THE THERAPEUTIC RELATIONSHIP
IN
PRIMARY CARE

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DECLARATION

This work has not previously been accepted in any substance for any degree and is not being concurrently submitted in candidature for any degree.

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STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged giving explicit references. A bibliography is appended.

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SUMMARY

This inquiry stems from my work as a psychological counsellor working in primary care. The late 20th century has seen an increasing focus on self and emotions (e.g. McCarthy 1989) with technologies such as psychotherapy and counselling (Rose 1999) as key means through which transformation of self takes place. The demand for therapeutic services continues to rise, and NICE guidelines (2004) recommend counselling as a treatment of choice in primary care, that is, in the surgeries of General Practitioners. Referral for counselling is for those with mild to moderate mental health problems (Cocksedge 1997), and counselling is offered typically for six to eight sessions. There is much research in the NHS concerned with evidence-based practice, whereas I sought to examine the client's voice with regard to their counselling, and how counselling fits within their life-world (Schutz & Luckman 1973). My aim was to gather accounts from people who had attended for counselling at their GP surgery. Using qualitative methodology, this was achieved via individual interviews with former clients. Following ethical approval, interviewees were recruited from 16 practices in South Wales. The focus is of client perceptions of counselling, examined through the ways in which the clients present themselves, their problems, and their counselling. The research questions are concerned with how former clients describe their counselling, and how client accounts can inform debates about how to enhance the delivery and practice of counselling in primary care settings. From the analysis of client accounts it can be seen that unique client factors, the diversity in interventions appreciated by clients, and contextual factors relating to the primary care setting, suggest that counsellors working in primary care be adaptive to their environment and sufficiently responsive to offer techniques and interventions from a range of therapeutic approaches, to best meet the needs of their clients.

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CHAPTER ONE

INTRODUCTION

It was like stripping something off, and then putting something back on again, but in a different way. It took me back to the bare essentials, and then I could put on experiences, and help myself, in a different way.....You can re-arrange it. To make it look – to make things more attractive. More settled, in your mind, especially. Look at things differently. The layers were there, but they were all in the wrong place. I think the counsellor helped me get them in the right place. [Yvonne]

Rationale for undertaking this research

This inquiry stems from my work as a psychological counsellor working in primary care as part of the evaluated pilot scheme described in this thesis as North Oaktown. The service was heavily audited, as I shall detail later in this chapter. I was involved in administering pre- and post-test questionnaires to clients, in addition to completing evaluation forms regarding the counselling and the clients' progress, and asking clients to return questionnaires after the counselling had finished. It was apparent early in the project that the clients experienced an improvement in subjective well-being, and that client satisfaction with the service was high. Data collected through CORE, (Mellor-Clark et al. 1999), a standardised evaluation method, reflected this improvement from a clinical population to a non-clinical one.

However, I noted that missing from the research was the 'voice of the client'. Outcome measure research often includes questions on client satisfaction with the counselling received, and of subjective well-being, but it does not seek to ascertain the client's perspective of the counselling process, nor to examine the place of counselling in the life-world, (Schutz & Luckman 1973), of the client. Thus, little is known of the meaning of counselling in a client's life, and how any changes that come about are integrated into the clients' life-world once the counselling is over. (Goss 2003).

Much of the existing literature is driven by the need for evidence-based research which is required for the funding of services, for example, within the NHS. This is inevitably shaped by the principles of quantitative research. However, it is claimed that 40% of the contribution to positive outcome in therapy is due to unique client factors. (Asay & Lambert 1999). These are described as the thoughts, ideas, actions, initiatives and traits of clients. So this study is complementary to evidence-based evaluative research. It seeks to elicit voices of clients, to uncover how counselling fits within their life-world, to explore why some counselling is experienced as more successful than others, and how clients describe effective change agents. This study accesses client views that are not necessarily obtained through other methodologies. I aim to explore those unique client factors that, according to Asay and Lambert, play the most important part in determining whether the therapeutic work will be considered successful. My conclusions have the potential to inform debates about how to enhance the practitioner's understanding of the therapeutic process from the client perspective.

I was also aware that with the increase in both demand for, and provision of, psychotherapeutic services had come criticism of a society that places such store in professional helping (for example, Furedi 2004), with, it is claimed, its potential for the stripping away of power from the individual. Recognising my personal bias in favour of counselling, I sought an opportunity to examine client accounts with respect to the issue of power.

My first degree in behavioural science comprised the disciplines of psychology, sociology and cultural anthropology, and I sought a means to research counselling using a similar wide-angled lens. Therapeutic interventions are often based upon historical notions of what is effective, passed down through generations of trainees, without attention to what clients have to say. Qualitative work provides a level and depth of personal detail that cannot be captured by quantitative inquiries. The qualitative interview in particular provides an insight into the *Lebenswelt,* or life-world, of the subject (Kvale 1996), an insight scripted in the lexicon of lay people. Such

interviews render visible a wide vista on the life of the counselling client, and provide essential information on the ways in which clients integrate their knowledge and experience of symptoms into everyday life.

This study

The aim of this empirical work was to gather accounts from people who had attended for counselling at their GP surgery. Using qualitative methodology, this was achieved via individual interviews with former clients. I examine what clients say about what makes counselling successful. The end of a course of counselling may not be a discrete end in terms of possible benefits. I wanted to find out what clients say about counselling after it is finished. Not as the counsellor hands over an evaluation form in the final session, but when they have had time to reflect on the counselling and its impact on their life. I chose to interview people many months after their counselling had finished, in order to allow time for them to assimilate the counselling into their life-world (Schutz & Luckman 1973) and to develop a narrative that includes the counselling.

The core of the thesis rests on an analysis of 23 client accounts of the counselling processes that they were involved in during the period between the spring of 2001 and the summer of 2002. Following ethical approval, interviewees were recruited from 16 practices in South Wales, and were interviewed at length about their experiences of counselling. The interviews took place a minimum of four months after the counselling had finished. A summary of client characteristics is provided in Appendix 5, and the issues that they raised in the interviews are examined in chapters four and five. My focus is client perceptions of counselling, successful or otherwise, examined through the ways in which the clients present themselves, their problems, and their counselling.

Totton (2004) commented that the term therapy is used to describe two distinct activities. It is seen as a short-term intervention, providing support for individuals faced with life transitions such as bereavement, adjustment to ill-

health and life-threatening conditions, or recovery after traumatic incident. In this way it seeks to provide the maximum amelioration of distress in the minimum of time. By contrast, it is also portrayed as a growthful re-organisation of the personality, which is likely to be a long-term activity. Totton described this as the 'practice of truth'. This study is of short-term counselling intervention of typically six sessions, with some flexibility available to counsellors. This study is located within a primary care setting. All clients were seen through referral by their GP, and all counselling was carried out at the patient's GP surgery.

Aims and objectives

Research questions: How do former clients describe their counselling in a primary care setting?

How can client accounts inform debates about how to enhance the delivery and practice of counselling in primary care settings?

Aim: To elicit and examine client accounts of their counselling in a primary care setting.

Objectives: To draw conclusions from the client accounts and to make suggestions that can inform debates engaged in by practitioners and service managers, of how to enhance the delivery and practice of counselling in primary care settings.

Outline of this study

In listening to the voice of the client, I heard not only of the counselling, but also of the clients themselves. In studying counselling from the client perspective, and in working toward meeting the objectives of this study, I will explore a number of themes that emerged through the client accounts. Firstly I will consider the client's perspective of 'what works' in counselling; secondly, the kinds of expectations that clients bring to counselling, based on perceptions that may be based on prior experience, media images and social and cultural folklore; thirdly, how clients present themselves, and the kind of

people that they are, and fourthly, where and how counselling fits in the life-world of clients. In the discussion chapter I shall consider how each of these themes may impact on the counselling process and potential for perceived success of counselling, and shall draw implications for practitioners and service issues for managers.

I will firstly offer some background to the context of the study. I will consider the nature of primary care, and then explore Department of Health and Welsh Assembly Government policy for delivering mental health care services in the primary care context. I will then discuss the setting for this study, namely the two pilot counselling services in primary care from which I accessed participants. I also include some evaluative audit data that provides a backdrop for this research. Finally I will lay out the structure of this thesis, by presenting a preview of each chapter.

1.1 PRIMARY CARE

This research inquiry is set in primary care in the surgeries of General Practitioners (GPs). These family doctors are the NHS' front line of routine patient contact. Primary care has been defined as 'first contact, continuous, comprehensive and co-ordinated care provided to individuals and populations undifferentiated by age, gender, disease and organ systems.' (Starfield 1994 p.1129). The National Assembly for Wales (2001a) proposed that primary care should provide effective first contact services, offer continuity of care, provide comprehensive services, co-ordinate services, offer personal care and improve population health.

There are changes in society, with the loosening of bonds of both family and community, and a degree of personal capital is required to make new relationships. Lay concepts of health are beginning to see unhappiness as conflicting with social norms and increasingly unacceptable on a societal and personal level. This leads to increased demands for health services and prescription drug use. At the same time, medical concepts of depression have

loosened in primary care, possibly due to drug manufacturers' marketing, alerting GPs to symptoms and offering hope of swift relief. (Shaw & Middleton 2001).

Over two thousand years ago the physician Galen commented that 60 per cent of people visiting their doctor suffered with symptoms that had an emotional rather than a physical cause. As then, so now, patients tend to somatize unhappiness and may present their emotional difficulties as physical symptoms. (Irving 1995). Around 40 to 60 per cent of patients' presenting symptoms often cannot be explained medically, and of the ten most common presenting symptoms in general practice, only 15 per cent will have a clearly attributed physical cause after one year. (Walton 2002).

1.1.1   Bringing therapeutic care into the GP's surgery

The potential of psychotherapeutic interventions in General Practice was probably first underlined by Balint (1964) who argued that a significant proportion of GP consultations involved psychological or emotional distress. This was so in many cases where it was only somatic (physical) symptoms that were presented. Balint further argued that the undergraduate medical curriculum should incorporate training in the use of psychotherapeutic techniques based on psychoanalytic principles, on the grounds that the best 'drug' that any physician could offer to the patient was the medical consultation itself. He used his psychoanalytic training to help GPs better understand their patients' needs, and to make more insightful responses to their patients' presenting problems. However, although Balint's work has profoundly influenced the way physicians are trained today, treatment is still mostly symptom-focussed and doctor-led. In contrast to Balint's call for family doctors to spend more time with their patients, typically GPs now have a consultation period of six minutes per patient, which is unlikely to improve under the newly introduced 'GP contract'. The number of referrals to clinical psychology services has risen with a consequent increase in waiting lists. In

an attempt to meet demand, Blakey et al. (1994) carried out a study of 100 patients referred by GPs for brief clinical-contact therapy. The therapy comprised two sessions arranged shortly after referral, without being placed on a lengthy waiting list, and a further, 'follow-up' session some three months later. A high number of patients reported satisfaction with the therapy received. When asked to what extent they thought their problems had been resolved, a significantly greater number reported feeling more competent to deal with their problems, than reported their problems were resolved. This may indicate that patients may not always be seeking a magical cure or 'quick fix', but rather, may be seeking skills and support to be better able to deal with life stresses. However, as might be surmised intuitively given the brief nature of this intervention, the least positively rated item related to 'sufficient time to talk'.

