional clinical interest especially if involved in research (Gavaghan, 2009). O'Donnell (2000) research confirmed Gavaghan (2009) suggestion that GPs with a professional interest in a particular speciality have a higher referral rate in that area of specialism. When a referrer has had a passionate interest in a particular subject the referrer's attitude is often noticeable in clients because they present in an enthusiastic manner reflecting the GP's behaviour, although displaying optimism nevertheless this external factor may influence the therapeutic relationship. Referrers are naturally subjective both obviously and imperceptibly. This bias can then be imparted to the client either purposely or inadvertently, nevertheless still affecting therapy (Gavaghan, 2009). Extracts from Gavaghan (2009) demonstrating referrer's influences on clients are included in Annex: 8. These examples provide evidence of referrer's individual biases and attitudes towards psychological therapies and how their influences affected the client's perspective of therapy and either hindered or facilitated the client's transition from, *"patient to client"* (Gavaghan, 2009) therefore influencing the therapeutic relationship.

I identified a trend of clients not attending initial appointments or arriving for therapy because the referrer had recommended therapy but stated that they did not want to engage in therapy on arrival. I discovered that due to referrers subjective predispositions they had referred patients who had encountered a certain predicament or diagnosis but had not collaboratively explored the referral with the

patient. This demonstrates the power of the referrer in a doctored-centred relationship that originated from the medical model (Gavaghan, 2009). Gavaghan (2009) ascertained these patients perceived the GP to be a dominant expert allowing them to make decisions on their behalf.

Gavaghan (2009) increased my awareness of referrers' subjective bias that often was not in the referrers' conscious awareness. If appropriate, I would sensitively address the issue of inappropriate referrals with the referrer. This action has resulted in increased self-awareness and consequently through self-reflection the referrer has realised that their personal life has intruded into the clinical doctor-patient relationship and influenced professional judgements. For instance, a GP who experienced cancer referred all patients who had an association with cancer for therapy and was unaware of her actions. Inappropriate referrals result in reluctant clients attending therapy hence is an external factor to the therapeutic relationship. I concur with Lees (1999, p, 103) *"A doctor's referral of a patient usually represents a referral of part of himself / herself to the psychodynamic counsellor"* however this may be in the referrers unconscious mind.

I am attentive to referrers' subjective preconceptions due to (Gavaghan, 2009) accordingly I can address inappropriate subjective referrals with the referrer therefore improving communications with the referrer which hones the referral process thus benefiting the client. Information attained after 2009 regarding possible solutions to subjective inappropriate referrals informed by Gavaghan (2009) is communicated in Annex: 8.

Gavaghan (2009) identified referrers allowing subjective presumptions influence professional objective opinions due to experiencing "*false empathy,*" (Mearns and Thorne, 1998, 1999, 2007; McLeod, 2007). It is defined, "*false empathy*" because it is from the GP's own frame of reference not that of the patient however, but the empathy feels authentic. (See Annex: 11. False empathy).

Gavaghan (2009) revealed because clients are more familiar with the clinical relationship than the therapeutic relationship they regularly experience difficulties

adjusting to the dissimilarities. For instance, clients frequently mention the unfamiliarity that I maintain eye-to-eye contact rather than observing a computer when I converse.

I consider the influence of the referrer and the referral process to be a vital component in the establishing of a therapeutic relationship as well as in the transition a person makes from a *"patient to client"* (Gavaghan, 2009).

3.5.3 Précis of the section and impact of research (Gavaghan, 2009) on professional practice and contribution to theory and knowledge related to therapy in an organisational context.

I suggest that socialising clients to therapy implemented as part of the referral process facilitates the establishing of the therapeutic relationship, instils hope and enhances clients motivation and collaboration in therapy (Kazantzis et al. 2009; Daniels and Wearden, 2011) facilitating the transition from "*patient to client*" (Gavaghan, 2009). I suggest the socialisation of clients to therapy is initiated by successfully developing a productive societal perspective including use of media (See Annex 7) and a proficient referral process.

Gavaghan (2009) has provided insight into external factors that have potential to influence the client thus the therapeutic relationship including the influence of the professional medical relationship, the referrer and referral process. I have greater understanding and empathic awareness of clients displaying resistance, reluctance or an external locus of evaluation (Rogers, 1951, 1961, 1975; Mearns and Thorne, 2000). My empathy enables me to empathically understand clients who may experience difficulties adapting to their role within the therapeutic relationship. This empathic understating enables me to communicate accurate empathy to the client and convey unconditional regard and congruence, (Rogers 1957, 1959) which facilitates the client's transition from *"patient to client"* (Gavaghan, 2009) and enhances the therapeutic relationship for the benefit of therapy.

I endorse that if therapists in an organisational context acquired more understanding of the influence of the referral system and referrers attitude on the client and

therapeutic relationship (Gavaghan, 2009) this comprehension would enable them to address any failings in the system to the benefit of therapy.

Since Gavaghan (2009) the culture of the NHS has continued I assume that patients will adapt progressively to their changing role within the developing organisational culture. I reason that the NHS reformation over time will benefit therapy because it will facilitate the transition from "*patient to client*" thus having constructive influence on the therapeutic relationship. (See Annex: 8. Continual NHS transition).

3.6 The influence of completing Gavaghan (2009) on my professional practice.

In this section, I summarise how Gavaghan (2009) has influenced my professional practice. I have referred the reader to supplementary information that will provide further understanding of theory and knowledge that augments this MPhil. The annexes contain information resulting from Gavaghan (2009) and also arising from secondary heuristic processing (Moustakas, 1990) because of the MPhil process.

Consequential to completing Gavaghan (2009) I have an enhanced awareness of detrimental influences initiated by organisational culture and dynamics and the societal perspective of counselling as well as the influence of other professional relationships and organisational processes that may have a bearing on the client and impede the therapeutic relationship. This newfound knowledge and awareness enables me to be more conscientious in endeavouring to establish a trusting mutual therapeutic relationship. I am able to consider harmful potential external factors that influence the therapeutic relationship before meeting the client due to increased awareness. My increased self-awareness means I recognise my feelings, and emotions regarding organisational and societal issues, therefore facilitating my communication of accurate empathy yet having improved self-awareness to identify false empathy.

Obstructive external factors to the therapeutic relationship are augmented if the same external factors affect the therapist as well as the client, as this could cause false empathy (Mearns and Thorne, 1998, 1999, 2007; McLeod, 2007), destructive

pessimistic collusion (Crandell and Allen, 1982; Carroll and Walton, 1997; Davies, 1997; McLeod and Machin, 1998; Stevenson, 2010), false empathy, (Schutz, 1967; Mearns and Thorne, 1998, 1999, 2007; McLeod, 2007), or parallel processes (Crandell and Allen, 1982; Carroll and Walton, 1997; Davies, 1997; McLeod and Machin, 1998; Stevenson, 2010) to the detriment of the therapeutic relationship. (See Annex: 10). I involve the client as soon as possible as a reciprocal equal participant in therapy in order to identify and address any detrimental obstructive external issues affecting the client that may have a tendency to encumber adversely the therapeutic relationship and to initiate from "*patient to client*" (Gavaghan, 2009). (See Annex: 9).

Gavaghan (2009) concluded that clients often present with an *"external locus of evaluation"* (Rogers, 1951, 1961; Thorne, 1992; Mearns et al. 2000, 2013) are anxious, reluctant, and resistant to engage in therapy due to external factors to the therapeutic relationship. Gavaghan (2009) advocates that it is crucial for therapists not to judge the client but empathically accept the client's thoughts, feelings, and behaviours in a non-judgemental manner, with the purpose of establishing a therapeutic relationship as a foundation for therapy (Rogers, 1957).

Empathic interactions conveyed with congruence encourage clients to feel understood, valued and important, as well as encouraging trust and candidness within the therapeutic relationship. A prudent non-judgemental accurate congruent empathic interaction can be a productive and positive way to attend to clients who have preconceived pessimism towards therapy, attributable to external factors to therapy such as organisational, cultural and societal influences. (See Annex: 10 Empathy and the therapeutic relationship). Appropriate self-disclosure in therapy develops congruence and empathy (Rogers, 1957) thus the therapeutic relationship. If external factors such as organisational and societal influences are impeding into the therapeutic relationship and I deem it appropriate, I empathically self-disclose and communicate my opinion congruently to the client. (See Annex: 10).

Gavaghan (2009) proposes that reluctant, resistant, vulnerable, and aggressive clients may only need to find genuineness, reassurance, acceptance and empathy from a therapist. This assists to create a safe, trusting encouraging therapeutic

relationship based on Rogers' core conditions (1957, 1959), in order to actuate therapeutic change in the client and discover from within themselves their inner potential that may have been lost to their consciousness for some considerable period.

In therapy, I continually encounter issues that influence the balance of power in the therapeutic relationship; the issue of power is intrinsic to therapy. I am aware of the power of organisational dynamics and culture and other external aspects that have potential to facilitate the development or exacerbate a person's '*external locus of evaluation'* (Rogers, 1951, 1961; Thorne, 1992). I am continuously attentive to power imbalances within the therapeutic relationship and aware of the possible unhelpful consequences to the therapy. (See Annex: 12). If conscious of any imbalance, I endeavour to equalise the power within the therapeutic relationship by rectifying the imbalance therefore empowering the client and concurrently promoting the client's transition from an external to an internal locus of evaluation (Rogers, 1961) and concurrently facilitating the development of clients self-power (Rogers, 1978). (See Annex: 13).

Gavaghan (2009) authenticates my previous belief, but more profoundly, that as a therapist my intent is to create a therapeutic relationship by displaying my natural self via the communication of Rogers' core conditions (Rogers, 1957) both orally and non-verbally, thus revealing my genuine, accepting, empathic understanding self. (See Annex: 14).

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ANNEX. 1. The stages of heuristic research (Moustakas, 1990).

Initial engagement.

Initial engagement involves the discovery of an intense and passionate interest or concern that holds important social meanings and personal compelling implications. The researcher searches inward for tacit awareness and knowledge. Self-dialogue takes place and an inner search is made to clarify the topic and research question**.** According to Moustakas (1990) during the '*initial engagement'* the task is to "*discover an intense interest, a passionate concern that calls out to the researcher"* (p. 27).

Immersion.

Immersion precedes the discovery and definition of the '*initial engagement'* and the emerging of the research questions. As a heuristic researcher, I believe that I am the optimum instrument in my research and the data is within me thus self-exploration and reflexivity is the best resource for data. I strived to achieve absolute immersion in my research questions. Moustakas (1990) describes the immersion of the researcher in the data during the immersion phase of heuristic research in the following manner, "*The researcher lives the question in waking, sleeping, and even dream states. Everything in his or her life becomes crystallized around the question." As the researcher, I immersed myself in everything connected with the questions. This involved self-searching; of feelings, thoughts, facts, emotions, ideas, images, dreams, drawings, intuition, reading, art doodles, the list is almost infinite. I frequently utilised spontaneous self-dialogue exploring my own intuitive "gut feelings" and drawing from within the tacit aspect of self-insight"* (Moustakas, 1990, p. 28).

Moustakas (1990) also stated that during immersion,

> *"The researcher is alert to all possibilities for meaning and enters fully into life with others wherever the theme is being expressed or talked about – in public settings, in social contexts, or in professional meetings. Virtually anything connected with the question becomes raw material for immersion, for staying with, and for maintaining a sustained focus and concentration. People, places,*

meetings, readings, nature – all offer possibilities for understanding the phenomenon" (Moustakas, 1990, p. 28).

In accordance with Moustakas (1990) I endeavoured to obtain data from whatever resources possible. Potential sources of data included diaries, learning records, personal journal, minutes of meetings, reading literature relating to research theme, self-dialogue, discussions, telephone conversations, public and official documents, previous research, observations, interactions with clients during therapy, case studies, meetings with people, client experience and evaluation questionnaires, questionnaires using open questions, interviewing and focus groups. Although my research is heuristic, I utilised data gathered from any source including documentary data to encourage further self-exploration and as a means of accomplishing immersion. McLeod (1999) cited the benefit in utilising previous documented data,

"Documentary data represents a resource which is under-utilised in counselling research. There is a powerful expectation in counselling research that doing research always involves going out and collecting new primary data. This is a pity, because there is a great deal of data that already exists and is not being exploited." (p. 105)

I used unstructured interviews with individuals as these interviews do not reflect any preconceived theories or ideas (May, 1991) and therefore are consistent with the methodology of qualitative research. I initiated the interviews with an open question such as, "*Can you tell me about your previous experience and perception of the NHS?"* The interview then progressed primarily upon the initial response of the co-researcher. Moustakas (1990) declares that general questions may be formulated in advance but genuine dialogue must be naturally occurring.