Blakey et al.'s (1994) findings contrast with Rowland et al.'s (1989) observation that patients who present with somatic complaints usually expect a somatic diagnosis. That is, they seek an indication that there is a physiological cause of their ailment, and they may resist a treatment or cure that only involves talking. Nonetheless, the situation today is increasingly of counsellors being employed in GP practices to address this need for working with individuals with emotional problems. (Papadopoulos & Bor 1998).

Counselling is now being funded within the NHS and surveys of patients show that talking therapies are preferred to medication. (e.g. Pill et al. 2001). In a survey of 1000 adults, nearly 60 per cent thought the NHS could do more to tackle mild to moderate mental health problems. (Norwich Union Healthcare 2004a). Yet research reveals a 'postcode lottery' for those seeking help, with substantial variability in the provision of psychotherapy and counselling in the NHS across the country, and in some places, no services at all. (Norwich Union Healthcare 2004a). Indeed, in a recent survey of more than 250 GPs, over 80 per cent admitted 'over prescribing' anti-depressants because there

was insufficient counselling available to meet the demand. (Norwich Union Healthcare 2004b).

1.1.2   The prevalence of psychological problems

According to surveys by the Office of National Statistics (ONS), the common mental disorders of depression and anxiety are two of the most important causes of disability in the community. Both are classified as neurotic disorders, which are in turn characterised by a variety of symptoms, such as fatigue, sleep problems, concentration difficulties, irritability, worry, panic and obsessions. These are present to such a degree that they cause distress and problems with daily activities. (ONS 2000b). On the basis of the most recent figures available, about one in six adults aged between 16 and 74 living in private households were recorded as having a neurotic disorder, such as depression, anxiety or a phobia. These mental health problems tend to affect women more than men, with 19 per cent of women and 14 per cent of men assessed as having a neurotic disorder. (ONS 2000a). Women were also more likely than men to be identified as having significant levels of both anxiety and depression. (ONS 2000b). The prevalence of treated anxiety is much higher among females than males. In 1998, 54 per 1,000 female patients in England and Wales were recorded as having been treated for anxiety by their GP, compared with 24 per 1,000 male patients. A sign that mental health issues are a growing concern, perhaps because of increased awareness, is that just four years earlier, the prevalence of treated anxiety was 42 per 1,000 female and 18 per 1,000 male patients. (ONS 2000a).

Most people who present with depression or anxiety are treated in primary care, that is, the General Practitioner's surgery. This is in accordance with current Department of Health (in England) and Welsh Assembly Government mental health policy that encourages secondary care to prioritise the severely mentally ill especially those with psychotic disorders. The main options for treatment in primary care are antidepressant medication and counselling, although as noted previously, counselling is not uniformly available. In 1998

in the UK there were over 23 million prescriptions for antidepressants, an 8% increase on the previous year, costing £320m and over double the number of prescriptions 10 years previously. (Middleton et al. 2001). In the ONS Psychiatric Morbidity survey for 2000, 4.5% of the population reported using antidepressants. (ONS 2002).

A number of concerns have arisen surrounding the prescription of antidepressants. There is a widespread view that patients are reluctant to take antidepressants and fear they are addictive. (Paykel et al. 1998). More recently general practitioners have also voiced disquiet about the increasing prescription of antidepressants and that relatively minor self-limiting states of emotional distress or 'problems of living' are being 'medicalised'. (Heath 2001). There has also been increasing awareness of withdrawal effects and possible increase of suicidal thoughts early on in antidepressant treatment. (Anon. 2003). The Drugs and Therapeutics Bulletin (2003) has suggested that primary care physicians should be reluctant to prescribe antidepressants in mild depressions and adopt a 'wait and see' approach. This reflects a concern that a large number of people could be receiving medication that is ineffective and possibly harmful. Recently published NICE guidelines (2004) take this further and recommend that GPs consider referring patients for counselling in cases of mild to moderate depression.

Considering the whole spectrum of mental illness, costs have been estimated at £77.4 billion in 2002, a figure that includes £12.5 billion as the cost of care (NHS, local authority, family and friends), £23.1 billion in lost output to the economy in people being unable to work, and £41.8 billion the cost in reduced quality of life, and loss of life, for sufferers. (Sainsbury Centre for Mental Health 2003). Given these levels of concerns it is not surprising that new methods of dealing with the common neurotic disorders, such as anxiety and depression, are being sought.

1.1.3   Department of Health policy

Counselling and psychotherapy have traditionally been available in the private and voluntary sectors, with a limited provision within psychiatric and mental health services. The Department of Health (DoH 1999) has called for the inclusion of psychological therapy to be provided in GP surgeries. In the United Kingdom it is estimated that 13 per cent of the adult population is affected by a mental disorder at any given time. Of these, 95 per cent attend their general practitioner at some stage during the course of their disturbance. (Goldberg & Huxley 1980). At present nine per cent of those with mental health problems are referred to secondary care services, whilst the overwhelming majority (91 per cent) are supported within primary care (DoH 1999).

Within the NHS National Service Framework for Mental Health (DoH 1999), standard two includes the following:

> 'Any service user who contacts their primary health care team with a common mental health problem should have their mental health needs identified and assessed [and] be offered effective treatments.....' (DoH 1999 p.28)

Standard three goes on to state:

> 'The majority of all health care is provided by the primary care team, and this should also be the case for *the majority of mental health needs* [italics added] (DoH 1999 p.28)

There is reference in the National Service Framework of non-directive counselling being 'less effective' (DoH 1999 p.30) for the treatment of depression, drawing on the work of Roth and Fonagy (1996). This could be an indication of a limited understanding of counselling, specifically of counselling in primary care, and certainly the bias toward a particular type of evidence and research methodology, (Eatock 2000), as I will explore in greater detail in chapter two.

'There is little acknowledgement that counselling has been welcomed into primary care *because* it is fundamentally different from medicine on approach, philosophy, values, and behaviour. Counselling has been deliberately invited into primary care as a diversified resource, seeking not 'cures', but understanding. To merge the evaluation of counselling with medical models (along with medical cultures and practices) is to deny its *raison d'etre.'* (Weiner & Sher 1995 p.147)

1.1.4   Welsh Assembly policy

The Welsh Assembly Government's National Service Framework for Adult Mental Health, (2002), outlines procedures for multidisciplinary services, stating 'comprehensive evidence-based psychological therapies must be accessible across Wales' (Key Action 26) and 'the majority of mental health care will remain within primary care as at present' (Key Action 33). Some 14 per cent of the population will be affected by mental health problems at any one time, and one in four will have some mental difficulty at some time in their life, with the majority going on to make a full recovery. (National Assembly for Wales 2001b). The Strategy Document also commented that 25 per cent of GP consultations have some mental health component, and that psychological treatments which are currently the domain of clinical psychologists will in future be offered by a range of multi-disciplinary practitioners.

1.1.5   Development of counselling in primary care

The provision of counselling in primary care developed piecemeal, reflecting the development of counselling as a profession. In 1993, only nine per cent of general practices in England and Wales had a practice counsellor. Thirty-one per cent of practices had one or more people undertaking counselling as a distinct activity, these included six per cent who had a clinical psychologist, 12 per cent a community psychiatric nurse, and five per cent a variety of others, including practice nurses and health visitors. (Sibbald et al. 1993). These findings were used to criticise the conduct of counselling in primary care, claiming only 50 per cent to be qualified in counselling. The findings showed some GP counsellors with little or no training or qualifications, and other

health professionals offering some form of counselling as part of their role. The situation was open to criticism as lacking in quality, standardised practice and accountability. Some counsellors acted on a voluntary basis, and do not exist within formal employment statistics. As a further complication, others were employed to act as counsellors, but due to funding regulations were given a job title that did not reflect their practice, and their counselling role was therefore invisible. (Dammers & Wiener 1995).

Questionnaire data collected in 1998 produced a picture of increasing professionalism, with 51 per cent of GP surgeries having a practice counsellor, and 75 per cent of those counsellors were qualified to at least Diploma in Counselling, and only six per cent with no qualification. (Mellor-Clark et al. 2001).

> 'This rapid growth of counselling in primary care has happened unofficially and almost by stealth over recent years until it has established a niche within many primary health care teams.' (Eatock 2000 p.161)

With the increase in provision, therapeutic services are now available to those less incapacitated by mental health problems. A distinction is made between treatment for severely mentally ill patients and the kind of counselling for life problems that is being offered in primary care. Referral guidelines are typically for those with 'mild to moderate emotional problems' (for example, Cocksedge 1997). Diagnostic decisions will depend upon subjective opinion, and to further complicate the picture, mental health problems are not necessarily constant, highlighting the problematic nature of reliance upon diagnostic categories, as I will discuss in chapter two. The current situation is in flux, with a move toward structured counselling services, often managed within an NHS psychology department (in Wales) or an NHS Primary Care Trust (in England). Such confusion prompts organisations such as the British Association for Counselling and Psychotherapy and the Association of Counsellors in Primary Care to push for increasing professionalism, qualifications and registration.

1.1.6   The nature of counselling in primary care

Financial resources in the NHS are always an important consideration, and in most cases, therapeutic counselling of a shorter duration is offered. Research continues to be carried out to ascertain the least amount of therapy that can be offered and still be effective. Counselling in primary care therefore requires an adaptation of the methods used in private practice or other settings, in terms of time-limited approaches, confidentiality ethics, note-taking, techniques of interventions, and dealing with referrals and missed sessions. 'As such, counselling in primary care is a specialised profession requiring specialist skills.' (Hudson-Allez 2000 p.211). Due to the lack of financial resources and in consequence, ubiquitous waiting lists, Hudson-Allez points to adjustments made by counsellors trained in a variety of theoretical approaches, to offering shorter-term work. Rather than making the client fit the counsellor's preferred way of working, the primary care counsellor fits the therapy to the specific presenting difficulties in a focused, time-limited way that works well for both of them, for example, Davidson et al. (1999), Hudson-Allez (2000). Counsellors 'try to adapt their ways of working to fit the contextual demands of working in primary care, rather than adhering to the methods of their training.' (Hudson-Allez 2000 p.205).

In particular, Hudson-Allez comments upon the pressured nature of the GP surgery environment. For example, patients being seen one after another without space for reflection between appointments, often in the doctor's own consulting room, noise filtering through from the waiting room, and not uncommonly, a doctor or receptionist, perhaps looking for notes or a quiet place to work, walking in on the counselling session.

Where there is counselling provision, the client group is likely to be one that has not traditionally had easy access to psychotherapy or counselling. Many clients who receive counselling at their GP practice would not have sought counselling elsewhere. They may either not have known how or where to find a good counsellor, or needed encouragement by the GP or other referrer to

see a counsellor. (Keithley 1995). Financial considerations are likely to be another reason for patients not seeking professional counselling.

1.1.7   On the matter of limited sessions

As explained above, counselling offered in primary care has developed as a specialism adapted to the unique environment of the Health Service. The work needs to be managed to fit within limited resources, so it is likely to be time limited or 'time conscious'. (Elton Wilson 1996). Time limits have the effect that not all of the client's difficulties can be addressed. Outcome studies tend to suggest that there is no measurable difference in therapeutic outcomes between long-term and short-term therapies. (e.g. Sabin 1992, Cade & O'Hanlon 1993). Time-limited therapy is helpful to a substantial proportion of clients, and is often as helpful as time-unlimited therapy. 'It can be said both that brief therapy is helpful, and that longer term therapy can be even more helpful.' (Messer & Wachtel 1997 p.8). 'Overall, research supports the value of both brief and moderate-term psychotherapy'. (Messer & Wachtel 1997 p.9).

In the US, private insurance-based managed health care is accessed by those eligible for sessions. Under this scheme, psychotherapy and psychological counselling are subject to a strictly limited number of sessions. This has reduced the autonomy of therapists, but may also 'motivate therapists to achieve their goals more quickly and effectively'. (Messer & Wachtel 1997 p.27). 'Time-limited therapy' is not necessarily of longer duration than 'open-ended therapy'. As noted by Barkham (1996), the average number of sessions of open-ended counselling can be between five and seven sessions. Howard et al. (1986) combined 15 outcome studies over 30 years and showed that while the percentage of clients improving gets higher as a result of more sessions, the greatest improvement occurs early in therapy and there are diminishing returns thereafter. For some more severely 'damaged' clients 'effective therapeutic work may not be possible until considerable work has

been carried out in establishing, for example, the therapeutic alliance.' (Barkham 1996 p.46). Thus,

> '[w]hat this means is that there are clients for whom briefer therapies are appropriate and clients for whom longer therapies are appropriate. The issue is to determine what is best for each client. It is not necessarily true that more therapy is always the preferred option.' (Barkham 1996 p.46)

This is not universally agreed within the profession, and Totton (1997) for example complained that the therapeutic value of restricted session work is limited. However, the daily reality is that 'in primary care there is not a choice between short-term and long-term therapy. It is usually a fiscal choice between short-term or no therapy at all.' (Hudson-Allez 2000 p.205).

1.1.8   Patient motivation for counselling in primary care

Missed appointments are higher when patients are not paying for the service, (e.g. Buckley 1999). A number of factors may be in operation. In other settings seeking counselling is usually an active choice on the part of the client, whereas in primary care the patient may feel obliged to attend to see the counsellor because they have been 'sent' by the doctor. They then may become reluctant to engage with the counselling work, or may 'drop out' and become part of the 'did not attend' (DNA) statistics. 'Although resistance is a concept that most therapists have to face in their work, reluctance to attend can be more common in primary care.' (Hudson-Allez 2000 p.211).

Whilst high numbers of missed appointments are commonplace in the NHS, this does not necessarily denote a reluctance to engage in counselling. As previously noted, about 90 per cent of people regarded by psychiatrists as having symptoms of depression and anxiety are treated in primary care, and it is claimed that up to a further 50 per cent of cases may go undetected in the GP's surgery. (Goldberg & Huxley 1992, Wright 1996). Pill et al. (2001) conducted focus groups in the South Wales Valleys to elucidate views from the general public regarding consulting their GP when concerned about

emotional problems. Their findings indicated that people often dismiss emotional problems as 'just part of life' and as inappropriate for the doctor's attention. For those who recognised the problem as an 'illness', often there was doubt as to whether the doctor was the best person to help, and antidepressant medication was often viewed with suspicion. From the focus group data, it emerged that if members of the public were to suffer from emotional distress, they would prefer to consult with a trained counsellor rather than a GP, nurse or psychiatrist. These findings are particularly noteworthy as the focus groups were drawn from rural and Valleys Wales in addition to urban settings, and were balanced for age and gender.

1.1.9 Section summary

Government health policy promotes support for the majority of people with emotional problems to be based in the primary care setting. I have explored the adaptations made by counsellors when counselling takes place in primary care. Counselling has been a growth activity in this setting over a number of years, and at the present time, there are studies to indicate the lay public's preference for counselling over more traditional support from GPs, nurses or medication.

1.2 COUNSELLING AND PSYCHOTHERAPY

In this section I will offer an overview of counselling and psychotherapy as they are portrayed in the literature by practitioners and teachers in the therapeutic domain. I will consider some of the definitions published of counselling and psychotherapy, and explore the varieties of therapy as they are 'written' rather than as they are 'performed'. Such textual representations may, or may not, refer to features that are replicated in practice. I will present some observations regarding the practice of therapy, the settings where it takes place, and the people who attend. I will then look at the different theoretical approaches to therapy. Finally I will move on to look at arguments for the integration of these therapeutic systems into a more

generic form of therapy, with the identification of common features across the various therapies.

1.2.1   Defining counselling and psychotherapy

Counselling and psychotherapy have been described as contemporary versions of forms of healing, reconciliation, adjustment and meaning-making that exist in all cultures. (J.D. Frank 1973).

> 'Counselling is the skilled and principled use of relationships which develop self knowledge, emotional acceptance and growth, and personal resources. The overall aim is to live more fully and satisfyingly. Counselling may be concerned with addressing and resolving specific problems, making decisions, coping with crises, working through inner feelings and inner conflict, or improving relationships with others. The counsellor's role is to facilitate the client's work in ways that respect the client's values, personal resources, and capacity for self determination.' (Rowland et al. 2000 p.222)

There are two definitions of counselling that are in popular use, and these are apparently mutually exclusive. (e.g. Bond 1995, Ferwerda 2004). One relates to counselling as offering advice and other forms of helping, with the wise counsellor as advice-giver dating back many centuries. The second definition refers to therapeutic counselling in psychological and social care, with counselling used as a term to describe a therapeutic activity. This emerged when Carl Rogers started working as a psychologist in America in the 1920s, at a time when the practise of psychotherapy was restricted to medical practitioners. Rogers was also keen to 'democratize' therapy, emphasising the autonomy of the client, and the importance of the client's contribution to the endeavour, which was in contrast to the established forms of psychotherapy practice that placed the person seeking help firmly in the role of 'patient'. Bond (1995) noted that 'two major ethical principles are closely associated with this way of counselling: respect for the client's capacity for self-determination and importance of confidentiality.' (Bond 1995 p.5).

In total over 400 forms of talking therapy have been differentiated. (Corsini & Wedding 1984). According to Horton (2000), there are four elements common

to all models of counselling. Firstly they have basic assumptions or philosophy; second, they have formal psychological theory of human personality and development; third they have principles and processes of change; and lastly they have related therapeutic operations, skills and techniques.

The practice of counselling

The professional title 'counsellor' is not protected by government charter, such that anyone may call themselves a counsellor. Not everyone is considered suitable to be offered counselling. According to Isaacson & Waller (1999), clients need to show curiosity about why their life is the way it is. They should have the ability to take responsibility for their problems and be able to imagine their life changing.

Counsellors and therapists consciously use reflective techniques to enable clients to gain awareness and insight into their own behaviour and actions. (e.g. Atkinson 1993). The experience of being in counselling has been described as:

> '...one of the more intense human experiences for both client and counsellor. For the client, the counselling hour may represent an oasis of meaningful communication amidst a life filled with manipulative relationships, unexpressed feelings and a sense of hopelessness. Counselling can also be a frightening experience with the client finding himself coming face to face with difficulties he has pushed aside for many years. Clients' experiences in counselling are as varied as the clients themselves, but the *intensity* of the experience tends to be the common feature.' (Mearns & Dryden 1990 p.vii)

As it developed and expanded, counselling has been adapted and modified, as it has taken root in an increasing variety of settings, for example, within the NHS, social services, psychotherapeutic communities, in organisations, as well as the voluntary and independent sectors. It is claimed that the majority of counselling is carried out by volunteers or paraprofessionals, in the not-for-profit sector. (Armstrong & McLeod 2003). In healthcare settings psychotherapeutic practice is carried out by counsellors, psychotherapists and

counselling psychologists, each of whom are attempting to carve out professional identities. For example, counsellors make a case to be valued separately from nurse-counsellors (e.g. Sharman 2003), and counselling psychologists set themselves apart from clinical psychologists:

> 'Counselling psychology derives from a different philosophical tradition to clinical psychology, humanistic rather than experimental. It argues that the most crucial factor in healing is not what we do with clients but how we are with them. In this formulation the emphasis is placed on the power of the therapeutic relationship (being) rather than the application of specific skills or techniques (doing).' (Woolfe 2002 p.169)

In addition to the formal counselling carried out by counsellors, psychotherapists and counselling psychologists, increasingly many mental health professionals, particularly community psychiatric nurses (CPNs) and social workers undertake counselling or psychotherapy training and seek to integrate counselling into their daily role. There is the potential for role confusion. 'Psychological therapy' is a broad term based on communication between professional and client, usually talking, and the building up of a respectful, trusting relationship. Its ultimate aim is to help the client with their psychological difficulties. As Freeth (2001) noted, the term counselling is often loosely applied in psychiatric settings. She claimed that there is a danger that counselling ceases to be understood as a clearly defined and specific activity offered by someone who has undergone a counselling training course.

> 'While mental health services and professionals within them are not always clear about what counselling is, and misapply the term, it will remain difficult for counsellors to establish a clearly identifiable and credible role within such services.' (Freeth 2001 p.16)

Psychotherapy and counselling: similarities and differences

Psychotherapy as a professional activity and academic discipline is much older than the counselling profession. (Freeth 2001). Counselling has been described as more superficial, with psychotherapy having a more intensive and time-consuming aim of deeper re-organisation of the personality. However, equally, the most intensive and successful counselling is

indistinguishable from intensive and successful psychotherapy. (Rowan 2001). There is evidently a paradox, in that psychotherapy and counselling are different, and they have different histories and associations, while at the same time, they are the same and have many identical interventions. (Rowan 2001). It can also be argued that it is the context that determines the work undertaken, not the training of the practitioner, nor the name given to the work. The context may determine a specific focus, such as relationship difficulties in a 'marriage guidance' agency, or health-related and existential issues in a cancer care centre. The context also determines whether counselling is short-term, for example, six to eight sessions, or whether a longer-term, or open-ended, agreement is offered.