Semi-structured interviews preceded unstructured interviewing after immersion in the information from the original unstructured interviews. I used the initial data from unstructured interviews to develop relevant and meaningful open-questions, consistent with Britten (1999) this enabled me to explore emerging themes in further detail. This sharing of data and emerging themes as well as self-disclosing experiences is consistent with heuristic research, *"Self-disclosure elicits disclosure;*

*there may be moments in the interview process when the primary investigator shares an experience that will inspire and evoke richer, fuller, more comprehensive depictions from the co-researcher." (*Moustakas, 1990, p. 47),

I also utilised the use of semi-structured focus groups, facilitating group discussions on specific topics for research purposes according to Morgan (1998). In the focus groups, I used similar open questions to the semi-structured interviews to accumulate comparable data from many participants simultaneously. The emerging themes from interviews and additional acquired data were discussed this providing further data and supplementary communication and comments. McLeod (1994, p. 100) promotes this form of data collection, "*Another method of checking both factual precision and interpretive sensitivity is to take drafts or parts of the research back to informants and ask them to comment on it.*"

The research moved backwards and forward through this heuristic research phase relative to each question and each participant or group of participants thus facilitating my total immersion in all the accessible data. By interviewing participants, I expanded my knowledge and understanding of the research question and immersed myself further in the data. I aimed to encourage qualitative depictions of a person's experience that are central to that person and included descriptions of feelings, thoughts, values and beliefs. I aspired to interview in a manner described by Moustakas (1990) experiences as a person-centred therapist assisted however interviewing was still challenging in order to be completely non-directive and not to influence the co-researchers emerging data. Moustakas (1990, p. 48) states that,

> *"In heuristic interviewing, the data generated is dependent upon accurate, empathic listening; being open to oneself and to the co-researcher; being flexible and free to vary procedures to respond to what is required in the flow of dialogue; and being skilful in creating that climate that encourages the co-researcher to respond comfortably, accurately comprehensively and honestly in elucidating the phenomenon."*

I used triangulation throughout the '*immersion phase'* to facilitate further immersion in all of the available information and data. I went through the immersion phase of heuristic research (Moustakas, 1990) for each individual research question and used triangulation as a technique to provide correlations of data and information connecting each question.

As I immersed myself into the data with each participant, group of participants or by acquiring data from other means of immersion, I documented my thoughts and feelings about the experience and process in my journal, as well as additional data, findings and the emerging themes and amalgamated depictions of the experience. I acknowledge, however, that there is no such thing as a pure description. I agree with Wolcott's (1994, p. 13) argument that, *"In every act of constructing data out of experience, the qualitative researcher singles out some things as worthy of note and relegates others to the background"* and *"Qualitative researchers typically introduce their studies with an essentially descriptive account."* Wolcott (1994) also stated that qualitative researchers should have awareness and acknowledge that their descriptions are filtered through their own perceptions.

Incubation

Incubation follows the immersion phase of heuristic research (Moustakas, 1990), concentration is relaxed and ideas are allowed to germinate. I retreated from the intense focus of the immersion phase and spent time participating in other activities not related to my research.

During incubation although the researcher is no longer absorbed in the topic in a direct manner the progress still occurs. The researcher's tacit understanding and intuition continue to be illuminated on levels outside ones immediate awareness. Douglass and Moustakas (1985, p. 50) refer to this as *"To know without awareness of how or why one knows, is the sine qua non of tacit knowing."* Moustakas (1990, pp. 28-29) describes the "incubation" phase of heuristic research as the researcher retreating from, *"the intense, concentrated focus of the research question"* therefore this period of incubation, *"allows the inner workings of the tacit dimension and intuition to continue to clarify and extend understanding on levels outside the immediate awareness."*

Illumination

Illumination occurs naturally and spontaneously at some unspecified point, conscious and unconscious aspects of knowledge start to emerge from ones tacit awareness (Moustakas, 1990). From my relaxed tacit condition, a clear sense of direction, presented itself and themes and patterns of the phenomenon emerged. This illumination provides access to new awareness, to either new discoveries or variations of former understandings. The researcher may have accumulated a mass of data that one is unable to make sense of but in the illumination phase, amalgamation of previous fragmented knowledge occurs. This new awareness may have been present but beyond immediate awareness, misunderstood realities are exposed and the truth of the experience is revealed. According to Moustakas (1990 p. 30) this phase proclaims nuances in meaning and the "*discovery of something that has been present for some time yet beyond immediate awareness."*

Moustakas (1990) maintains that tacit knowing is fundamental in heuristic research. To explain further the tacit aspect I will use Polanyi (1969) explanation who said that when we make a statement we always know approximately, what we mean to say before we say it. We are unable to explain how we know what we mean to say, this is tacit knowing. Nevertheless, we need tacit knowing in the processes of understanding in order to understand and apply explicit knowledge. In essence, *"we can know more than we can tell"* (Polanyi, 1983, p. 4). Polanyi (1969) explains that tacit knowing is comprehending or making sense of experience thus gaining understanding.

Moustakas (1990) said that tacit knowing is the capability of the researcher utilising the use of '*self*' to facilitate the illumination of an issue or problem and it is part of the process of attaining knowledge. Sela-Smith (2002, p. 60) explains the tacit dimension of personal knowledge as,

> *"Internal place where experience, feeling, and meaning join together to form both a picture of the world and a way to navigate that world. Tacit knowledge is a continually growing, multileveled, deep-structural organization that exists*

for the most part outside of ordinary awareness and is the foundation on which all other knowledge stands.

Moustakas (1994, p. 28) describes the process of illumination as "*one that occurs naturally when the researcher is open and receptive to tacit knowledge and intuition.*" During the heuristic research process phase of illumination, I experienced a number of '*illuminating moments*.' These often occurred unannounced therefore; I was at all times prepared to capture the emerging information and data by having a Dictaphone or notebook at hand including having a notebook beside my bed. I then at the first opportunity recorded the information from my illuminated moment into my Journal.

Explication

Explication requires a further period of focusing, indwelling, self-searching in order to thoroughly examine various layers of meaning within the data and therefore gain a more complete understanding of the discoveries. The researcher endeavours to discover nuances, textures and constitutes of the phenomenon that are illuminated further via focus, indwelling and self-exploration. In due course, a comprehensive depiction of the essences of the experience materialises.

Indwelling is an essential process during the explication and creative synthesis stages of the heuristic research process (Moustakas, 1990). Indwelling refers to the process of directing attention inward in order to seek a deeper, more comprehensive understanding of the nature or meaning of a human experience. Moustakas (1990, p. 24) describes the process as, "*The indwelling process is conscious and deliberate, yet it is not linear or logical."* Focusing is a further essential process in heuristic research Moustakas (1990) states that, *"Focusing is an inner attention, a staying with, a sustained process of systematically contacting the more central meanings of an experience. Focusing enables the researcher to see something as it is"* (p. 25).

As the heuristic researcher, I purposely created an inward space to assist the process of indwelling, focusing and self-searching with the purpose of discovering a comprehensive depiction of the dominant themes and core essences of the research experience. A created portrait developed illustrating the core meanings of the

phenomenon as experienced by individual participants and myself, however concurrently represented all of the participants in total.

Creative synthesis

Creative synthesis is the final phase of the heuristic inquiry and emerges from the researcher's experiences and personal knowledge of the phenomenon. If the researcher has diligently adhered to the process of heuristic research (Moustakas, 1990) and the process has unfolded naturally, the final phase spontaneously occurs to form a creative synthesis. Moustakas (1990) cites a creative synthesis can only be achieved when, *"A comprehensive expression of the essences of the phenomenon investigated is realized" (p. 31)* and *"through tacit and intuitive powers*" (p. 31).

The researcher extracts the final essences of the phenomenon and creates a composite picture of their discovery, an artistic representation of the findings. The creative synthesis encapsulates the heuristic researcher's interpretations an amalgamation of the main themes that emerged from the research experience, and presents a comprehensive depiction of the essences of the experience in Gavaghan (2009) the creation of a written thesis. I was aware that my heuristic research begins and ends with the researcher nevertheless I endeavoured to incorporate the co-researchers' experiences in the creative synthesis and although the co-researchers did not actively engage in the writing process creating the creative synthesis their experiences that they shared with me contributed to the final creative synthesis.

ANNEX: 2. The development of IAPT services.

IAPT services are a governmental initiative offering psychological treatment interventions approved by the National Institute for Health and Clinical Excellence (NICE) to people with common mental health problems, principally depression and anxiety disorders (Layard et al. 2005, 2006, 2007, 2009, 2011, 2012; Layard, 2005a, 2005b, 2006a, 2006b, 2011, 2012a, 2012b, 2012c, 2012d, 2012e, 2012f, 2012g; Gyani et al. 2013; NICE, 2004).

The IAPT programme evolved from Layard (2005) that suggested improving provision of psychological therapies in the treatment of depression and anxiety would have beneficial impact on those able to work thus reducing absenteeism due to psychological health and facilitating the return to work of others. Layard (2005) argued that this would incur potential savings for the Department of Work and Pensions (DWP). Layard (2005) reinforced his economic argument by means of a clinical and moral perspective accentuating inequitable and inconsistencies in the delivery of psychological therapy and the potential benefit to individuals and society in general by improving mental health and general wellbeing. Layard has continued to develop his original IAPT proposals (Layard, 2005) and has been influential in the development of IAPT services (Layard et al. 2005, 2006, 2007, 2009, 2011, 20012; Layard, 2005a, 2005b, 2006a, 2006b, 2011, 2012a, 2012b, 2012c, 2012d, 2012e, 2012f, 2012g; Gyani et al. (2013).

Data.

An IAPT service has a plethora of data that is available to be utilised for research, the data is of a qualitative as well as a quantitative nature. The qualitative data consists of information from IAPT, (2013a, 2013b) and other data including; data from service-user involvement groups (randomly selected clients are invited to a forum to discuss and explore their experiences), recorded sessions of therapy such as those recorded to evaluate CBT therapists using CTS (R), (Blackburn, et al. 2001, 2002), transcripts and minutes from meetings and clinical discussions. Quantitive data is captured and encapsulated via electronic databases and IT systems. The IT systems collate data that can be produced in graphs and diagrams. Therapists ‘Caseness’ a common IAPT terminology for clinical performance is also accessible

on the database (Griffiths and Steen, 2013). The searches for information on the database are almost infinite which emphasises the amount of rich quantitive data readily available.

ANNEX: 3. Documented statements.

a. Statements in regard to induction training informed by Gavaghan (2009).

A documented statement in an annual appraisal confirmed the important contribution of theory and knowledge gained from the process of completing Gavaghan (2009) and consequently shared in a training environment, *"In additional to his professionalism as a therapist. Andrews hard work and dedication contributed to the successful establishment of the service, his experience and knowledge were an invaluable asset predominantly his contribution to staff induction and development and in the creation of a unique organisational culture."* (MHCO, 2011).

My contribution in the planning and delivery of the induction training specially pertaining to organisational culture and dynamics was beneficial according to

feedback provided by those whom evaluated the training. The following is a extract from a written evaluation provided by a trainee high intensity therapist, "*Andrew made me think totally out of the box, yet by doing so I could understand more what went on within the box. By box I mean therapeutic alliance".* (Lynsey, 2010).

b. Client statements in regard to the organisational website.

The following are examples demonstrating how the website was an influential aspect on clients therapy extracted IAPT, (2013a) clients experience after an assessment and *IAPT, (2013b)* clients experience completed on discharge from therapy,

"I am now looking forward to therapy which has giving me a little hope while I wait. The website has helped I watched how it worked with clients before phoning for the first time. Because I had an idea what to expect I wasn't as nervous. I now am reading the self help stuff and trying to use it to change my life while I wait to see someone." IAPT *(2013a)*

"The website provided me with an idea of what to expect from therapy, the film of the therapist and client was not like I had experienced before. I was hopeful but a

little sceptical before meeting my therapist. The therapy however was outstanding and exceeded all expectations. I have changed my life around and would go on camera to say so." IAPT (2013b)

c. <u>Client statement regarding pessimistic attitude towards the changing NHS.</u>

"I was pissed off with the NHS. No one listened or cared. What's the point of doing all them stupid questionnaires when no one gives a shit. I was totally dissatisfied with everything to do with the NHS. Months waiting for appointments then to be cancelled, re-arranged - with link workers, psychologists, psychiatric people, then back to see you in the same room that it all started the GP's room. I was pissed off with you and I am sorry for been rude I was just so annoyed with the system." Gavaghan (2009, p.138).

d. <u>Clients statement regarding positive changing attitudes of people towards the transition of the NHS.</u>

"Unbelievable, still stunned, so quick and positive. I went to the GP first thing the morning, we discussed options to keep me at work, went home with a prescription for anti-depressants and to wait for a contact from someone about therapy, thought it would be weeks. By the end of the day I have had a telephone assessment for talking therapy, I have chosen to attend a group for relaxation, while I wait for CBT, which sounds useful, I have also received stuff by email to read about my depression. I have hope again that I can get through this thank goodness to the NHS and IAPT service. Now I know about CBT can't wait to have therapy." IAPT (2013a)

e. A statement from a client describing their mental illness as a physical condition, as it is more acceptable.

A client with depression stated, *"I wish that I had a broken leg or arm so everyone could see that I am not well. I am ill this is worse than a broken leg and arm combined and times by 100 but to everyone I am a waster the lowest of the low because nothing is visible"* (Gavaghan, 2009, p. 98).

f. A statement from a client in IAPT service regarding the influence of organisational and societal external factors to the therapeutic relationship.

"I had therapy at the hospital step 4 it's called. I know they discharged me because of waiting lists needed me out of the system I was clogging it. Same happened at the surgery with the counsellor six sessions, as if that would help but suppose keeps lists down. That's all we hear in the press ranting about waiting lists and waiting times not just in hospital accident departments. After my telephone appointment I am happy I know have up to 20 sessions but can come back. I feel reassured and positive about therapy now." Extracted from clients comments after assessment PEQ, IAPT (2013a)

ANNEX: 4. How exploration of the traditional hieratical organisational culture of the NHS (Gavaghan, 2009) influenced professional practice and development within an organisational context and assisted in managing the stresses relating to the development of an IAPT service.

I was employed within a newly commissioned IAPT service prior to the service becoming operational. Gavaghan (2009) increased my knowledge pertaining to organisational dynamics and culture in addition to how organisational factors influence the provision of therapy and the therapeutic relationship. I advocated that training on the development of organisational culture and sub cultures as well as the development and process of group and cultural dynamics, should be provided to staff informed by learning from Gavaghan (2009). I agreed with the decision to provide induction training that also considered leadership and quality management systems theory, as I contemplated this would inform constructively the development of the IAPT service organisational culture and the development of groups. The induction training was informed by theories of group development and dynamics (Tuckman, 1965, 1977, 2011; Brown, 2000; Hogg et al. 2001; Gavaghan, 2009), leadership, (Antonakis et al. 2004; Northouse, 2004), quality management systems theory, (Dale, 2003; International Organization for Standardization, ISO 9001, 2008).

The increased awareness of organisational cultures and dynamics encouraged all staff to reflect on their individual contribution to the establishing and development of a new service and interrelated developing culture, assisting in the creation and development of a preferred organisational culture and assisting to address potential difficulties and impeding factors to the development of this culture. The enhanced appreciation of various organisational dynamics outside of the therapeutic relationship enabled therapists to improve their clinical practice by gaining awareness of how organisational influences can affect the client, therapist and therapeutic relationship, thus gaining greater understanding of the influence of the delivery of therapy within the organisational context whilst also facilitating empathic development in therapists.

A statement in appraisal and feedback provided by those whom evaluated the training confirmed that learning gained from Gavaghan (2009) contributed to theory

and knowledge in the field of therapy in organisational contexts. (See Annex. 3). A summary of how Gavaghan (2009) influenced the development of organisational culture and ethos of the IAPT service is in recorded format entitled "*The MHCO Vision"* (MHCO, 2012a; YouTube, 2013a).

Since Gavaghan (2009) I have discovered research evidence confirming that the culture and dynamics of an organisation as well as leadership and quality management are connected and therefore have the potential too positively augment each other or adversely have detrimental effect on these aspects of an organisation (Yiing and Ahmad, 2009; Bozorgi-Nezhad et al. 2012). Bozorgi-Nezhad, et al. (2012) argued that organisational culture influenced quality management recommending that, "*Before the implementation of quality management in the organization the management needs to have awareness of the main culture that exists in the organization."* (p. 12598). This evidence confirms that the planning and delivery of the induction training was appropriate and based accurately on the needs of individual staff and the service.

The process of establishing and developing a new IAPT Service was a difficult and complex transition collectively and individually, and produced extreme levels of stress for everyone. A completely new workforce came together with dissimilar experiences of organisational cultures and prior experiences combined with disparate therapeutic modalities as well as individual expectations and ideas of the IAPT service operational methods. Additionally the majority of the staff had the supplementary pressure of attending mandatory University based training as well as delivering therapeutic interventions in a metaphorical "blank canvass" of a developing service with embryonic procedures and protocols.

The development of group dynamics (Tuckman, 1965, 1977, 2011) was evident stimulated by extreme work related stress, inconsistencies and uncertainties. Individuals became vulnerable and reacted by defensive behaviours, forming into groups and becoming hostile to other individuals and groups. These groups formed based on shared identities but were fluid, changing and transient, which added to the difficult complex and complicated developing organisational dynamics. Colleagues stated that learning from the induction training had augmented increased awareness

of the development of organisational cultures and dynamics (Gavaghan, 2009) and had assisted them to '*normalise'* the process of group dynamics according to Tuckman (1965, 1977, 2011). '*Normalise'* in this instance is a coping strategy used to preemptively depathologise problems and the persons view of the problems *"as ordinary difficulties of life,"* (O'Hanlon and Weiner-Davis, 1989, p. 93).

Therapists' adverse stress initiated by organisational dynamics process of transition and change and evolving culture became apparent in; team meetings, group discussions, informal conversations, group and individual supervision, and case management. Colleagues stated that due to increased awareness of the development of organisational cultures and dynamics (Gavaghan, 2009) as well as the process of group dynamics (Tuckman, 1965, 1977, 2011) ameliorated constructively the process of this stressful period of organisational development. Therapists frequently commented on their increased attentiveness in the undertaking of endeavouring not to allow the negative detriment influences of the organisational culture and dynamics to impede into the therapeutic relationship.

Rizq (2011) and Steel (2012) research concluded that therapists whom deliver therapy in an IAPT service experience higher levels of stress compared to therapists employed in other contexts with high rates of burnout, sickness, absenteeism.

A staff survey regarding retention and managing stress within the IAPT service (MHCO, 2010) identified a common emerging theme that could be related to the distribution of knowledge and theory related to Gavaghan (2009),

- *Having an increased insight of organisational culture and sub-cultures.*
- *Self-awareness of organisational influences that influence client, therapist and therapy.*
- *Understanding of the development of organisational cultures and dynamics.*

Increased learning concerning the traditional hieratical organisational culture of the NHS and how organisations influence the client and therapeutic relationship has

enabled me to contribute to the establishment and development of an IAPT service by conveying theory and knowledge (Gavaghan, 2009).

Annex: 5. The hierarchical position of counselling within an IAPT service.

Gavaghan (2009) suggested that the modality of counselling hence the therapist and client are perceived to be low in the hierarchical organisational structure of the NHS. My experience in IAPT services have re-confirmed Gavaghan (2009), especially when counselling is compared to other modalities of therapy. In IAPT services, counsellors receive less remuneration with inferior employment contracts compared to therapists delivering other therapeutic modalities. Additionally counsellors are expected to produce the same clinical outcomes but delivering half the amount of sessions that other therapists are permitted. Quantitative outcome measures demonstrated that the counselling modality is as clinically effective as other therapeutic modalities including CBT but achieved in fewer sessions (Gavaghan Caseness, 2013) see Appendix: 2.

IAPT services utilise the medical model (Laing, 1971; Engel, 1977; Sheldon, 1992; Bynum, 2008) conversely, Gavaghan (2009) discovered that the person-centred therapeutic relationship is in contrast with the medical model. Since Gavaghan (2009) counsellors have successfully found employment in some IAPT services but have to conform to some extent with the medical model. Larson et al. (2012) suggested that some counsellors engaged in the diagnostic medical model for professional reasons, primarily to gain acceptance by the hieratical NHS sub-cultures. Another reason was to obtain and retain employment within the hieratical IAPT. As a consequence of Gavaghan (2009) I have improved awareness of the dynamic of the medical model within organisational cultures and in relation to therapeutic modalities with a Rogerian foundation. I have conveyed my knowledge to therapists who deliver therapies based on Rogerian principles, which has enabled them to adjust to the organisation culture and dynamics of the IAPT service and use of the medical model without compromising person-centred philosophies.

Gavaghan (2009) has enabled me to be more effective in coaching, clinical supervision and case management of counsellors who use a Rogerian therapeutic approach within an IAPT service because I have increased awareness of external influences to the counselling and the therapeutic relationship, including the influence of other epistemologies and the medical model (Laing, 1971; Engel, 1977; Sheldon,

1992; Bynum, 2008). Communication of this enhanced understanding (Gavaghan, 2009) enabled counsellors to be perceptive of external factors that influence the client, thus the therapeutic relationship consequently facilitating increased accurate empathy within the therapeutic relationship (Rogers, 1957). Counsellors have corroborated that by implementing knowledge from Gavaghan (2009), has enhanced their self-awareness and therapeutic practice, which they stated is substantiated by evidence contained in IAPT (2013b) from their clients.

Research since Gavaghan (2009) correlates with the original findings. Moorman (2011) published an article entitled "*Counselling not valued in the NHS,"* which described her undervalued experiences as a counsellor within the NHS. James (2010) suggested that if therapists remained in the NHS than they must learn to manage their frustration and anger about the lack of fairness in the work place especially due to the lack of acknowledgment of Rogerian based therapies. Larsson et al (2012) recognised that counselling has several conflicting epistemological models and that some counsellors had a desire to engage in the diagnostic medical model for professional reasons, primarily to be accepted by organisations such as IAPT, NHS.

If someone has not had a NHS career and apply for a High Intensity Psychological Therapist role with an IAPT service or if they make an application for BABCP provisional accreditation, they have to demonstrate additional competencies than NHS colleagues whom apply. Non-NHS applicants in addition have to submit a portfolio of evidence, which meets the criteria of the Knowledge Skills and Attitude (KSA) requirements of BABCP (2013). This demonstrates another hierarchy system with those from a traditional counselling background disadvantaged and perceived subordinate compared to NHS employees. IAPT services now employ theorists from other modalities, counsellors however are paid 'A*genda for Change*' pay scale 5/6 whilst CBT therapists are paid pay scale 7/8, (Gyani et al. 2013).

An examiner for Gavaghan (2009) (Appendix: 1) suggested I explored, "*proposed statutory regulation of counsellors within the Health Professionals Council (HPC), that might cause clients to see counsellors as medical."* DH (2011d) however announced that the Government did not intend to proceed with statutory regulation. Nevertheless, in the interim the HPC (2009a, p. 14) stated, *"The standards for*

psychotherapists were based on a NHS centred medical model." This statement authenticates an unfair prejudice for therapists whom conform to the medical model. Potentially forcing other therapists to conform to the medical model to be accepted and be employed in statutory organisations like the NHS and IAPT services. This correlates with the conclusions of Gavaghan (2009) that counselling, as a profession, is not a valid organisational member, and has a subordinate position in the organisations hierarchical culture as well as continuing conflict with medical orientated cultures.

Annex: 6. Development of the Time to Change, (2008) programme.

During the MPhil process, I studied evaluation of the Time to Change (2008) campaign. The Guardian (2013) reported that according to independent evaluation of the campaign, in the first four years, people with mental health problems are experiencing less discrimination and are feeling more empowered thus enjoying increased social contact, astonishingly however evidence suggested that attitudes among mental health professionals had not improved. Henderson and Thornicroft (2013) evaluated the Time to Change (2008) programme suggesting that mental health professionals pessimistic attitude and behaviour towards mental health may be a 'clinical fallacy' because of professionals experiencing more resistance to change due to the accumulated experiences of working with mental health patients. When evaluating Henderson and Thornicroft (2013) conclusions, and comparing these with Gavaghan (2009) I argue that the ingrained attitude towards patients with mental health by medical professionals potentially will have a detrimental influence on therapy as it influences how clients perceive their 'self' and the therapy offered. I concur with Henderson and Thornicroft (2013) that negative experiences of mental health patients regarding interrelationships with health professionals will deter people from seeking further help, support and therapy. In addition the negative attitude of mental health professionals in general will have potential to have a detrimental influence on clients perspectives of therapy and hence the therapeutic relationship.