Much of the confusion and debate in the field stems from there being no clear definition of what therapy actually is. Rowan (2000) proposed two kinds of therapy. Firstly, adjustment therapy, which is dedicated to cure. The client comes for relief, and removal of painful, even disabling, symptoms. Client and therapist agree what is wrong, and a plan can be agreed for a restoration of normality. Secondly, liberation therapy, which is dedicated to emancipation. The client may come in with similar symptoms but soon reveals that more is involved, or may bring vague complaints but no specific symptom focus. According to Rowan, such a client is in need of personal growth. Some of the psychotherapies draw more naturally toward the adjustment or to the liberation. The thrust of Rowan's argument is that viewing only one aspect of therapeutic work limits one's view and understanding of therapy. (Rowan 2000).

Given the confusion in the field, and lack of agreed distinction, for the purpose of this study I have chosen to use the terms 'psychotherapy' and 'counselling' interchangeably, whilst acknowledging that the counselling service used by the participants in the research offers 'counselling' carried out by professionally trained 'counsellors'.

1.2.2   Psycho-therapeutic approaches

The field of psychotherapy rests upon foundational beliefs, which are the basic propositions generally taken for granted as fundamental givens or truths. (Mahrer 2000). As I will expand upon below, the three key approaches of psychotherapy are psychodynamic, cognitive-behavioural and humanistic-existential. More recent adaptations include, amongst many others, systemic approaches and narrative therapy. Integrative approaches seek to combine or integrate the schools and techniques of the disparate groups.

Psychodynamic approach

The foundational beliefs of Freud's psychoanalysis (e.g. 1940) focus on biological drives, which if repressed, lead to neuroses. Later theorists and practitioners have deviated from Freud's theory and developed it to emphasise the importance of early relationships, for example, Jung, Adler, object relationists such as Winnicott and Guntrip, Bowlby who identified the importance of attachment, the self-psychologist Kohut, through to present day psychodynamic writers, such as Malan and Jacobs. (see, for example, Burton & Davey 1996, Gomez 1997). This approach promotes:

> '...considerable interest by the counsellor in the difficulties of early childhood relationships with significant others, particularly the mother. In some hands this can become a narrative of the patient in terms of being a victim of parental oppression (see Alice Miller, 1983) and offers as a vision of cure the possibility of a reparative relationship with the therapist as the 'good enough' mother.' (Burton & Davey 1996 p.115)

The practice of the therapy involves the analyst or therapist making expert, knowledgeable interpretations of the patient's behaviour, psychological defences and relationship styles. With the insight gleaned from this information, the patient no longer needs to continue the familiar behaviours that are unsatisfying, based on transferring feelings from an earlier relationship onto this present one, and can adopt new ways of relating. (Burton & Davey 1996).

Cognitive and behavioural approaches

The behavioural approach originated with Pavlov and continued through the work of Skinner (1953), who understood human development in terms of learning theory. This has led to present day therapies that regard phobias and problem behaviours as unhelpful learned responses that can be unlearned. The approach has been further combined with theories of cognition, which consider the interpretation of events as troubling, rather than the events themselves. Once depressed, the patient's thoughts become characteristically negative, as described by Beck et al. (1979). The therapy seeks to re-educate the patient to be more flexible, and less negative, in how events are understood. (Scott & Dryden 1996).

> 'The focus on thoughts does not mean that cognitive therapists believe that thoughts cause all problems. However, thoughts play a powerful role in maintaining dysfunctional moods and behaviors regardless of their origins. For example, a woman may become depressed following a great personal loss in combination with a genetic predisposition toward depression. Even if her depression is conceptualised as resulting from environmental and biological stressors, a cognitive focus would then be an important part of the treatment.' (Padesky & Greenberger 1995 p.4)

According to Padesky & Greenberger (1995), a positive therapist-client relationship is a critically important foundation for successful therapy. Clients are most likely to discuss problems honestly and openly in a relationship that seems safe and trustworthy. The best cognitive therapists are warm, empathic, and genuine with their clients, which are qualities basic to any good therapeutic relationship.

Humanistic-existential therapies

Both the psychodynamic and cognitive-behavioural approaches are essentially deficit models, viewing the therapist as provider of knowledge and skills that the patient does not have. By contrast the 'third force', humanistic, claims to offer a human potential model. Maslow's underlying philosophy (e.g. 1970) is that as a unique individual, everyone has the capacity within themselves to reach their full human potential for self-actualisation. This is represented in

therapy through, for example, Rogers' theory (e.g. 1961) that embraced concepts of ideal and actual self, and conditions of worth. (McLeod 1996). A further dimension within this 'third force' is the existential-phenomenological, which draws on the philosophy of Husserl, Heidegger and Sartre. Here,

> 'therapy is not something that one has done to oneself by another who has quasi-magical ways of 'making you better'. Rather, therapy is the opportunity to look at oneself more accurately and realistically in order to explore, reconsider and possibly choose to alter the various meaningful conclusions arrived at in the past and better understand how such conclusions may have limited one's potentialities for being and, hence, be the 'source' of current unhappiness or disturbance.' (Spinelli 1989 p.130)

Systemic and narrative approaches to therapy

In systemic approaches to therapy the client is viewed not as an isolated being, but as located within wider systems of family, workplace, community, and society. This approach recognises that individuals both influence, and are influenced by, the environment they find themselves in. In narrative therapy (e.g. White & Epston 1989) the story of clients' lives, which develops in therapy, is not considered a 'real' history, archaeologically reconstructed, rather, it is but one possible narrative, perhaps more orderly, detailed, and coherent than the pre-therapeutic one, but not necessarily more true. (Omer & Strenger 1992). In this approach, psychotherapy becomes:

> 'a narrating and renarrating of one's story, in the process of which the story gets elaborated, transformed, and repaired'. (Messer & Wachtel 1997 p.13)

The integration of therapies

There has been a rise of psychotherapy integration since the 1970s. According to Roth and Fonagy (1996), ultimately, theoretical orientations will have to be integrated, since they all approximate models of the same phenomenon, that is, the human mind in distress. Many therapists describe themselves as 'integrative', some using a theoretical model that intentionally integrates aspects of two or more approaches (e.g. Clarkson 1995), others using their own preferred combination. Initially practitioners used the term 'eclectic' to denote their use of skills from a range of therapies to be utilized in

response to a client's presenting problem. However, what differentiates such a combined approach from an integrative therapy is the presence of an overarching integrative theory which binds the various therapeutic approaches in terms of some higher-order theory or model. (Barkham 1996). Others present generic helping models, such as Egan (2002).

In addition to this acknowledged integrative theory, there is also evidence to suggest that therapists from differing approaches operate using similar interventions under different names, for example, Fiedler (1950) showed how experienced therapists from different orientations were more similar in their client-work than they were with novice practitioners within their own approach.

1.2.3 The centrality of relationship

The centrality of the therapist – client relationship is widely recognised, and the findings of psychotherapy research have identified this factor as perhaps of the greatest importance alongside therapeutic technique. 'The capacity to develop a treatment alliance is likely to be the most important mediator of therapist experience.' (Roth and Fonagy 1996 p.356). The notion of therapeutic alliance originates within the psychodynamic perspective, as a 'pact' between analyst and patient (e.g. Freud 1940). Others, for example Bowlby (1988) considered the alliance itself to be curative. Equally, the relationship between counsellor and client is also understood as the essence of humanistic therapies. From a cognitive-behavioural standpoint, social learning theory would suggest that the client's perception of the therapist as expert, attractive and trustworthy will enhance the therapist's influence and increase the benefit from therapy. (Roth and Fonagy 1996). Clarkson's (1995) theoretically integrative relational model is predicated upon the relationship between therapist and client, describing all aspects of the therapeutic work as being performed within five discourses, or domains, of relationship: namely, the relationship of the working alliance, the relationship of the transference/ counter-transference, the relationship of the reparative or developmentally

needed, the relationship of the person-to-person, and the relationship of the transpersonal.

1.2.4   Section summary

Whilst the profession of counselling and psychotherapy has its roots in discrete theoretical schools, the present position appears to be one of integration. This is developed uniquely by individual practitioners, or captured within a theoretically integrated model such as Clarkson (1995). Within the analysis of this present study I will look for evidence of this integration within the client narrative accounts of their counselling. Perhaps with the exception of narrative therapy, counselling and psychotherapy can be seen to take a modernist position whereby there is understood to be an underlying cause or base of pathology. The location of this cause is seen to be within the individual or their relationships, there is a means of diagnosing the pathology or deficit, and there is a means of eliminating the pathology. Narrative therapy actively uses the narrative itself as the vehicle for change. With all approaches, 'problem' narratives are thus replaced by alternative, more upbeat ones. All theoretical orientations, to a greater or lesser degree, acknowledge the essential nature of the relationship between therapist and client.

1.3 SETTING FOR THIS STUDY

In this section I will offer details of the two counselling services through which I recruited my interviewees. I include some descriptive material, and present a summary of data collected as a means of evaluating the services. These evaluative data were used to secure further funding and expansion of the counselling service.

I accessed former counselling clients who had received their counselling through one of two managed counselling services in primary care, North Oaktown Group and Ashville Group (both pseudonyms). These were evaluated pilot projects, each of which had received funding from their Local

Health Groups to offer counselling to patients referred by GPs. Counsellors were based in GPs' surgeries, and the services were to operate for two years and one year, respectively. The North Oaktown service was funded from June 2000 to May 2002, whilst the Ashville service was funded from April 2001 to March 2002. Both services were under the management of the same NHS Trust Psychology Department. At the close of the pilot projects, an expanded counselling service, covering the whole of Oaktown, Ashville, and the surrounding area, was funded.

North Oaktown Group comprised seven GP practices with a total patient population of approximately 56,000. Ashville Group comprised ten practices with a population of about 55,000. Counselling provision was allocated on a pro-rata basis based on patient population per practice. Both localities contain a mix of housing and socio-economic groups, and both have older housing, 1960s social housing estates, and modern residential developments. The counselling services were described as offering a structured approach, of typically six sessions. There was no prescribed theoretical approach to the work, and the counsellors had training in a variety of generic counselling and specific approaches. A total of eleven counsellors were employed, each on a part-time basis, and all were accredited by BACP or of accreditable standard, that is, having achieved a diploma in counselling (two to three years' training) plus 450 client contact hours. Some had further qualifications, most commonly, an MA in Counselling.