Annex: 7. The importance of developing a productive societal perspective relating to an IAPT service.

Gavaghan (2009) accentuated the importance of having an awareness of societal perspective of therapy including how the media influence the societal perspective of an organisation. The societal influence of therapy is an external factor that influences the client, thus the therapeutic relationship, either beneficially or detrimentally depending on the societal perspective of the organisation and the provision it provides. (Gavaghan, 2009).

The IAPT service had considered the societal perspective of the organisation for marketing purposes in particular the referral of potential clients. I communicated findings from Gavaghan (2009) suggesting that the societal perspective has a bearing on therapy, which then became an important consideration when implementing media and promotional incentives.

The outcomes of Gavaghan (2009) were taken into consideration when developing a website (MHCO, 2012b). The website included suitable self-help material and incorporated ex-clients' experiences of therapy including utilising the format of video production. These revealed both the client and therapist experiences of therapy and realistic information relating to the therapeutic process including, referral process, first session and discharge. MHCO (2012b) has had substantial influence on clients pro-active societal approach towards the service and their optimistic motivated attitude to participation in therapy therefore having an external beneficial consequence on the therapeutic relationship. I suggest that socialising clients to therapy by use of the website (MHCO,2010a) and other resources' facilitates the establishing of the therapeutic relationship by instilling hope and developing clients motivation towards therapy (Kazantzis et al. 2009; Daniels and Wearden, 2011). Examples of clients comments of how the website (MHCO, 2012b) was influential are included in Annex: 3. "*The MHCO Vision"* (MHCO, 2012a; YouTube, 2013a) in video format and other resources such as MHCO (2012a, 2012b, 2013a) were informed by the conclusions of Gavaghan (2009).

Gavaghan (2009) encouraged therapists to gain understanding of external factors that have potential to inform the therapeutic relationship including influences prior to therapy such as the societal perspective and referral systems. Since Gavaghan (2009) I have studied research by Wilder et al. (1997) Lacy et al. (2004) and Sharman and Seber (2004) whom concur with Gavaghan (2009) regarding external factors before therapy commencing having potential to influence therapy.

Annex: 8. Referrers subjective bias to referrals and a solution via the referral process. And. Continued NHS transition since 2009 instigating gradual positive influence on clients.

The following are extracts from Gavaghan (2009) demonstrating referrer's influences on clients regarding their referral for therapies.

a. This client arrived for counselling with the expectation that I would be able to solve all her issues, she stated, *"The Doctor said that you would sort me out as you are the best!"* (Gavaghan, 2009, p. 119).

b. The following client arrived at the first session without having an understanding of talking therapy whatsoever, stating*, "I don't know why I am here the Doctor told me to come so I am here"* (Gavaghan, 2009, p. 119).

c. The client stated, *"Dr. H said that CBT would help me and that you will help me alter my negative thinking then I will feel better and come to terms with all this death. He also said that you need to fix the miscarriage first."* (Gavaghan, 2009, p. 199). The GP's directive attitude confused the client and detrimentally influenced the therapeutic process because at the time I did not deliver CBT.

d. The subsequent client arrived at the initial session with a proactive attitude towards therapy and an understanding of her part in the therapeutic process, *"I know that you haven't got a magic wand and can't make things better. I will have to address my problems myself with your help and support."* (Gavaghan, 2009, p. 120).

These examples provide evidence of the referrer's individual biases and attitudes towards psychological therapies and how their influences have affected the client's perspective pertaining to their therapy and either hindered or facilitated the client's transition from, *"patient to client"* Gavaghan (2009) therefore influenced the therapeutic relationship.

Since Gavaghan (2009) I have observed comparable evidence of referrers influence from clients attending the initial assessment in an IAPT context, however this is not as observable from clients whom attend for their initial therapy session. The decrease in adverse bias from referrers may be due the implementation of an

appropriate referral process in the IAPT service that socialises the client to therapy at assessment prior to therapy therefore filtering referrer's subjective biases. Socialisation to therapy originated from CBT (Roos and Wearden, 2009; Neenan and Dryden, 2011) is implemented as part of the referral process for some IAPT services regardless of the modality of therapy. Kazantzis et al, (2009, p. 144) argue that socialisation to therapy facilitates additional therapeutic effect including, *"Instils hope, and consequently enhances a given clients necessary motivation and willing collaboration in treatment.* This quotation bears a resemblance to the rationale of Gavaghan (2009) transition of a patient from, *"patient to client".* Daniels and Wearden (2011) in a preliminary study stated that their research concluded that the active socialisation process of a client to therapy contributes to the therapeutic relationship but recommended further research.

When re-evaluating Gavaghan (2009) I discovered other reasons that cause trends in GP referrals to psychological therapy services, including;

a. New enthusiastic GP's starting consultation with patients and having a genuine desire to be of assistance to all patients.
b. As a result of recent advertising such as IAPT marketing literature.
c. GP continual professional training involving mental health or meetings regarding mental health.
d. The publication of research or publishing of policy documents or clinical guidelines is also capable of generating an increase in referrals from individual GP's. I have recognised increases in referrals of clients with depression after publication of NICE, (2009, 2009a,), which updated the guidelines for the treatment and management of depression in adults and after publicity regarding the World Health Organisation, (2013) guidelines for the '*management of conditions that are specifically related to stress'* recommended EMDR.

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I agree with Ashworth, (2002 p. 41) whom concluded that, *"The dominant influence on psychiatric referral rates may well be individual GP attitudes, such as the characterisation of GPs into 'conduits' (who merely recognise and refer such cases to 'experts') and 'containers' (who aim to prevent an inappropriate referral burden by*

offering primary care interventions)." Conversely, by facilitating communicating with both types of GP "*conduits*" and "*containers*" and understanding their individual rationale, assists to encourage and develop an efficient and appropriate referral system for potential psychotherapy clients. Foot et al, (2010, p. 5) stated that a feature of a high-quality referral process is when, "a*ll parties are able to construct a shared understanding of the purpose and expectations of the referral."* Inappropriate referrals to the IAPT service are discussed with the referring GP. A member of staff who has clinical expertise is always available to discuss the appropriateness of any referral with the referring GP. Moreover, is available to discuss a referral with a GP on behalf of the service or client or to refer the client to another more appropriate service. O'Donnell (2000) recommended a similar shared communication system to improve appropriateness of GP referrals. The provision of communication provides a service to both "*conduit*" and "*container*" GP's and continually improves the referral process and professional relationships to the benefit of the client.

Continued NHS transition since 2009 instigating gradual positive influence on clients.

Since 2009 the process of transformation of the NHS has continued (DH. 2010, 2011c, 2013a; 2013b, 2013c, 2013d). The NHS Constitution (2013) stated the NHS belongs to us all and the constitution became law. Gavaghan (2009) studied the transition of the NHS and implications of how this may influence patients, clinicians and professional relationships.

The heuristic nature of re-evaluating Gavaghan (2009) has produced further evidence contradictory to the conclusions of Gavaghan (2009) primarily that patients in general now have more positive attitudes towards the transformation and restructuring of the NHS and the changing culture. Nevertheless, for cultural change and development to be noticed by more NHS patients not just those within my awareness it has to be a continuous process. Verbal evidence obtained regarding the changing attitudes of people towards the transition of the NHS are corroborated by written evidence from clients and other professionals. IAPT (2013a*) is an* example at Annex: 3d. I consider that the IAPT services I am employed in has embraced the ethos of the transforming NHS from my personal experience and

confirmed when subsequently studying documents and policies, (DH, 2011, 2011a, 2011b, 2012a, 2012b; IAPT, 2009, 2011a, 2013c, 2013d, 2013e; Clark, 2011, 2013; Clark and Turpin, 2008; MHCO, 2012a, NHS Constitution, 2013).

Annex: 9. The therapeutic relationship and my professional practice.

My intent as a therapist regardless of what modality of therapy I am delivering is to endeavour to establish a therapeutic relationship according to Rogers (1951, 1957, 1959, 1961, 1970, 1977, 1980, 1989). I also consider how Rogers philosophy has been developed by others when establishing developing and maintaining a therapeutic relationship, (Mearns, 1994, 1997, 2003; Thorne, 1992; Mearns and Thorne, 1988, 1999, 2000; Mearns et al. 2000; Mearns and Cooper, 2005; Clarkson, 2003; Buchanan and Hughes, 2000; Cooper, 2004; Tudor, 2004; Kirschenbaum and Jourdan, 2005; Casement, 2006; Gillon, 2007). I undertake to create a therapeutic relationship by having a comprehensive understanding of the Rogers core conditions (1957, 1959, 1980). Rogers, (1980, p. 139), describes the qualities of the core conditions as follows, *"The qualities of positive regard, and therapist's congruence, which, together with empathy, I hypothesized as promoting the therapeutic process."* I aim to convey these core conditions (Rogers, 1957, 1959, 1980) to the client whilst concurrently encouraging trust and collaboration by involving the client in the therapeutic process.

Due to Gavaghan (2009) I have an enhanced awareness of detrimental influences initiated by organisational culture and dynamics, the societal perspective of counselling and other NHS professional relationships as well as organisational processes that may have a bearing on the client. This newfound knowledge enables me to be more conscientious in endeavouring to establish a trusting mutual therapeutic relationship. I involve the client as soon as possible as a reciprocal equal participant in therapy in order to identify and address any detrimental obstructive external issues affecting the client that may have a tendency to impede adversely into the therapeutic relationship.

Evaluating Gavaghan (2009) has made me more acutely aware of external factors that may influence the client and the therapeutic relationship in an organisational context. Consequently, I now consider potential external factors that may intrude into the therapeutic relationship before even meeting the client and endeavouring to establish the therapeutic relationship. I concur with Lambert (2010) that therapists should consistently monitor client's reactions to the therapeutic relationship. Due to my increased knowledge and understanding, I also monitor external influences to

the therapeutic relationship that may adversely affect the therapeutic relationship such as organisational and societal influences (Gavaghan, 2009). I argue that if therapists constantly evaluate, monitor, and reflect on the therapeutic relationship and have a comprehension of external influences that may affect the therapy this diligence and awareness will lead to increased opportunities to address proactively any deterioration or flaws in the therapeutic relationship. Subsequently, maintaining and developing the therapeutic relationship, avoiding premature termination of therapy and having an increased awareness when to modify any therapeutic strategies and therapeutic interventions.

The process of evaluating my research (Gavaghan, 2009) has substantiated again the importance of the therapeutic relationship in other modalities of therapy not just person-centred therapy. Since 2009, I have completed further training in psychological therapies specifically, CBT, EMDR and Mindfulness, which I have integrated into my therapy. I have also case-managed and supervised therapists from varying modalities of therapy including psychoanalytical, psychodynamic and gestalt therapists. I agree with Orlinsky and Rønnestad, (2005) and Boyd-Franklin et al, (2013) regarding the importance of lifelong personal and professional development for therapists. Consequently, I have continued to expand my learning for instance the secondary heuristic process completing the MPhil in which I studied the therapeutic relationship from varying modalities of therapy that are personal to my employment as a clinician and clinical supervisor including; CBT, (Safran and Segal, 1996; Persons, 1989; Gilbert and Leahy, 2007; Beck, 2011); mindfulness based therapy, (Germer et al. 2005: Hick and Bien. 2010); psychoanalytical and psychodynamic psychotherapy, (Wiene, 2009; Maroda, 2010; Mc Williams, 2011; Messer, 2004); gestalt therapy, (Mackewn, 1997; Yontef, 2002); EMDR, (Dworkin, and Shapiro, 2005); supervision relationship, (Bowen, 1986; Yontef, 1996, 1997; Ellis and Ladany, 1997; Falender and Shafranske, 2004; Frawley-O'Dea et al. 2002; Ladany, 2002).

Rogers, (1961) who is considered the creator of person-centred therapy describes the core conditions, and the therapeutic relationship;

> *"A relationship characterized by a high degree of congruence or genuineness in the therapist; by a sensitive and accurate empathy on the part of the therapist; by a high degree of regard, respect, liking for the client by the therapist; and by an absence of conditionality in this regard, will have a high probability of being an effective therapeutic relationship."* (Rogers, 1961, p. 265).

Aaron Beck whom pioneered Cognitive Therapy and was active in the development of CBT cited a similar description of the therapeutic relationship, "*The relationship requires therapist warmth accurate empathy and genuineness. Without these therapy becomes "gimmick orientated"* (Beck, et al. 1993, p. 135). The following quotation regarding Mindfulness and the therapeutic relationship reiterates both the previous viewpoints of Rogers (1961) and Beck et al. (1993), with Hick and Bien, (2010, p. *5)* stating that, "*Within the client-therapist relationship, mindfulness is a way of paying attention with empathy and presence, and deep listening can be cultivated, sustained and integrated into our work as therapists."*

The American Psychological Association (APA) conducted the largest ever review of research on the therapeutic relationship. Norcross, (2002, p. 441) primary conclusion was, "*The therapy relationship, makes substantial and consistent contributions to psychotherapy outcome independent of the specific type of treatment."* Norcross, (2002, 2011) emphasises the importance of the therapeutic relationship stating that the therapeutic relationship accounts for why clients improve or fail to improve as much as the modality of therapy. I concur that the therapeutic relationship is a substantial and consistent factor in the success of therapy whatever therapeutic approach (Wampold, 2001; Lambert and Ogles, 2004; Roth and Fonagy, 2004; Norcross et al. 2008; Norcross, 2002, 2011). Norcross, (2011) declared that after decades of reliable and viable scientific research the conclusions signify that successful psychotherapy is influenced by the client, the therapist, the treatment method, the context in which the therapy takes place and the therapeutic relationship.

Evaluating Gavaghan (2009) has corroborated once more the importance of the therapeutic relationship in therapy regardless of the modality of therapeutic

intervention or the approach to therapy used by a supervisee in the clinical supervision relationship. I agree with (Ellis and Ladany, 1997; Falender and Shafranske, 2004; Ladany, 2002) who consider the supervisor-supervisee relationship as crucial to the process of supervision as the therapist-client relationship is to the process and outcome of psychological therapies.

I have gained further understanding not only of the paramount importance of the therapeutic relationship whatever the therapeutic modality but I have acquired further understanding and reveal additional external factors that may influence the therapeutic relationship. I have an enhanced comprehension of external influences influencing the therapeutic relationship such as organisational culture, processes and dynamics, societal perspectives, and professional relationships with non-therapists. I discovered that it is a challenge for the therapist to establish, develop then maintain a therapeutic relationship and to promote therapy positively when the client perceives the therapist to be an integral element of an organisation that the client has preconceived negativity towards therapy due to organisational, cultural and societal influences. My learning from research (Gavaghan, 2009) has enabled me to apply the same understanding regarding external factors to the therapeutic relationship to other organisational contexts not only the NHS.

Annex: 10. Empathy and the therapeutic relationship.

As a direct consequence of the research (Gavaghan, 2009) I suggest that therapists employed within the context of an organisation would inform their therapeutic practice beneficially by acquiring an understanding of organisational culture and dynamics. I suggest that therapists become acquainted with an understanding of how organisational culture naturally develops, changes and transforms and how this may influence both staff and clients because this will enable therapists to have greater knowledge and understanding of factors influencing clients that have potential to impact on the therapeutic relationship. This enhanced understanding may enable therapists to be more perceptive of clients and external factors influencing the therapeutic relationship therefore facilitating communication of the core conditions especially accurate empathy (Rogers (1957, 1975) within the therapeutic relationship.

I examined empathy further when evaluating Gavaghan (2009) including researching the definitions of empathy. I examined the definition from a variety of modalities of therapy with the purpose of acquiring more conception of the perspective of empathy and its relationship with therapy. I discovered no existing agreed definition or understanding of empathy exists. Numerous, often contradicting, definitions of empathy exist, influenced by many factors including the originators profession, psychological approach, philosophy, research methodology, and personal bias. Bohart et al. (2002, p. 89) state that a problem in researching empathy is that, *"The is no consensual definition."* Duan and Hill, (1996 p. 269), concur, *"The lack of specification and organisation of different views of empathy has led to theoretical confusion, methodological difficulties, inconsistent findings, and neglected areas of research in the field."*

The study, research, and practice of Rogers (1949, 1951, 1957, 1959, 1975,) and others such as Kohut (1959, 1971, 1977, 1984,) influenced researchers and practitioners to continue developing and evolving the theory of empathy utilising wide-ranging research methodologies. Rogers (1957) argument that empathy is one of the *"necessary and sufficient conditions of therapeutic personality change"* (Rogers, 1957, p 95) has generated the majority of research and empirical findings

on the subject of empathy and the therapeutic relationship and consequential clinical outcomes.

The following is a synopsis of empathy definitions; *"As if one were the other person"* (Rogers, 1959, p. 210); *"transposing oneself into the thinking and feeling and acting of another"* (Dymond, 1950, p, 344). Truax and Carkhuff (1967) defined empathy as assuming the internal frame of another. Rogers (1957) describes empathy as the therapist living in the world of the client and taking the clients view. Katz, (1963), Rogers, (1975), Beck, (1995) and Truax and Carkhuff, (1967) all describe empathy as entering the world of the client. Katz, (1963, p.5) *"stood in his shoes."* Rogers, (1975, p. 4) entering the clients, "*private and perceptual world."* Beck, (1995, p, 8) *"Wearing the clients shoes."* Truax and Carkhuff, (1967, p. 285). Perceiving the clients *"perceptual vantage point"* (Kohut, (1959, p. 462) who argued that empathy is the basis of all human interaction and *"an essential constituent of all psychological phenomena."*

Psychoanalytic therapists such as Kohut, (1977, 1984) have a different perspective towards empathy and view empathy as part of the psychoanalytic cure. Mehrabian and Epstein (1972) describe empathy as a process of feeling and an instantaneous reaction to the emotions of another individual therefore principally an affective phenomenon. Conversely, Barret-Lennard (1981) perception of empathy is that of a cognitive concept referring to the intellectual comprehension of someone's experience. Thwaite and Bennett-Levy (2007) provide a CBT standpoint of empathy referring to the importance of the therapist understanding of the cognitive element of empathy in order to conceptualise the client's distress in cognitive terms and then create a cognitive formulation with the client. Houston (1990) when writing about intellectual empathy suggested that if therapists were more empathic to clients cognitions, clients would respond receptively encouraging further in depth communication.

In my experience CBT therapists view '*affective empathy'* and '*cognitive empathy'* as two distinct separate areas. I appreciate this perspective may be due to the influence of significant literature relating to the CBT approach because according to

Safran and Sega (1996, pg. 85) *"A problem often encountered in cognitive–behavioural writings is thinking of empathy and cognitive exploration as independent activities."* By the process of evaluating Gavaghan (2009) and experience as a CBT therapist, I have become increasingly aware of the cognitive aspect of empathy. I therefore concur with Gladstein (1983) whom states that empathy is either affective or cognitive depending on the circumstances and context. Gladstein, (1983 p. 468) described cognitive empathy as, *"Intellectually taking the role or perspective of another person*" and affective empathy as, *"responding with the same emotion to another person's emotion"* (Gladstein, 1983, p. 468).

I consider that a common tendency within psychological therapies is to assume empathy is a straightforward reflection of the client's feelings and a means of reassuring the client by gaining superficial understanding of the client's communication and reflecting this understanding back. In contrast, I determine empathy to be a more complex and a multifaceted process within the therapeutic relationship. Exploring the various definitions of empathy has increased my understating of empathy as well as had beneficial bearing on my delivery of psychological therapies because I have implemented the theory and improved learning into my clinical practice. Additionally my clinical supervision has benefited because of an augmented conceptualisation of empathy from differing therapeutic approaches.

The MPhil process has re-confirmed that empathic understanding if communicated with accuracy and congruence facilitates the therapeutic relationship (Rogers, (1951,1957, 1959, 1961, 1970, 1977, 1980, 1989; Mearns and Thorne, 1988, 1999, 2000; Mearns et al. 2000, 2013; Mearns and Cooper, 2005). Empathic interactions conveyed with congruence encourage clients to feel understood, valued and important, as well as encouraging trust and candidness within the therapeutic relationship. A prudent accurate congruent empathic interaction can be a productive and positive way to attend to clients who have preconceived pessimism towards therapy, attributable to external factors to therapy such as organisational, cultural and societal influences.

I deem that as direct consequences of Gavaghan (2009) I have a profound understanding of empathy and the appliance of appropriate accurate empathy within the therapeutic relationship. This understanding assists me to make a judgement when to use an appropriate empathic therapeutic interaction. Gavaghan (2009) emphasise that if the client is sceptical regarding counselling due to organisational and societal influences conveying Rogers (1957) core conditions especially empathy and congruence assists in establishing a trusting productive therapeutic relationship. Rogers (1957) core conditions are inseparable and equally important. Nevertheless, Rogers (1997) suggested that the order in which the conditions occur is significant and empathy transpires last, this citation encapsulates the concept, *"When the relationship is characterised by genuineness and respect, the actual work of counselling is helped by the empathic understanding of the meaning, significance and content of the client's experiences and feelings."* (Milner, 1980, p. 146).

I have discovered via completing Gavaghan (2009) that the core conditions are complex and multidimensional and the therapeutic relationship is a multifaceted phenomenon, paradoxically the core conditions are individual and separate attributes yet interrelated and inseparable. I concur with Mearns and Thorne (1988) and Bogart, et al. (2002) whom recognise this correlation, *"Just as empathy perfectly integrates with congruence, unconditional positive regard also takes its place as inseparable from the other two." (*Means and Thorne, 1988, p. 58) and *"While conceptually it may be possible to separate empathy from Rogers other therapeutic conditions, from warmth or positive regard and congruence or genuineness, in practice it is not*." (Bogart, et al. 2002, p. 102).

Annex: 11. Parallel process, false empathy, self-awareness, self-disclosure within the therapeutic relationship.

Obstructive external factors to the therapeutic relationship are augmented if the same external factors affect the therapist as well as the client as this could cause false empathy (Mearns and Thorne, 1998, 1999, 2007; McLeod, 2007), destructive pessimistic collusion (Crandell and Allen, 1982; Carroll and Walton, 1997; Davies, 1997; McLeod and Machin, 1998; Stevenson, 2010), false empathy, (Schutz, 1967; Mearns and Thorne, 1998, 1999, 2007; McLeod, 2007), or parallel processes (Crandell and Allen, 1982; Carroll and Walton, 1997; Davies, 1997; McLeod and Machin, 1998; Stevenson, 2010) to the detriment of the therapeutic relationship.

False empathy (Mearns and Thorne, 1998) may feel like empathy to the therapist but it is false as it is from the therapist's own frame of reference. Empathy implies a continuing aspiration and undertaking to understand the client's perspective regardless of the therapists own perceptions, experiences, emotions and values. Rogers (1959, p. 210) described empathy as,

> *"The state of empathy or being empathic, is to perceive the internal frame of reference of another with accuracy, and with the emotional components and meanings which pertain thereto, as if one were the other person but without ever losing the "as if" condition."*

Rogers (1959, p. 210) explains the "*as if*" concept of empathy as, *"It means to sense the hurt or the pleasure of another as he senses it and to perceive the causes thereof as he perceives them, but without ever losing the recognition that it is "as if" I were hurt or pleased and so forth."* Sharing a common culture such as the organisational culture of the NHS or encountering similar experiences may promote trust and aid communication in the therapeutic relationship. Nevertheless recalling one's own personal experiences when listening to the clients situation and dilemmas and sympathising whilst identifying with one's own experience may be a hindrance to empathy as it is false empathy because it is from the therapists own frame of reference (Mearns and Thorne, 1998, 1999, 2007; McLeod, 2007). I am conscious to remain in the client's frame of reference and not have what Shutz, (1967, p. 114),

refers to as, *"projective theory of empathy*" and describes as, *"For here we are reading our own lived experiences into the other person's mind and therefore are only discovering our own experiences."* Accordingly, it is essential to maintain the necessary distance and boundaries with clients issues and situation so as never to lose the Rogers (1959) '*as if condition;* and to maintain ethical professional boundaries (British Association for Counselling and Psychotherapy, (BACP), 2002, 2013).