The client group were specified as those with mild to moderate mental health problems. Referral guidelines were developed following Cocksedge (1997), and were issued to GPs to assist with referral decisions. Referral criteria included mild to moderate depression and/or anxiety, bereavement, response to physical illness, response to trauma, and relationship problems. A copy of the guidelines is included as Appendix 1. Typically, referral for counselling was suggested by the GP, although patients themselves may request a referral. At the time of the study, the service was newly introduced and little known in

the local community. Private counsellors and therapists were available locally, and there was some voluntary sector counselling provision, usually with long waiting lists. However, my experience as a counsellor in this setting suggested that most people were unaware of the voluntary sector provision, and the majority of clients did not consider paying privately to be an option. The primary care setting appeared to recruit individuals into counselling who may not otherwise have sought, or been offered, any kind of talking therapy.

1.3.1   Recording the client population

As the first of the evaluated projects, North Oaktown Group counselling service was evaluated through the use of four measures, which included Clinical Outcomes in Routine Evaluation (CORE) and a client opinion questionnaire.

Clinical Outcomes in Routine Evaluation (CORE) is a comprehensive evaluation measure (Mellor-Clark et al. 1999), developed to answer some of the criticisms made against the talking therapies as being 'unscientific and unproven'. The authors' stated intention is to compile a large database of pre- and post-test scores to demonstrate the efficacy of counselling and psychotherapy. (Mellor-Clark & Barkham 2000). In utilising this measure, CORE forms are completed in part by the client within the session, and in part by the counsellor. They include pre- and post-test measures of subjective well-being, in addition to demographic information (age, gender, marital status, employment status, ethnicity, etc.). They also record reasons for referral, presenting issues, severity of symptoms, changes in medication, number and frequency of sessions, type of counselling undertaken, and factors relating to how the counselling was ended (such as planned, or 'dropped out'). The cut-off point to determine 'clinical population' was set using data from university students, staff and friends, representing a non-clinical population (n = 1,106), contrasted with clinical data from a number of sources that included NHS therapy services, a student counselling service, and a staff counselling service (n = 890).

The locally developed client opinion questionnaire (McBride 2002) was returned by the client anonymously by post at the end of counselling. It contained mostly fixed-choice questions relating to service provision, for example, satisfaction with pre-counselling information, waiting-lists, and number of sessions. There was also a space inviting clients to comment on the service they had received.

In her unpublished doctoral thesis, (McBride 2002), the counselling services manager reported very high GP satisfaction with the service, reduction in referrals to the Community Mental Health Team (CMHT), and reduction in 'did not attend' (DNA) rates for assessment at the CMHT.

By way of describing the setting from which my interviewees were drawn, I will present a summary of results, drawing on McBride (2002), using both CORE forms (completed by counsellor and client), and the Client Opinion Form (completed by the client). The evaluation data covers a two-year period for North Oaktown, and one year for Ashville, and offers detail of the client population in the counselling services from which my interviewees were drawn.

1.3.2   Results of CORE evaluation

1) Demographic data

Data were received from 493 clients in North Oaktown and 311 clients in Ashville. As would be anticipated, similar figures were recorded for gender and age across the two services. The gender spilt was 72% female / 28% male in North Oaktown and 71% / 29% in Ashville. Age range was 17 - 73, with an average 39 years, in North Oaktown, and 17 - 72 in Ashville, average 36 years.

2) Clinical populations

Referral criteria to the counselling service are 'mild-to-moderate' emotional difficulties, (Cocksedge 1997), although CORE audit data suggests that this is not always the case, and that many clients fall within a 'clinical population' for mental ill-health. (Mellor-Clark et al. 2000). The CORE data offers evidence of movement from a clinical population to one which reflects a non-clinical population. In North Oaktown 50.0% of clients achieved reliable and clinically significant change, in Ashville the figure was 60.7%. This is further detailed below in sub-section 8 'client outcome'.

3) Waiting time

Counsellors managed their waiting list individually. Some doctors made many referrals, other very few. As this counselling provision was new, initially there were no lists, but in some surgeries, lists grew rapidly. The mean average waiting time in North Oaktown was 15 weeks. In Ashville the mean was 5 weeks. Since the North Oaktown figures are from two years' service delivery, this may illustrate the increase in waiting lists over time.

4) Medication

In North Oaktown 67% of the clients were taking prescribed medication for psychological problems at the time of referral, and of those, 91% were taking anti-depressant medication. In Ashville the figure was 52%, of whom 94% were taking anti-depressants. It is not clear why a greater proportion of patients were prescribed medication in North Oaktown than in Ashville, although this may reflect differences in GP attitudes and practice.

5) Identified problems / concerns

The percentage of clients identified with specific difficulties was as follows in table 1.1:

Table 1.1 Identified problems

Identified Problems/ Concerns	North Oaktown	Ashville
Anxiety	80%	94%
Depression	73%	81%
Inter-personal problems	51%	45%
Self-esteem	43%	38%
Bereavement/ Loss	34%	37%

This total is greater than 100% as many clients were identified as having more than one problem or concern. A very high percentage of patients are identified as having anxiety, especially in Ashville. This may reflect subjective opinion, in that the form is completed by the counsellor. Clients were not formally assessed using psychological assessment tools.

6) Length of counselling intervention

The counselling services offered a 'structured approach' which placed a limit on the number of sessions available, described as 'typically six sessions'. Clients were not necessarily seen weekly. In North Oaktown the average length of counselling contact was ten weeks, with the average number of sessions being six. In Ashville the length of counselling contact averaged at eight weeks, with the average number of sessions being four. A closer analysis of the findings showed that the Ashville results include data from clients who attended for one session only, which had the effect of making the mean client contact of shorter duration.

7) Type of counselling intervention

Counsellors identified their counselling approach as follows:

Table 1.2 Type of counselling intervention

Intervention	North Oaktown	Ashville
Person-Centred	37%	39%
Cognitive-Behavioural	43%	48%
Supportive	22%	32%
Psychodynamic	35%	19%
Structured/ Brief	28%	17%
Cognitive	15%	6%
Integrative	56%	12%

The sum of these figures is greater than 100%. It may be that counsellors used a combination of approaches when working with a client. There are also marked variations across the two services, which may be due to their being only a small number of counsellors working in the services, such that data are easily skewed.

8) Client outcome

Table 1.3 Outcome of counselling

	North Oaktown n = 172	Ashville n = 81
reliable & significant change	86 (50%)	51 (61%)
reliable change	28 (17%)	13 (16%)
no reliable change	54 (31%)	18 (21%)
deteriorated	4 (2%)	2 (2%)

Not all clients completed pre- and post-test client outcome forms, for a number of reasons, for example, where the client failed to attend the final session. In North Oaktown completed forms were available for 172 clients (35% of the total), and for Ashville 81 clients (23% of total). Of those referred to the service, some may attend for assessment, thus completing a client outcome form, but may not choose to continue for the counselling sessions, or may not be considered suitable for short-term counselling and be referred elsewhere. The returns thus represent a minority of the total referrals, and show that if clients continue to attend through until the end of

the therapy, they are likely to have made improvements to their well-being. However, in common with other counselling evaluations, they say nothing of those who do not attend the final sessions, or those who drop out earlier in the work.

1.3.3   Seeking the clients' opinion

This second set of findings, summarised below, were collected and presented in full in McBride (2002). Clients were given 'freepost' envelopes in which to return evaluation forms to the NHS Trust psychology department. From a range of questions, I present findings from those most relevant to the client experience of counselling addressed in my research. Clients were asked to comment on waiting times, how well understood they felt, whether the counselling was useful, the number of sessions offered, and whether the counselling had helped with their problems. In contrast to the CORE data presented above, which emphasises the clinician's views, the data from client opinion forms can be seen to gather an evaluative response to the quality of service received.

1) Waiting time

How satisfied were you with the waiting time for your first appointment?

Table 1.4 Satisfaction with waiting time

	very satisfied	**satisfied**	**dissatisfied**	**very dissatisfied**
North Oaktown n = 103	29 (28%)	41 (40%)	22 (21%)	11 (11%)
Ashville n = 80	39 (49%)	30 (38%)	10 (13%)	1 (1%)

2) Empathy

Did you feel understood by the counsellor?

Table 1.5 Experience of empathy

	well understood	understood	Not understood	misunderstood
North Oaktown n = 104	78 (75%)	26 (25%)	-	-
Ashville n = 83	66 (80%)	17 (20%)	-	-

3) Usefulness

Did you feel that the counselling you received was useful?

Table 1.6 Usefulness of counselling

	very useful	useful	not useful	unhelpful or wrong
North Oaktown n = 107	76 (72%)	28 (27%)	-	-
Ashville n = 83	60 (73%)	23 (27%)	-	-

4) Number of appointments

Were you satisfied with the number of appointments you were given?

Table 1.7 Satisfaction with number of appointments

	very satisfied	satisfied	dissatisfied	very dissatisfied
North Oaktown n = 40*	26 (65%)	12 (30%)	1 (3%)	1 (3%)
Ashville n = 82	45 (54%)	32 (39%)	4 (5%)	1 (1%)

5) Help in dealing with problems

How helpful has the counselling been in helping you deal with the problem(s) that led to your referral?

Table 1.8 Helpfulness of counselling

	very helpful	helpful	unhelpful	very unhelpful
North Oaktown n = 39*	26 (67%)	11 (28%)	2 (1%)	-
Ashville n = 80	54 (66%)	26 (32%)	2 (3%)	-

6) Improvement

Overall, has the problem(s) improved as a result of counselling?

Table 1.9 Improvement as a result of counselling

	improved a lot	improved somewhat	no change	worse
North Oaktown n = 39*	18 (46%)	18 (46%)	3 (8%)	-
Ashville n = 82	45 (55%)	31 (38%)	6 (7%)	-

*These findings are taken from unpublished service evaluation reports. (McBride 2002). The low returns from North Oaktown for some questions suggest that some data were omitted from the inputting process.

1.3.4   Section summary

In this section I have offered a description of the development of the two counselling services from which I drew my interviewees. I paid attention to the evaluation procedures conducted in the counselling services, and offered a selection of findings presented in the counselling manager's unpublished doctoral thesis. (McBride 2002). Whilst the majority of comments are overwhelmingly positive, a few critical notes are made, in particular concerning waiting times, and for some, of there being no discernable change in the problems that brought them to counselling. Inevitably, such an evaluation tool does not record the nature of 'the problem'. My choice of findings to present here reflect the aspects of counselling that clients brought forward in their interview narratives in this present study. I will expand upon

matters relating to client opinion with respect to my own interview data in chapter four, and further, in the discussion in chapter six.

1.4 STRUCTURE OF THIS THESIS

In this introductory chapter I have set out to show what it is that distinguishes counselling in primary care from counselling in other settings, how counselling as an activity and as a treatment of choice has developed in the primary care setting, and how government policy supports the provision of counselling in primary care. This chapter also contains a detailed description, including evaluative data, of the counselling services that formed the setting for this study.

In chapter two I offer a brief review of the literature regarding different types of research in the therapeutic field. There is a body of research devoted to the effectiveness and efficacy of psychological therapies seeking to answer the questions: does therapy work? which therapies work better than others? and which therapies work better with which group of patients? (see, for example, Roth & Fonagy 1996). This research tends to be quantitative, based upon the medical model and assumes a degree of homogeneity amongst patients and their symptoms not seen in a real-world population.

Over 400 therapies have been identified (Corsini & Wedding 1984) and there is a considerable literature written to support particular models of psychotherapy. Studies to ascertain effectiveness of therapeutic treatments use randomised controlled trials that treat therapy as a standardised given, and their results are used to promote certain treatments in preference to others, for example, in the NHS, cognitive behavioural therapy. (Department of Health 2001). However, it is claimed that certain research methods favour certain therapeutic approaches, and further, the challenge to the notion of discrete disorders puts the whole matter of evidence based practice in doubt. (e.g. Marzillier 2004). There is also challenge to the notion of 'schoolism' and

the claim that any one theoretical approach is more effective than another (e.g. Clarkson 1995). It appears that generic factors, that are common across all theoretical orientations, are the significant change agents. (e.g. J.D. Frank 1973, Asay & Lambert 1999).

I also look at the literature on client views, normally collected using qualitative methodology, however the data have been gathered from a variety of counselling settings, for example, marriage guidance, family centres, community counselling centres, and the research is of specific client groups, with specific presenting problems, and/or using a specific approach to the work, for example, an unlimited sessions psychodynamic approach. In chapter two I also acknowledge those clients who have published accounts of their therapy, and describe the sociological concepts that I will later draw upon in the discussion of my findings.

In chapter three I present a detailed account of how this study was carried out, including design decisions, recruitment of participants, procedures for data collection and analysis. I discuss the use of thematic analysis of content, a form of discourse analysis, in order to analysis the data collected through the in-depth, individual interviews. I also include an account of how the focus of the enquiry broadened from its initial focus of clients' perception of counselling, and the presentation of self and their life-world, to include contrasting stories of other forms of therapeutic intervention.

Themes that emerged through the interviews are explored in the next two chapters, beginning with the voice of the client on counselling in chapter four. Firstly I present clients' evaluative accounts of their counselling. There are debates in the field that centre on whether there are specific effective factors, or whether generic features are the essence of successful therapy. I examine the factors that clients drew upon to explain the success or failure of counselling. I identify factors in clients' accounts of their counselling, which

formed three clusters, namely relationship factors, specific interventions, and contextual factors relating to short-term counselling in the doctor's surgery.

Also in this chapter are contrasting accounts of those who had experienced some form of therapeutic intervention other than in primary care, such as from secondary mental health care services, both prior to the GP counselling and since. Around half of the interviewees had received some other form of therapeutic support. Client accounts contained many comparisons between the GP counselling and these other episodes. For the majority, but not all, the GP counselling was evaluated more favourably than other forms of professional support.

I then look at how people described their expectations and hopes of counselling. Interviewees drew on their own personal previous experience of therapeutic counselling, on the experience of others, and also on media representations. In this chapter I also look at client accounts of change, including those who felt they had not benefited and who described their counselling in primary care as less than satisfactory, or disappointing. The counselling was presented as having one of three outcomes. Firstly, significant improvement and the problem was resolved, or was no longer an issue. Secondly, some degree of improvement, but the problem was not fully resolved, or where the client felt more able to deal with the problem. Thirdly, where the counselling was not satisfactory or was not what the client wanted.

In chapter five I use sociological concepts to further the analysis of client accounts, in the voice of the client on self. I firstly look at how people accounted for their being a client. This chapter comprises themes of the origins of clients' troubles. I examine factors that are drawn upon by clients and the nature of difficulties or causal factors presented. The origin of difficulty was presented as located in difficult or strained relationships with family members or at work, currently or in the past. These troubled relationships can be described as 'loss', firstly loss of the 'good' relationship to

which one is morally entitled; secondly, loss of another, through bereavement, or of a relationship, through divorce, and thirdly, loss of health, in oneself or others in the client's close family.

In this chapter I also consider moral accounts and identity narratives in the presentation of self. According to A.W. Frank, (1995), there is a moral imperative to present ourselves and construct an identity as people with morals and integrity. I examine how former counselling clients construct their identities as persons of moral integrity and the kinds of moral tales that are presented, with reference to themselves as people who have had counselling, and with reference to the taking of medication. Interviewees presented accounts of themselves as essentially strong people, with integrity, who had encountered a situation that was too much too deal with alone. In this chapter I chart client accounts of identity as a sufferer and the various current life positions as 'cured' of their symptoms, 'managing' their problems, or as viewing themselves as having no hope of relief.

The next part of chapter five focuses on the life-world of the client, and their lived experience. I look at accounts of symptoms and trigger factors. I examine the nature of need for help and what prompted the referral for counselling. Finally I explore how clients describe friends, family and other forms of social support, and how these compare with professional therapeutic support. This includes the way in which clients drew upon non-professional support, and what is considered helpful and what is not. Family and friends were frequently presented as ineffective or unhelpful in easing or resolving emotional troubles.

In chapter six I discuss the findings presented in chapters four and five in relation to previous research and literature. I identify issues arising from the client accounts, for example, the importance of flexibility of approach and of involving clients in the decision-making regarding the spacing of sessions and of closure. I also highlight the importance of addressing deeper issues even in

short-term counselling, and the effect on the client when the counsellor, or the counselling service, is perceived as too busy. Having examined client expectations of counselling I indicate the importance of clear contracting between counsellor and client. I also examine client accounts to consider how these can be mapped onto A.W. Frank's (1995) illness narrative positions of restitution, chaos and quest. I speculate on the potential impact of these positions on how therapy is experienced as successful or not.

In chapter seven, the concluding chapter, I offer a summary of the findings of this present research in the manner of issues to inform debates concerning the management and practice of counselling in primary care settings. I make suggestions for further research, and I reflect on personal learning through carrying out this study.

1.5 CHAPTER SUMMARY

In this chapter I firstly described the rationale for this study. I set out my aims and objectives for the research as being to elicit the voice of clients as a means to inform debates in advancing therapeutic practice and service provision in primary care settings.

I discussed government policy in delivering support to the majority of people with mental health needs in the location of their GP surgery. I have presented some of the current challenges in adapting counselling to primary care settings. I have noted that, despite reservations expressed regarding the use of empirical research, as discussed in chapter two, there is a need to produce evidence-based research of counselling in order to secure continued funding of counselling services. Funded services provide psychological therapies to an expanding patient group, that of the lay public who are not disabled by severe psychiatric problems, but whose lives are limited by milder emotional difficulties and life events.

I also presented some of the definitions of counselling, and a review of the established therapeutic orientations, namely, cognitive behavioural, psychodynamic, and humanistic-existential, with acknowledgement of recent adaptations and integration. There is also a move toward recognising systems-based approaches which places the individual within a wider system of family, workplace, community, etc. Narrative therapy incorporates principles of social construction in the form of self-narrative, that is, a storying of one's life. This is utilized within the therapy by facilitating the client to develop a more positive or satisfying story. The literature consistently points to an increasing integration in therapeutic practice, and to the centrality of the therapeutic relationship.

I have then described the two primary care counselling services which form the backdrop for this study. I have outlined the evaluation procedures that were conducted, and reported some of the survey results that reflect client opinion. I have concluded by providing a summary of the chapters of this thesis.

CHAPTER TWO

THE LITERATURE ON COUNSELLING AND PSYCHOTHERAPY

The counsellor loaned me a book called 'Feel the Fear and Do It Anyway'. And that, I thought, was amazing. Because I was going "Oh that's me. That's me! That's me! Oh yeah, that's me!" [Angie]

In this chapter I begin by examining some of the research in counselling in primary care settings. I will then review some of the literature concerning the effectiveness of counselling as an intervention. Most research over a number of years revolved around the issue of whether counselling 'works' or not, and is mainly empirical in nature. There are very few robust studies available, but mostly smaller scale works of audit and evaluation. In order to balance this with more mainstream research, I shall present a review of generic studies conducted in counselling and psychotherapy in a number of settings. Such literature highlights the quest to identify and isolate effective factors in psychotherapeutic work, and is, in itself, critiqued by those whose extensive research indicates the efficacy of generic factors that are present regardless of theoretical orientation.

However, it can be argued that some of the most important assessments are those that emanate from clients themselves. I will therefore move on to focus on what clients seemingly think of successful and unsuccessful therapy. Such an examination of counselling from the client perspective will serve well as a grounding for this present study. In the final section of this chapter I will position counselling in terms of the wider culture. That is to say, to highlight how counselling belongs in a culture in which the concept of 'self' plays a major role, and to look at how a focus on self has formed the major part of the psy-sciences. This section includes critiques of the centrality of the psy-sciences in modern society and an examination of the potential for abusive practice within the realm of the therapeutic services. I will use such concepts

of self when exploring themes that emerge from client accounts of their counselling. Finally in this chapter I will introduce the concept of accounts as a means of accessing, in this case, the client perspective of their experience of counselling.

2.1 RESEARCH IN COUNSELLING IN PRIMARY CARE

In this section I will concentrate on research carried out in the domain of counselling in primary care settings, and the issues that such research generates. Firstly I will consider the few randomised controlled trials (RCTs) that have been undertaken, and also explore other types of research methods used to study counselling in primary care, such as small-scale surveys, evaluation studies, and seeking the client experience of counselling.

The impact of counselling services in primary care is typically measured using a variety of qualitative outcome data, for example, patient satisfaction and patient well-being, and also quantitative data, for example, changes to consultation and prescription rates. (Rowland & Tolley 1995). Roth and Fonagy (1996) are dismissive of much of the research located in primary care as lacking in rigour. Their criticisms include that of insufficient information about procedures that were carried out, such as the form of therapy employed, and by whom, whether these were qualified counsellors, unqualified or other health care professionals. Roth and Fonagy (1996) made recommendations for formal research and audit of psychotherapeutic work carried out in primary care, and for counsellors to be supervised by specialists with a knowledge of working with the more severely disturbed. No specific recommendations were made as to which therapies should be employed in primary care, other than to comment 'the appropriate therapy depends on the form and severity of presentation' and that 'structured interventions based on theoretical models *appear* to be more effective than generic counselling.' (Roth & Fonagy 1996 p.367, italics added). No definition is offered of the

term 'generic counselling', and such lack of definition in itself is cited as a criticism of the studies reviewed.