BACP (2013, p. 6), amendment states, *"Practitioners should not allow their professional relationships with clients to be prejudiced by any personal views."* This statement has activated profound self-reflection in me, as the statement seems to suggest that therapists should conform to the statement in an automatic verbatim manner. Whereas I argue that, it is difficult to implement precisely into ones practice as a therapist because self-awareness is something that has to be developed and just because someone is, a therapist may not mean that particular therapist can mechanically conform to the statement. Self-awareness is something that has developed all through my life not just since becoming a therapist, however a career in therapy has facilitated the process with persistent self-exploration and self-reflection of my experiences of clinical practice, supervision, personal and professional development, and as a self-reflexive therapist and researcher consistent with Etherington (2004). Self-awareness allows me to reflect on and to question my own beliefs, awareness and values, and my natural prejudices and an awareness of how these have potential to influence my professional and personal life and interactions with others. Self-awareness often perceived to belong to Rogerian based therapy modalities however is evident in other therapeutic approaches including CBT, (Praskoa, et al. 2012; Safran and Muran, 2000; Bennett-Levy et al. 2003; Bennet-Levy and Thwaites, 2007). Regardless of the modality of therapy I deliver I concur with Praskoa et al. (2012, p. 377), *"If therapists are unable to recognize their own thoughts and feelings, or the effects of their attitudes in a therapeutic situation, then they are helpless against these thoughts and feelings, which may control the therapist's behaviour to the disadvantage of the client and therapist alike."*

Self-awareness is an ethical reflection of significance because it assists in endeavouring not to harm clients by unconsciously addressing one's own emotional unfinished issues through the client and it encourages therapists to be self-aware of any prejudiced personal view that may intrude into the therapeutic relationship. Self-awareness is an important factor in developing Rogers core condition empathy (Rogers, 1951, 1957, 1975; Dixon, 1980; Brennan, 1987). I concur with Duan et al. (2002) suggestion that self-awareness and learning about oneself is an effective way to develop a therapist's empathic understanding for others.

I argue that if therapists have a comprehension of false empathy as well as self-awareness this will assist in preventing their personal views prejudicing their opinions towards clients thus demonstrating Rogers core condition "*unconditional positive regard"* (Rogers, 1957, 1959, 1961). Whilst also preventing any adverse affect on the therapeutic relationship such as destructive therapist collusion, harmful parallel processes and implicit concealed false empathy.

Self-awareness assists the therapist to have awareness to identify potential external factors that may influence the therapeutic relationship, and how these may affect them personally, which assists in maintaining the therapeutic relationship. I consider that completing the process of the MPhil has increased my self-awareness, and related knowledge, enabled me to be diligent in avoiding becoming complacent, opinionated and inaccurate in my empathic understanding and subsequent communication with the client. I am more aware of the potential of false empathy hindering my ability to empathise accurately thus detrimentally influencing therapy. Gavaghan (2009) and MPhil heuristic research (Moustakas, 1990) has increased my understanding of client's perspectives and associated feelings regarding organisational and societal influences. Simultaneously, I have more self-awareness to recognise my own feelings, and emotions regarding organisational and societal dynamics, therefore facilitating my communication of accurate empathy to the client whilst having an increased awareness for the potential of false empathy.

I am aware of the potential for false empathy, (Schutz, 1967; Mearns and Thorne, 1998, 1999, 2007; McLeod, 2007) to occur then inaccurately deducing that the influence on each client is comparable especially when encountering recurring

clients with similar organisational influences and external factors to therapy. I agree with Casement (1990) who describes therapists that use previous past experiences with clients to make sense of present clients presenting issues as shortsighted and biased. I also maintain this can lead to therapists becoming complacent, lethargic or too confident of their self and judgements. The attitude of therapists described by Casement (1990) has a potentially destructive likelihood for therapy and a probability that the therapist is likely to convey false empathy or inaccurate empathy. I encourage continual reflective practice and personal self-refection and ongoing development of self-awareness to assist in the prevention of correlating previous clients with present clients when communicating empathy and congruence.

As a supervisor of therapists employed in organisational contexts, my increased comprehension of organisational cultures and dynamics, as well as improved understanding of false empathy (Mearns and Thorne, 1998, 1999, 2007; McLeod, 2007) and organisational parallel processes (Crandell and Allen, 1982; Carroll and Walton, 1997; Davies, 1997; McLeod and Machin, 1998; Stevenson, 2010) has positively enhanced my supervisory practice. I utilise learning from my research to enable me to recognise false empathy within supervisees that was not part of their awareness therefore facilitating supervisees' self-reflective practice and increased awareness of potential detrimental external factors to the therapeutic relationship within organisational contexts. My improved knowledge of organisational parallel process, as well as understanding of the influence of parallel process in supervision (Falender and Shafranske, 2004, 2008), has benefited me as a supervisor in an organisational context as I have greater awareness when organisational issues, as a parallel process, impede into the supervision relationship emulating from the supervisor or supervisee or indirectly via the therapeutic relationship. Falender and Shafranske (2008) state that parallel process relates to the dynamics of the therapeutic relationship stimulating and being reflected within the supervisory relationship, or conversely, the dynamics of the supervisory relationship being replicated in the therapeutic relationship with the client.

I was astounded during CBT training that so little attention was giving to the therapeutic relationship and self-awareness, instead the priority was a focus on learning techniques. I therefore concur with Boyd-Franklyn et al. (2013) whom

described a disturbing trend in new therapists now focusing on learning techniques, subsequently discounting, and ignoring the importance of the therapeutic relationship. As an IAPT service case manager I have observed therapists, especially those delivering CBT, deliver therapy to similar clients with the same diagnosis, from the same geographical area, using the same modality of therapy, from the same room, on a daily basis. No matter how diligent, professional and self-aware therapists are, false empathy has potential to occur due to this mundane routine of delivering therapy. I observe CBT therapists in a state of what I regard as '*autopilo'* delivering therapy with barely any awareness of the therapeutic relationship in general and particularly false empathy, which is usually outside the awareness of the therapist due to having an undeveloped self-awareness. Turpin and Wheeler (2011) created the IAPT Supervision Guidance document, and state that CBT therapists are to receive supervision from CBT supervisors with BABCP Accreditation. I agree with the rationale of Turpin and Wheeler (2011) recommendation in that it is an essential part of developing CBT practice and is a requirement of the BABCP as a professional organisation. I argue nevertheless that if in addition to CBT supervision, that individual or group supervision or training was provided with a supervisor or trainer with an understanding and knowledge of the therapeutic relationship that incorporated self-awareness, self-reflective and self-reflexive practice as well as awareness of external factors such as organisational culture and dynamics. This may then benefit the CBT therapist immensely therefore beneficially informing therapy and clinical outcomes.

If external factors such as organisational and societal influences are impeding into the therapeutic relationship (Gavaghan, 2009) and I deem it appropriate, I self disclose and communicate my opinion congruently to the client. I have discovered that the therapeutic intervention of self-disclosure (Rogers, 1957; Jourard, 1971; Derlaga and Berg, 1987; Knox et al. 1997; Hill and Knox, 2001; Knox and Hill, 2003; Audeta, and Everallb, 2010) is a more productive therapeutic intervention than communicating false empathy that often has adverse consequences to the therapeutic relationship. McLeod (2007) emphasised the detrimental effect of false empathy,

> "*A danger of false empathy is that it places the counsellor into a position of an all knowing expert, which can then inhabit the development of a collaborative mutual exploration of issues."* (p. 139).

When considering the appropriateness of using self-disclosure, I consider ethical issues according to BACP, (2013). For instance, I consider the following, issues relating to keeping trust; client determination and self-harm and the need to ensure the therapeutic relationship does not become detrimental to the client or the standing of the profession; the quality of care and the need to clarify and agree rights and responsibilities of both the practitioner and client.

Therapist self-disclosure with intent to facilitate a therapeutic relationship is a component of humanistic psychotherapies. I concur with Rogers (1957, 1961) and Jourard (1971) who both advocate therapist's use of self-disclosure, proposing that it assists to establish and maintain a therapeutic relationship through genuineness, empathy, and unconditional positive regard (Rogers 1957) that are conveyed to the client. Rogers (1957, 1961) and Jourard (1971) believe that self-disclosure could foster honesty, understanding, trust, and openness between client and therapist thus benefit the therapeutic relationship. Rogers (1957) stated that if the therapist is congruent then self-disclosure may occur and that within the relationship the therapist should be a congruent, genuine, integrated person and that he is freely and deeply himself the opposite of presenting a facade. I reason that appropriate self-disclosure demonstrates that the therapist is a congruent, genuine person and that he is communicating precisely himself. Hill and Knox (2001) stated that if therapists use self-disclosure cautiously, it is helpful in the immediate process of therapy. Knox et al. (1997) argued that therapist self-disclosures resulted in positive consequences for clients including new insight or a new perspective from which to make changes and that an improved or more equalised therapeutic relationship develops. Research conducted by Audeta and Everallb (2010, p. 340) on clients experience of the therapeutic relationship in the context of receiving therapist disclosure during therapy, concluded that, "*Therapist disclosure does have a bearing on the quality and therapeutic value of the client therapist relationship."*

Self-awareness and self-disclosure are interrelated with congruence (Rogers 1957), however, I exercise caution when displaying congruence by self-disclosure. I consider heightened self-awareness essentially important when considering self-disclosure in therapy because understanding one's 'self' including an awareness of personal feelings, opinions, perspectives and beliefs, assists in deciding if something is appropriate to be expressed and will it be beneficial to therapy. I am cautious when self-disclosing because to use self-disclosure as an intervention shifts focus from client to therapist. Paradoxically, if employed prudently and appropriately, self-disclosure can facilitate trust and mutuality in the therapeutic relationship, demonstrating a mutual understanding and facilitating the communication of the core conditions (Rogers, 1957) especially congruence and empathy. For instance if organisational and societal influences are impeding into the therapeutic relationship and I deem it appropriate, I self disclose and communicate my opinion congruently to the client.

The following is an extract from a recorded session of my therapy demonstrating congruence and empathy;

Client: *"I did not expect to have to wait this long for therapy. I was proper pissed off, I wasn't going to come just bin it and not attend."*

Therapist*: "I sense that you are frustrated even angry about your wait for your first appointment, even now. (pause) I genuinely agree that your wait was not ideal. However, we are taking measures to reduce waiting times. When I had to wait a similar time for an appointment to see a specialist in hospital, I was frustrated too."* (Demonstrating; empathy, congruence and appropriate self disclosure)

Client: "*Thanks. I mean thanks for understanding and at least trying to do something about it. It's nice to know that you have been there and really understand how I feel about the wait."*

Wosket (1999, p. 155) describes by means of metaphor the beneficial impact on clients when therapists self-disclose, "*I do believe that some clients can benefit from a depth that derives from the therapists living river of personal experiences, including*

their flotsam and jetsam, than from a sanitised pool of pre-prepared clinical strategies and interventions."

When I started delivering CBT I did feel as if I was providing therapy from, *"a sanitised pool of pre-prepared clinical strategies and interventions."* When I was able to express my, "*living river of personal experiences, including my flotsam and jetsam"* the resulting written feedback from clients using IAPT, (2013b), was significantly more constructive regarding the therapy. Norcross (2002, p. 96) stated, *"Empathy might be more important to cognitive behavioural therapy than others."* I concur with Norcross (2002) because I consider that empathy enhances beneficially my CBT practice.

Despite my enthusiasm for the intrinsic worth of appropriate self-disclosure my CBT clinical supervisors have previously informed me that as a CBT therapist practicing to the CTS-R according to Blackburn et al. (2001, 2002) I should never self-disclose or share elements of my 'self' with clients. I have debated against their guidance as I am not a CBT therapist practicing to the CTS-R, Blackburn et al. (2001, 2002) but an integrative psychological therapist informed by CBT. I utilised relevant evidence in my debate regarding justification for my rational to continue the use of 'self' in my therapy such as;

a. Academic literature and research evidence, including findings from my research Gavaghan (2002, 2009) and resulting acquiring of knowledge.
b. Statistical data regarding, Caseness-recovery rates (Gavaghan Caseness, 2013, contained in Appendix: 2), appraisal information and client feedback, (MHCO, 2011, 2012c, 2013b).

I now provide a synopsis of personal statistical data regarding clients recovery between 01/04/12–31/03/13. The MHCO IAPT service average recovery rate for Step 3 including CBT achieved by averaging outcomes in depression and anxiety is 54.70 % compared to my Caseness score of 93.18%. The entire service average recovery score for anxiety is 60.88% whilst my score is 92.50%. The entire service average recovery score for depression is 63.64% whereas my score is 97.37%. I deem my recovery rates to several reasons predominantly my use of 'self' in therapy

and the significance that I place on the role of the therapeutic relationship within therapy whatever the therapeutic modality including appropriate self-disclosure.