2.1.1   Research: large-scale studies

Despite the criticism of empirical research, which I will discuss later in this chapter, this form of evaluation is required in order to validate the continued funding of psychological services in the NHS. In a review of recent research, the NHS Centre for Reviews and Dissemination (2001) reported the results of six RCTs with a total of 772 patients. They indicated that when followed up in the short-term (up to six months), counselled patients demonstrated a significantly greater reduction in psychological symptoms, such as anxiety and depression, than patients receiving usual GP care. The RCTs reported high levels of patient satisfaction with counselling, (e.g. Boot et al. 1994, Hemmings 1997), and that patients were more satisfied with counselling than with usual GP care (Friedli et al. 1997). However, Ward et al. (2000) compared therapy using different approaches, namely, 'non-directive' counselling, and cognitive-behavioural therapy, with 'usual care' from a General Practitioner. A total of 464 patients were assigned to the three groups, whilst excluded from the trial were anyone taking medication, including anti-depressants. From their findings it appeared that at four months there was a measurable improvement in both of the treatment groups by comparison with those receiving routine GP care. However, at 12 months there was no significant difference in improvement between all three groups. Such findings need to be treated with caution, as none of the patients in the study were prescribed medication. This does not reflect the real-life situation, which I will comment upon further in the following section of this chapter, as well as in my findings from my interview data.

2.1.2   A systematic review of research in primary care

Very few studies meet strict criteria to be considered robust in their findings. Early studies in primary care included accounts of counselling offered by social workers and other heath professionals with little or no training in

counselling. In a review, considering only RCTs, only those trials which used counsellors accredited by BACP (or an equivalent level of competence) and only those providing non-directive counselling in primary care, over 2000 abstracts and references were screened, 38 merited detailed assessment, but only four met the above inclusion criteria. Referring to Boot et al. (1994), Freidli et al. (1997), Hemmings (1997) and Harvey et al. (1998), patient satisfaction with counselling received was seen to be consistently high. 'While there are no clear cost advantages associated with either counselling or GP care, counselled patients tend to be more satisfied and tend to show modest but statistically significant improvements in symptom levels than do those treated by GPs.' (Rowland et al. 2000 p.229).

2.1.3   Review of the grey literature

In a review of the 'grey literature' of 26 reports prepared mostly for Health Authorities and NHS Trusts, key measures were found to be referral descriptors, levels of distress, patient and GP satisfaction with the service, reduction in psychiatric symptoms, effect on GP consultation rates and cost-effectiveness. Each report used different measures, for example, some noted the GP's reason for referral, whilst others recorded scores from standard measures e.g. Beck's Depression Inventory (BDI). (Beck et al. 1961). Symptoms recorded were of a comparable level to those who attend CMHTs, although the level of distress measured may be less chronic. (Hemmings 2000). Of client satisfaction from one study, 'high ratings were not dependent upon any individual counsellor and there were no significant differences between practices'. (Hemmings 2000 p.240). Of GP satisfaction, in one study where GPs completed written questionnaires, 94 per cent stated that feedback from patients was positive, and 100 per cent stated that counselling was either important (49 per cent) or essential (51 per cent). (Hemmings 2000). A reduction in psychiatric symptoms was seen through the use of screening tools as outcome measures. While none of these studies used a randomised controlled design, all were consistent in showing a positive outcome with a group of patients who had a moderate to severe degree of

symptoms. People with this level of disturbance tend not to 'spontaneously remit' in the short term, (Mann et al. 1981, Lloyd et al. 1996), and frequently attempt to relieve their distress by a continued and often inappropriate use of medical services. (Goldberg & Bridges 1988). The effect of the availability of counselling on GP consultation rates was assessed. A variety of measures were used that often delivered conflicting results. (Hemmings 2000). Similarly, on cost-effectiveness, there were no clear findings. Aspects under consideration included prescribing rates, referrals to CMHTs and other secondary services, these being psychotherapy, psychology and psychiatric outpatients. Some studies showed considerable savings, whereas others showed little or no benefits.

2.1.4   Small scale evaluation

Many small-scale research papers that audit and evaluate individual counselling service provision, for example Bourne (1999) and Buckley (1999), have been published in specialist primary healthcare journals. Bourne (1999) carried out an appraisal at her GP practice, using a sample of 50 clients. Clients returned questionnaires designed with a Likert scale of 'smiley faces' to indicate their satisfaction or subjective improvement. The number of visits to the GP, and GP prescribing rates for these patients, were analysed. In both cases, there was a significant decrease in the number of appointments made and of anxiolytics prescribed. A reduction in referral on to mental health services was also seen. This small study lacks academic rigour, with no control group and therefore no comparison. Also, since clients were being asked to return postal questionnaires to their counsellor, rather than someone independent of the counselling service, they may have been reluctant to express critical views.

Using a different methodology, Buckley (1999) presented the results of an audit he carried out at his GP practice, of 69 patients who completed counselling during a 16-month period. He found a decrease in GP contact following counselling, and a reduction in referrals to specialist mental health

services. Due to a change in procedure during this time, his audit included patients who received counselling free of charge, and also those who made a contribution to the cost, according to a sliding scale based on income. He further included a 'control group' made up of patients referred for counselling but who did not attend. When analysed, results showed the most improved, as measured by the number of subsequent GP appointments, were those in the group who had paid toward the cost of counselling sessions. The least improved were in the 'control group' of non-attenders, who showed a slight increase in their request for consultations with the doctor. (Buckley 1999).

2.1.5   The nature of research in primary care

There are values embedded within counselling that clients must be respected and not 'used', and that to make 'follow up' contact with clients may be perceived as an invasion of privacy. (Keithley 1995). Research involves questioning individuals about what could have been a very painful time for them. In addition, there has been scepticism about the reliability and validity of client reports.

> 'Clients are likely to have difficulty in assessing the contribution of counselling to their improved or worsened state of health, well-being, or circumstances, compared to the contribution of all the other things that are likely to have happened to them over the same time. Their memory is likely to be selective and subsequent experiences can lead them to re-formulate the past in ways which 'make sense' in the light of their present circumstances.' (Keithley 1995 p.273).

Such criticism applies if one adopts an approach to research that specifies an objective scientific standpoint. However, qualitative methodology privileges subjective accounts, and serves my purpose well, in that my aim is to elicit client accounts. Further, I was careful to address and follow the principles of ethical research values, as I will discuss in detail in the following chapter.

2.1.6   Keithley's study in primary care

I shall review a study of counselling in primary care in some depth, that of Keithley (1995), who interviewed 82 clients who had received marriage

guidance counselling in a GP practice. Themes emerged that included the convenience of having counselling locally, balanced by a possible lack of anonymity, in that others might observe that they were attending for counselling, and also a restriction of choice, there being only one counsellor available to them. Clients did not highlight lack of confidentiality as a particular problem, assuming that information would be shared with GPs, and with some considering this to be of benefit. By contrast, counsellors and GPs reported their concern of lack of confidentiality of client information. (Keithley 1995).

Clients in the study had difficulty answering Keithley's interview question 'Did counselling help you at all?' She reported that just over a half of those interviewed gave a positive response, a quarter expressed mixed feelings, and one-fifth said it had not helped. When asked to expand upon their initial response, 'clients expressed a complex mixture of feelings, which was inadequately conveyed, if at all, by a uni-linear concept of 'helpfulness – unhelpfulness'. (Keithley 1995 p.277). She noted that in some cases the initial response was misleading, and cautioned future researchers to adopt an in-depth, qualitative approach rather than rely on simple answers to simple questions.

There is evidence to suggest that the perspectives of clients and counsellors on the process and the outcomes of counselling can differ, e.g. Llewelyn (1988). As an example, of those disappointed by the counselling they received, claiming it unhelpful, the clients in Keithley's study pointed to 'the inadequacy of counselling in relation to their situation', whereas counsellors concentrated on the 'inappropriate expectations of clients and their inability to 'use' counselling.' (Keithley 1995 p.279). This highlights the question of whose views are considered most valid - practitioners, service-users, or both. 'The uniqueness of counselling may make generalizable analysis difficult, but strengthens the case for seeking client views.' (Keithley 1995 p.273). Increasingly the views of clients will be sought in their role of 'service-users',

as part of the evaluation of NHS services. The Welsh Assembly's Framework, (WAG 2002), explicitly seeks users' voices as part of on-going evaluation of services. 'Scientific' meta-analysis of research literature is not the best way to access the subtleties of patient experience. (Brennan 2001). However, those who use the counselling service are not normally consulted or surveyed as to their opinions of the service, other than, for some, a brief end-of-contact evaluation form. Whereas, it can be seen that,

> 'clients hold privileged access to certain aspects of counselling: they are a critical source of information that is often overlooked in counselling research.' (Paulson et al. 2001 p.58)

2.1.7   Section summary

In this section I have examined research set in primary care, from large-scale evaluative studies, to small-scale surveys of counselling in individual GP practices. Few controlled trials have been carried out, not least because of the difficulties of conducting research with patients receiving therapy. As for the numerous smaller surveys, a wide range of measures have been used, and overall findings point to high customer satisfaction with counselling services, and a decrease in demand for other services, such as referral to secondary mental health services. I have examined Keithley's (1995) study in depth, highlighting recommendations to carry forward into this present study, in particular, the need for a free-flowing interview in preference to a rigid question format, in order to more fully access the client's perception and presentation of their experience of counselling.

2.2 EFFECTIVENESS STUDIES AND COMMON FEATURES

In this section I will look at how empirical research in the context of counselling and psychotherapy is presented in the literature. There appears to be a tension within the field, between those who seek to research psychotherapeutic activity using positivist principles, and those who vehemently oppose this. I will begin by looking at research into the effectiveness of counselling, and explore some of the criticisms that have

been put forward of the validity of such research, for example, the premise of treating psychotherapy in the manner of a natural science. (e.g. Marzillier 2004). Much of the research is directed towards identifying which therapies are more effective than others, whereas other studies put forward a case for generic features that occur across therapies as being the crucial change agents.

2.2.1 Empirical studies: 'What Works for Whom?'

Intensive psychotherapy research initially began as a response to Eysenck's (1952) critique of psychotherapy, when he published findings to indicate that psychotherapy was ineffective and that, given time, patients would recover without specialist help. As the demand for, and availability of, psychotherapeutic treatment has spread, resources have again been directed to address the question of the effectiveness of counselling and psychotherapy. Empirical research has established the effectiveness of therapy and also provided the basis for investigating components of what might make therapy effective. Recent changes within the NHS, with services required to carry out audit of evidenced-based treatments, the question of external validity, that is to say, 'does therapy work?', has come to the fore once more. (Barkham 1996).

Roth and Fonagy's (1996) extensive analysis of research studies of psychotherapy, published as 'What Works for Whom?', used the American Psychological Association's DSM-IV diagnostic categories (APA 1994) as its organising principle. DSM is rooted in a medical model of symptomatology, with differentiated psychiatric disorders. Roth and Fonagy considered numerous examples of randomized controlled trials (RCTs) and other research from both the US and the UK. Many of the UK studies were undertaken with patients offered psychotherapy within specialist adult mental health services. Roth and Fonagy drew conclusions and made recommendations as to the most effective choice of therapy for patients with specific diagnoses, and their findings formed the basis of the Department of Health's 'Treatment Choice in

Psychological Therapies and Counselling: Evidence Based Clinical Practice Guidelines'. (DoH 2001). Yet it has been noted that the various therapeutic approaches all seem to achieve roughly comparable results (see, for example, Elliot et al. 1993; Luborsky et al. 1993; Lambert & Bergin 1994).