Written evidence from clients extracted from IAPT, (2013b), confirms the appropriate use of 'self' and self-disclosure and how this intervention has had beneficial consequence on therapy and been instrumental in client's recovery. The following is an extract, IAPT (2013b);

> *"It is difficult to explain in words the way this service has helped me. From starting out as a bit of a wreck, an understatement. I have been on a journey of self-discovery and attitudinal change, which has had profound effect on my mental health. I have been accompanied / chaperoned by a very understanding therapist whose credibility, support, guidance, knowledge and skills have had enormous positive effect on my mental health and improved well-being. Most importantly, his credibility and genuineness has assisted my recovery and he gained this by his honestly in disclosing some of his struggles in life. Thank you Andrew."*

Annex: 12. Power and external locus of evaluation within the therapeutic relationship.

Gavaghan (2009) concluded that clients often present as anxious, reluctant, and resistant to engage in therapy due to external factors to the therapeutic relationship. These external influences comprise of, organisational culture and dynamics including the cultural power of the NHS, previous experiences of the NHS or therapeutic interventions, societal perspectives of talking therapies, and the influences of the referral process and referrer all have potential to have detrimental effect on the client thus therapeutic relationship. This understanding enabled me to have an increased awareness and sensitive empathic appreciation of clients anxieties, concerns, and become more conscious that these may have a damaging impact on the dynamics of a therapeutic relationship.

I encounter clients who are frequently anxious and experiencing apprehension regarding therapy including displaying reluctance, resistance and even occasional aggression and frustration towards therapy. Gavaghan (2009) advocates that it is crucial for therapists not to judge the client but empathically accept the client's thoughts, feelings, and behaviours in a non-judgemental manner, with the purpose of establishing a therapeutic relationship as a foundation for therapy. Once the therapeutic relationship is established, I then integrate other appropriate therapeutic practices, as appropriate.

Gavaghan (2009) proposes that reluctant, defensive, resistant, vulnerable, and aggressive clients may only need to find genuineness, reassurance, acceptance and empathy from a therapist. This assists to create a safe, trusting encouraging therapeutic relationship based on Rogers core conditions (1957, 1959), in order to actuate therapeutic change in the client and discover from within themselves their inner potential that may have been lost to their consciousness for some considerable period.

Smith and Norton (1999) in a publication on counselling skills for doctors within the NHS acknowledge that many people are unwilling to undertake responsibility for their own autonomy and take personal control of their 'self'. This correlates with Rogers'

theory of the '*locus of evaluation'* (Rogers, 1951, 1961; Raskin, 2004a, 2004b; Mearns and Thorne, 1988, 1999, 2000; Mearns et al. 2000, 2013; Mearns and Cooper, 2005). A '*locus of evaluation'* is when a person listens to others opinions and judgements rather than their own and is influenced by external factors including experiences of the cultural power of the NHS (Gavaghan, 2009). A person becomes dependent on the opinions, advice and guidance of others. This describes many clients with an internal locus of evaluation within the context of the NHS, "*Disturbed people constantly betray the lack of an internal locus of evaluation and turn desperately to external authorities or find themselves trapped in a paralysis of indecision."* (Thorne, 1992, p. 33).

I am now more aware of the power of organisational dynamics and culture and other external aspect that have potential to facilitate the development or exacerbate a person's external locus of evaluation Gavaghan (2009). I thus am continuously attentive to power imbalances within the therapeutic relationship and conscious of the possible unhelpful consequences to the therapy especially if the client has an external locus of evaluation and perceives the therapist to be an expert within an apparent powerful organisation such as the NHS (Gavaghan, 2009).

Bristol Royal Infirmary Inquiry (2000), cited examples of cultural expectations of medical doctors that compare precisely with Carroll (1996) definition of an organisation with a power culture, "*Medical culture has traditionally been based on power"* (Bristol Royal Infirmary Inquiry, 2000, p. 3). Power continually influences our daily experiences in a manner comparable to this quotation, "*For power is the social element in which we exist. It is almost impossible to think of a human experience which is not shaped by power that does not carry either a positive or negative charge of power."* (Smail, 1991, p. 2). In therapy, I continually encounter issues that influence the balance of power in the therapeutic relationship. I determine that the issue of power is intrinsic to psychological therapy. If discrepancies exist between the therapist and client for instance, social standing, age, culture, class, professional status, race, gender, or sexual orientation, an imbalance of power may then transpire in the therapeutic relationship.

If perceived as a professional with a position of power within the organisation it is

imperative that I endeavour to be non-judgemental and to convey my genuine self, as well as communicate accurate empathy (Rogers, 1957) in particular if the client's anxieties are regarding the power of the organisational culture and myself as therapist (Gavaghan, 2009). This will assist in establishing a therapeutic relationship in accord with Rogers (1951, 1957, 1975, 1977). Gavaghan (2002, 2009) discovered that clients express an array of feelings during therapy, the most prevalent include, powerlessness, guilt, inadequacy, fear, relief, confusion, anxiety, shame, failure and embarrassment. I concur with Rogers (1951) who argues that explorations of feelings are more likely to promote therapeutic change than examining and focusing on facts. I additionally believe that this exploration facilitates the establishing, developing and maintaining of a therapeutic relationship that endeavours to be mutually trusting with a balance of power between the client and therapist. I agree with Rogers, that everyone has self-power and inner resources to facilitate personal-growth and the therapeutic relationship is a conduit for clients to discovery self-power,

> *"From the perspective of politics, power and control, person-centred therapy is based on a premise, which at first seemed risky and uncertain: a view of man as at core a trustworthy organism. I have recently described it as; the gradual formed and tested hypothesis that the individual has within himself vast resources for self-understanding, for altering his self-concept, his attitudes, and his self-directed behaviour."* (Rogers, 1978, p. 7).

If conscious of any imbalance, I endeavour to equalise the power within the therapeutic relationship by rectifying the imbalance therefore empowering the client and concurrently promoting the client's transition from an external to an internal locus of evaluation (Rogers, 1961) and concurrently enable client's self-power (Rogers, 1978). This quotation is as applicable today by Mearns and Thorne, (1988, p. 18) *"In the counselling relationship this implies an ever-watchful attentiveness to any imbalance between counsellor and client and a constant seeking to equalise power through any procedures, whether verbal or otherwise, which can remedy such imbalance."* I endeavour to promote a therapeutic relationship that is mutually trusting with a balance of power between the client and the therapist.

False empathy (see Annex: 10) has detrimental influence to therapy and I concur with McLeod (2007) who stated that false empathy places the therapist in a position of power thus inhibits mutual communication and collaborative exploration. Having an understanding of the potential of external factors like organisational culture influences that may intrude into the therapeutic relationship (Gavaghan, 2009) facilitates therapist's genuine accurate empathic understanding including any issues relating to power imbalance within the relationship, therefore enabling these to be addressed mutually. Consequently empowering the client and assisting the client's transition from an external to an internal locus of evaluation (Rogers, 1961) and from "*patient to client*" (Gavaghan, 2009). Rogers (1961) defines the process of a client's transition from an external locus to an internal locus of evaluation when the client is able to make their own decisions without the need of approval from others, the person becomes comfortable within their self, looking internally to evaluate a situation and no longer relying on the external world for decision-making.

The sharing of power in the therapeutic relationship empowers clients, which is cognate to the philosophy of humanistic counselling (Rogers, 1951, 1957, 1959, 1961, 1970, 1977, 1980, 1989; Mearns and Thorne, 1988, 1999, 2000; Mearns et al. 2000, 2013; Thorne, 1992; Raskin, 2004a, 2004b; Mearns and Cooper, 2005); Evans et al. 2011). I encourage the sharing of power in the therapeutic relationship because empowering clients to share power is also constructive in addressing and neutralising any power issues or dynamics developing from external influences to therapy (Gavaghan, 2009). I encourage the client to become autonomous and strive to facilitate a mutual balance of power that is empowering for the client. This enduring citation is still pertinent describing the sharing of power in the therapeutic relationship, *"I learned that the power issue in person-centred counselling is not about me holding back on my expertise, but is concerned with creating a relationship which is empowering for my client*." (Dryden, 1992, p. 80).

Wosket, (1999 p. 36) states, *"The power of the relationship in counselling hinges on the fact that it is normally the only relationship that the client and counsellor have."* I agree that it may be the only relationship between therapist and client but also

external factors have the potential to affect the power between client and therapist. To facilitate a mutual balance of power I am mindful of factors including external dynamic that may influence the power within the relationship (Gavaghan, 2009). I am also conscientious not to present as an aloof professional, displaying any purported status and knowledge within an influential professional organisation such as the NHS or IAPT service. In the therapeutic relationship, two individuals communicate with one another within a unique relationship with mutual agreement to produce effective change for the client or enhance their wellbeing (BACP, 2013b). Nonetheless, it is not just two individuals communicating with each other, it is often two different expectations, assumptions, values, social worlds, professional backgrounds, genders, ages, ethnicities, and cultures, all these factors relate to the dynamic of power within therapy. The therapeutic relationship is a complex and multidimensional phenomenon and the balance of power within the relationship can be affected by other external influences such as, the client's previous experience of the NHS or therapy, preconceived views of therapy influenced by societal influences, organisational dynamics and cultural influences (Gavaghan, 2009).

The issue of the balance of power is intrinsic to all therapeutic approaches not only modalities of therapy based on Rogerian philosophy. The implementation of learning from Gavaghan (2009) has influenced my professional practice assisting me to gain an improved understanding and awareness of the dynamic of power, which enables me as a therapist to address in a pro-active manner the issue within therapy to the benefit of the therapeutic relationship and consequently clinical outcomes.

Annex: 13. The change of the client's external locus of evaluation due to the process of therapy founded on the therapeutic relationship.

Gavaghan (2009) recognised that at the start of therapy many clients have an external locus of evaluation (Rogers 1951, 1961) which means that clients look for direction, guidance, and advice from the therapist. The external locus of evaluation I discovered (Gavaghan, 2009) often developed from placing medical professional in a position of expertise and authority and placing the responsibility for promoting their individual positive change with that professional. Rogers (1951) also stated "*Early in therapy the person is living largely by values he has introjected from others, from his personal cultural environment."* (p. 149). Gavaghan (2009) discovered that client's expectations in the initial stages of therapy are often comparable to what they would expect from their previous experiences with other medical professionals, epitomising their familiarity with the medical model (Laing, 1971; Sheldon, 1992). This client mindset client may benefit other modalities of therapy that use the medical model for instance CBT but is detrimental to Rogerian humanistic approaches as the mindset hinders the transition from an external to internal locus of evaluation, (Rogers, 1951, 1961) and the change "*from patient to client" (*Gavaghan 2009).

Gavaghan (2009) identified that patients who encounter difficulties assuming the role of an autonomous patient within the 'patient-centred' doctor-patient relationship or are unfamiliar with this type of relationship are likely to experience problems also adapting to the role of client within the therapeutic relationship. Conversely, Gavaghan (2009) discovered that clients who are referred from referrers who are patient-centred and collaborative in their clinical transactions adapt far more quickly to the style of therapy deep-rooted in Rogerian philosophy. This is because they are familiar with professional relationships based on mutuality and respect and therefore are more adaptable to the transformation from '*patient to client'* (Gavaghan 2009) and subsequent positive change to their '*locus of evaluation'* (Rogers 1961), and to experience '*personal power'* (Rogers 1977). Rogers (1977) considered personal power the opposite to external authority and power, expressing personal power as a person developing an individual set of values and manner of relating, drawn from within rather than from external influences, stating*; "These new persons have a trust in their own experience and a profound distrust of all external power."* (Rogers, 1977,

p. 274). Gavaghan (2009) discovered that many people find it difficult to accept responsibility for their self and would rather place the responsibility onto others especially someone that they perceive to be the expert, Rogers (1961) refers to this as '*locus of evaluation'* and '*conditions of worth'* (Rogers 1951, 1959).

According to Rogers (1951, 1959, 1961) when born we have a real-self a trustworthy human organism in comparison with self-concept that is a personal creation of self that has developed through life experiences often influenced by organisational power or significant people. Rogers (1951, 1961) viewed the child as having two basic needs, positive regard from other people and '*self-worth'*. The manner in which we think about ourselves our '*self-worth'* are of fundamental importance to psychological health and to the likelihood that we can achieve ambitions in life (Rogers 1959). Rogers (1951, 1959, 1961) believed that we needed to be regarded positively by others, to feel valued and respected. If however someone seldom receives praise or encouragement from significant people, but continually receives criticism, despite striving to achieve, and receive positive regard, eventually these people will no longer trust the '*self'* that endeavours to achieve and will encounter confusion and internal conflict deliberating that trying to accomplish must be wrong. They then start responding to the conditions of worth imposed on them. Rather than risk ridicule and rejection, they adapt many values, beliefs, attitudes and opinions of significant other people in order to gain conditional positive regard. This quotation encapsulates the concept of Rogers (1951, 1959) "*conditions of worth*",

> ***"****Our capacity to feel positive about ourselves is dependent upon the quality and consistency of the positive regard shown to us by others, and where this has been selective we are the victims of what Rogers described as conditions of worth. In other words, our self-regard becomes as selective if not more so than the regard bestowed on us by others. We have worth in our own eyes only on condition that we think, feel and behave in ways that others have told us are worthy of love and respect."* (Thorne, 1992, p. 30).

Clients who have developed Rogers (1951, 1959) *'conditions of worth*' find it easy to place the responsibility onto others especially someone that they perceive to be the

expert such as a therapist. Gavaghan, (2009) suggests that therapeutic outcome measures will be more positive and the client will gain increased benefits from therapy once they are able to assume the role of a client willing to participate in therapy, in collaboration with the therapist, as an autonomous individual within a therapeutic relationship. Gavaghan (2009) recommends that using the therapeutic relationship therapists should strive to encourage clients to develop their own internal locus of evaluation (Rogers 1961) and to aim to possess their own personal power (Rogers 1977) therefore enabling them to recognise that responsibility and choice are within themselves thus changing their '*conditions of worth'* and developing '*self-worth'.* Rogers (1959) believed a person who has '*self-worth'* has confidence and positive feelings about their self. I encourage a therapeutic process that enables a client to express their personal power as they develop an individual set of values and manner of relating, drawn from within rather than from external influences.

Gavaghan (2009) has increased my understanding of the process a client encounters when experiencing the transition relating to their '*locus of evaluation'* (Rogers 1961). As a therapist, I gain immense professional contentment when I observe clients in therapy recognise that '*locus of evaluation'* lies within them and then gradually they stop looking to others for approval or disapproval. Instead, clients become self-aware of their own choices and gain confidence in their own ability to make decisions. This beneficial transition in the clients is problematical to measure by quantitative outcome measures due to the subjective nature of the change. The following is qualitative written data from a client *(*IAPT, 2013b),

> *"At the start I did not want to attend just went because of the Doctor. It's not what I expected, it was different. I wanted answers and understanding of what was wrong with me instead I got more questions. I found myself thinking between appointments and gradually doing things for myself. Others noticed changes in me saying I had stopped asking them questions and advice. I now think I have found me as I trust my own decisions and can actually decide what I want to do for me."*

I discovered through completing Gavaghan (2009) that when clients convert to an internal locus of evaluation they develop trust in their own set of internal values, ideas, and beliefs that amalgamate and are congruent with their self. I therefore advocate that the sooner a person can make the transition from "*patient to client"* (Gavaghan 2009) then the change of locus of evaluation starts occurring to the overall benefit for the client. Rogers (1961) theory of locus of evaluation and his perspective of personal power (Rogers, 1977) are comparable to what Gavaghan (2009), described as *"from patient to client".*

The process of "*patient to client"* (Gavaghan 2009) is related to the person-centred approach to therapy, as it encourages clients to accept responsibility for their own life and to trust in the inner resources that are available to all those who are prepared to participate in the quest to search and discover self-awareness and self-acceptance. As transition continues to an internal locus of evaluation the client experiences what Rogers (1961, p. 119) describes as,

> "*The individual increasingly comes to feel that this locus of evaluation lies within himself. Less and less does he look to others for approval or disapproval; for standards to live by; for decisions and choices. He recognises that it rests within himself to choose; that the only question, which matters, is, "Am I living in a way which is deeply satisfying to me and which truly expresses me."*

Gavaghan (2009) suggests that therapists should endeavour to encourage the client to participate in therapy with autonomy, recognising, understanding and trusting the realisation that they have individual choice and personal power.

Annex: 14. A more profound understanding of the core conditions (Rogers, 1957) within my therapeutic practice facilitated by completing Gavaghan (2009) and secondary heuristic processing activated by completing the MPhil.

Gavaghan (2009) research as well as additional learning from evaluating this research as an MPhil has confirmed that it is imperative to endeavour to convey Rogers (1957) core conditions and impart empathetic understanding in both oral and non-verbal communication in order to establish a therapeutic relationship that will provide a facilitative environment of positive-growth for the client. In particular when clients may be reluctant or resistant to therapy due to external influences to the therapeutic relationship (Gavaghan, 2009).

When evaluating Gavaghan (2009) due to secondary heuristic processing (Moustakas (2009) I recognised further Rogerian influences and correlations relating to my research and therapeutic practice that previously I was unaware of. I became aware that I really trusted and had a profound belief in resistant and reluctant clients similar to Rogers (1961, p. 73) *"the core of man's nature is essentially positive"* and a person is a "*trustworthy organism"* Rogers (1977, p. 7a). I also related to Rogers (1959) who maintained that the human organism has an underlying "*actualizing tendency*", which aims to develop all capacities in ways that maintain or enhance the organism and move it towards autonomy.

I consider that I am now able to communicate empathy more accurately informed by increased knowledge, and self-awareness gained from Gavaghan (2009) especially regarding external influences that have potential to affect the client and influence the therapeutic relationship. I endeavour to be a congruent therapist with all clients however, I am more self aware of my actual congruence with reluctant and resistant clients due to completing the MPhil. I am now more aware of what Rogers (1959) meant in that a therapist could not be congruent all of the time, because perfection is impossible. My increased self-awareness and understanding of Rogers (1957) core condition congruence, paradoxically assists me to be congruent as I can be the genuine me not an act or a facade. The core condition unconditional positive regard, Rogers, (1957) I undertake to express in the following manner to all clients but in particular reluctant and resistant clients, *"not as a scientist to an object of study, but as a person to a person. He feels this client to be a person of self-worth; of value no*

*matter what his condition, his behaviour or his feelings. He respects him for what he is, and accepts him as he is, with his potentialities (*Rogers, 1965, p. 22*).* The therapeutic process facilitates simultaneously the transition of a patient from "*patient to client*" (Gavaghan, 2009). Gavaghan (2009) authenticates my previous belief but more profoundly that as a therapist my intent is to create a therapeutic relationship by displaying my natural self via the communication of Rogers core conditions (Rogers, 1957) both orally and non-verbally, thus revealing my genuine, accepting, empathic understanding self.

APPENDIX: 1. Examiners Coursework Report.

University of Manchester. **School of Education.**

Doctorate in Counselling.

Examiners Coursework Report.

NAME OF FIRST EXAMINER. Clarie Lennie.

NAME OF SECOND EXAMINER. William West.

NAME OF STUDENT. Andrew Gavaghan.

STUDENT REGISTRATION NUMBER. 5780795.

TITLE OF RESEARCH PAPER. Years 1 – 3.

RESEARCH PAPER. Assignment 1 and Assignment 2 and Assignment 3.

SUBMISSION DATE. 18 May 2009.

PASS.

FIRST EXAMINER FEEDBACK.

Andrew, I am delighted to receive this piece of work. I appreciate the difficulties that you have experienced over the last few years and it is a testament to you that you have been able to remain largely on track and not interrupt your studies with us.

That said, I do wish that you had been able to break this piece into 3 shorter assignments. I think it would have been helpful to your progression and development of writing. Having said that I agree with the comments below from William that you have improved this piece and although lengthy, you have thought about guiding the reader through the piece. Strangely, my main concern too was around your contents page I felt that it was a bit of a turn off to the assignment so as William suggests think carefully about what the aim for a contents page is and amend your presentation accordingly.

Your work seems to begin rather abruptly and we need a section at the very start explaining what the parameters are to the piece i.e. what are you aiming to do here. You need to comment further on the differences between reflexivity and reflection and use material from your own logs to demonstrate how it impacted on this piece of research / assignment.

This is a very dense piece of writing and in the thesis we would always urge you to try and find a table or chart that summarises your key findings in a piece of research. I think I recall in a tutorial you discussing each of these factors that are mentioned in your assignment and how they might inter relate in a diagrammatic form – this would certainly be helpful in this piece.

There are two things to reflect on here for me. Firstly, do look to update your references and secondly Andrew do please use us more. We are not just here on your designated Tuesdays if it is difficult to get here - we are always here! I am doing more on more telephone tutorials so please keep in touch as you now progress to the panel and thesis.

SECOND EXAMINER FEEDBACK.

Andrew it is good to read this submission which is informed by a wide range of literature your own thinking and clinical practice.

There are still a number of points I wish to make to further develop your work. Your contents page need section of the assignments given page numbers and should not be underlined or in bold which rather shouts at your reader and indeed should be helpful to your reader. Also do not quote from authors in bold – italics is enough. Be aware of having too many last century references e.g. on page 26.

With regard to your first section on reflective practice, it needs an introduction and you need to clarify the difference between self-reflection and reflexivity. I found this a fascinating read and I think it worked pretty well. I would have liked to have liked to have read about your direct experiences of “tracking down and tracing back” here perhaps with some rich diary extracts.

It might help your forthcoming thesis to draw some maps / tables showing the therapeutic encounter at the centre of organisational culture and sub-culture also as a way of summarising your data collection etc. This would break up the impact of so much written text!

Your discussions of the appointments system and limit on the number of sessions are valid drawing on your own professional experiences and that of your clients to really illustrate the changes involved including your experience as a would be patient. (Curiously, I am facing a similar challenge today with blocked ears!).

I am shocked, if not surprised, to read your quotes from your fellow “professionals” with regard to your clients. I think your section on the “societal perspective to counselling” is brilliant.

I found your exploration of the doctor – patient relationship and referrals for counselling most interesting. I wonder if you have any thought on the proposed statutory regulation of counsellors within the Health Professionals Council which might well cause clients to see counsellors as “medical”.

APPENDIX: 2. Caseness. Andrew Gavaghan 01/04/12 – 31/03/13

Overall Clinical Results

	Condition At Assessment	At Condition At Discharge		Caseness Performance	
		Clinical	Not Clinical		
Clinical	44	3	41	93.18%	Service Total: 58.16%
Not Clinical	2	0	2		Step 2 Service Total: 63.94%
Grand Total	46	3	43		Step 3 Service Total*: 54.70%
					Counselling Service Total: 53.8
					Multi-Step Service Total: 52.84%

* Excludes Counselling

GAD		Band at end			
Band at assessment		15+	10-14	8-9	5-7
15+	23	0	1	2	8
10-14	14	0	0	0	2
8-9	3	0	0	0	0
5-7	4	0	0	0	1
0-4	2	0	0	0	0
Grand Total	46	0	1	2	11

* Excludes Counselling

PHQ		Band at end			
Band at assessment		20+	15-19	10-14	5-9
20+	12	0	0	1	5
15-19	12	0	0	0	7
10-14	14	0	0	0	3
5-9	7	0	0	0	1
0-4	1	0	0	0	1
Grand Total	46	0	0	1	17

	Caseness Result
0-4	92.50%
12	Service Total: 60.88%
12	Step 2 Service Total: 65.91%
3	Step 3 Service Total*: 57.69%
3	Counselling Service Total: 58.23%
2	Multi-Step Service Total: 55.96%
32	

	Caseness Result
0-4	97.37%
6	Service Total: 63.64%
5	Step 2 Service Total: 70.45%
11	Step 3 Service Total*: 60.16%
6	Counselling Service Total: 58.44%
0	Multi-Step Service Total: 58.17%
28	

APPENDIX: 3. Abbreviations.

APA. American Psychological Association

BABCP. British Association of Behavioural and Cognitive Psychotherapies.

BACP. British Association for Counselling and Psychotherapy.

CSQ. Client Satisfaction Questionnaire.

CBT. Cognitive Behavioural Therapy.

DH. Department of Health.

DWP. Department of Work and Pensions.

DSM-IV-TR. Diagnostic and Statistical Manual of Mental Disorders. 4 Revised.

EMDR. Eye Movement Desensitisation and Reprocessing.

GMC. General Medical Council.

GP. General Practitioner.

HSSI. Heuristic Self-Search Inquiry.

IAPT. Improving Access to Psychological Therapies.

NHS. National Health Service.

NICE. National Institute for Health and Care Excellence. Prior 2005 National Institute for Health and Clinical Excellence.

PEQ. Patient Experience Questionnaires.

PGDip. Post Graduate Diploma.

HPC. Health Professionals Council.

UK. United Kingdom.