2.2.2 The validity of effectiveness research

Criticisms have been put forward to undermine this approach to researching psychotherapy. As a founding principle, medical research is centred on the evaluation of the effectiveness of specific interventions or treatments, whereas counselling and psychotherapy depend upon the quality of the therapeutic relationship and the level of engagement with the client. (McLeod 2001). Effectiveness studies are based upon the premise that standardisation of therapy and diagnostic categories of disorder are unproblematic. However, according to Nelson-Jones (2001):

> 'The concerns of many clients do not fall into circumscribed problem areas and the unavoidable messiness of much therapeutic practice does not easily lend itself to empirical research studies'. (Nelson-Jones 2001 p.8)

In practice, there are limitations to the generalisability of RCTs. There can be a number of confounding factors, not least, the need to select participants who have a clear and single diagnosis, when in practice, patients present with symptoms of a number of diagnoses (co-morbidity). The possibility of the researchers' and practitioners' enthusiasm for the therapy under evaluation, the additional assessment measures carried out on the client, the effect of additional scrutiny of the therapist, may all influence findings, as I will explore further below. Roth and Fonagy acknowledge 'research into psychotherapy necessarily and inevitably changes the nature of the therapy itself'. (Roth & Fonagy 1996 p.13).

Diagnostic categories

The validity of diagnostic categories has been questioned. Standard measurement instruments such as the DSM, its latest revision being DSM-IV-

Tr, (APA 2000), were developed to account for psychological and behavioural pathology amongst institutionalised psychiatric inpatients. Whilst it may be appropriate and applicable to the two per cent of the population who are seen in psychiatric services, it may not be of relevance with a wider client group. (Shaw & Middleton 2001). For many therapeutic models, the 'presenting problem' is not the focus of the therapy, making it inappropriate to adopt strict DSM diagnostic criteria. (Bohart et al. 1998). Furthermore, as Marzillier (2004) noted, 'people do not *have* depression, anxiety or schizophrenia like they have measles, diabetes or heart disease.' People can have similar symptoms but be classified as having different disorders, or have the same disorder but display different symptoms. According to Marzillier (2004), once the diagnostic criteria are called into question, the claim of scientific rigour becomes invalidated.

A controlled environment versus the 'real world'

Studies are usually carried out in a controlled research environment, which may bear little resemblance to the 'real world'. Difficulties occur when attempting to standardise the type of counselling offered, the type of problems that patients have, and the duration of the intervention. (Rowland et al. 2000). Outside clinical trials, adherence to a pure form of therapy is rare; co-morbidity is common and the length of treatment is rarely uniform. (Parry 2000). Standardised treatments to standard patients over a standard time may not represent the reality of counselling, and may thus have little relevance as an evaluation of the 'real' work of counsellors. In the main, trials consist of a series of trade-offs between internal and external validity. In general, the higher the internal validity, that is, the higher the level of control – or standardisation – of patients, types of problems, intervention, and so on, the lower the external validity – or representativeness - and vice versa (see, for example, Hemmings 2000, Rowland et al. 2000).

'In conducting efficacy research, which is intended to prove that a treatment works, one seeks patients who (a) fit neatly into one particular DSM category, (b) will be treated by manual-driven (i.e. carefully specified) therapies, and (c) are assigned randomly to the

different treatment conditions (randomised controlled trials). To be considered effective, a therapy has to be shown to work in the less controlled environment of everyday practice.' (Messer & Wachtel 1997 p.23)

Seligman (1995) listed five differences that occur between the highly controlled research environment of efficacy research, and the 'real world' of everyday clinical practice. First, the therapy is not always of a fixed duration. Second, the therapy tends to be self-correcting, disregarding unsuccessful techniques or modalities, and replacing them with others. Third, patients often actively choose their therapist and their therapeutic models rather than being assigned to a particular therapist delivering a defined intervention. Fourth, patients often have multiple problems requiring interactive choices between therapist and client. And fifth, the focus is often on general functioning rather than specific symptoms. According to Seligman (1995), the efficacy study is the wrong method for empirically validating psychotherapy as it is actually done, because it omits too many crucial elements of what is done in the field.

Bias toward certain therapies

Psychotherapy research has been criticised for its overemphasis on empirically validated treatments (EVTs), and it is claimed that there is an inherent research bias toward certain therapies. EVT research contains a narrow focus on symptoms or readily measurable social behaviour. (Messer & Wachtel 1997). 'The criteria often employed in EVT research are covertly value laden, reflecting definitions of therapeutic success more congenial to some approaches than others'. (Messer & Wachtel 1997 p.22). It is recognised that it is easier to conduct research on therapies based within the cognitive and behavioural traditions, since they are most closely based on a scientific model. There have been many more studies carried out on these approaches, however, this contrasts sharply with therapy as it is usually conducted, where most therapists base their work on psychodynamic or integrative approaches. (Jensen et al. 1990).

Therapist differences

In empirical research there are often assumptions made of the researcher and the model of counselling being used. RCTs seek to measure technique. Yet even where treatment is set out in a manual, there is no evidence that the manual has been followed faithfully. Differences between therapists are unlikely to be taken into account. The therapist's contributions include the technique used, the 'skilfulness' of the therapist, which includes the capacity for reducing the discrepancy between the patient's and the therapist's point of view, and the personal qualities of the therapist, such as warmth, capacity for empathy, likeability and perceived sincerity. (Schaffer 1982).

2.2.3   Common features of therapy

J.D. Frank (1973) concluded an exhaustive comparative study of therapeutic and healing practices by summing up their common features. Firstly a particular kind of relationship: patients must feel that the therapist genuinely cares about their welfare. Secondly, that the therapy or healing happens in locations designated by society as places of healing, a temporary refuge from the demands and distractions of daily life. Third, all psychotherapies are based on a rationale or myth which includes an explanation of illness and health, deviancy, and normality, in other words, they must exist within a culturally congruent narrative. To be effective, the therapeutic myth must be compatible with the cultural world view shared by patient and therapist. The fourth common feature is the task or procedure prescribed by the therapy or the therapist.

J.D. Frank (1973) went on to claim that therapeutic efficacy lies not within the *specific approaches* or schools of therapy, which differ, but in their *functions*, which are the same. Regardless of the therapy being offered, if successful, patients gain an experience of learning, both cognitive and experiential. They also have hope of relief of symptoms, gain experience of success, overcome

their sense of alienation from others and learn that others care about their well-being. Finally, he noted that all therapies arouse the patient's emotions.

> '...the effect of successful psychotherapy seems to be to accelerate or facilitate healing processes that would have gone on more slowly in its absence....If psychotherapists did no more than reduce duration of suffering and disability, this would be well worth their efforts.' (J.D. Frank 1973 p.334)

J.D. Frank's (1973) conclusions regarding common features have been supported by psychotherapy research that has demonstrated repeatedly that a substantial proportion of the variability in therapeutic outcomes is unexplained by differences between formally defined therapeutic procedures, differences between client groups, or the interaction between these two factors (see, for example, Beutler et al. 1994, Garfield 1994). It is impossible to isolate any single approach or technique within therapy. The research consistently points to there being common factors across all therapies, and it is these common factors that form the vehicle for change. An analysis of four decades of outcome research has shown that there are four main factors of change, namely client factors (percentage contribution to positive outcome 40%), relationship factors (30%), hope and expectancy (15%) and model and technique (15%). (Asay & Lambert 1999).

According to Asay & Lambert (1999), the most important predictors of success of a psychotherapy encounter are client factors, namely, the thoughts, ideas, actions, initiatives, and traits of clients. Second to such factors, the client's perception of the therapeutic relationship is responsible for most of the gains resulting from the therapy. Models and techniques are much less important than generally thought. Asay and Lambert (1999) claim that research on these common factors make clear that various techniques, such as confrontation, the 'miracle question' in solution focussed work, or eye movement desensitisation (EMDR) techniques, are better viewed as different means of empowering one or more factors responsible for treatment outcome rather than unique to a specific treatment model. As noted earlier in this

chapter, this is in line with how experienced clinicians actually practice, in that the further away they are from training (e.g. Fiedler 1950), the less they identify with any one approach. They are more likely to tailor treatment to the makeup and characteristics of the individual client.

2.2.4   Overestimating change

As a further criticism, it is claimed that research lends itself to overestimating change due to therapy. In researching the efficacy of psychotherapy, it is by no means established how much improvement is actually due to therapy. 'The therapeutic session represents only a tiny fraction of the patient's encounter with others, so results attributed to psychotherapy may really be due to concurrent life events.' (J.D. Frank 1973 p.334). Again, this further highlights the value of accessing client accounts.

2.2.5   Section summary

In this section I have looked at research into effectiveness, and the use of empirical research, in the domain of therapy. I have considered a number of criticisms of the use and validity of such research, in particular, the appropriateness of the modernist, quantitative research that draws upon the scientific method when employed within the domain of the psy-sciences, which has its emphasis on the interrogation of the self and the emotions. I have touched upon literature that supports the notion of generic factors, with Asay and Lambert's (1999) claim that 40% of contribution to positive outcome is due to unique client factors. I also noted how professionals, both therapists and researchers, may overlook the impact of concurrent life events and assume that all change is due to the therapy. As noted by Brennan (2001), given this broad sweep of criticism of empirical research it is apparent that 'scientific' meta-analysis of research literature is unlikely to be the best way to access subtleties of patient experience, and I shall therefore move on to consider the voice of the client.

2.3 CLIENT VOICES

In this section I will look at client voices, and the way in which clients describe counselling and psychotherapy. Therapy portrayed through the eyes of professionals is often at odds with accounts given of the therapeutic process by its recipients. Whilst many studies have been carried out to ascertain the effectiveness of counselling, or a particular approach to psychotherapy over another, less has been published of the client's experience of being in therapy. (McLeod 1990). I present various findings here, although throughout the diverse reports, it is not always clear exactly which kind of counselling has been given by which kind of therapist, to which kind of clients. Some consumers of psychotherapy, often disillusioned patients who have undergone psychodynamic or psychoanalytic treatment, have written descriptive, autobiographical accounts of what they experienced as abusive or bad practice, for example, Dinnage (1988), Alexander (1995), and Sands (2000). I begin with a focus on the academic literature pertaining to client voice.

2.3.1   Different vantage points: the therapist's and the client's

Existential psychotherapist Yalom and his patient 'Ginny' wrote an account of the same therapy from both the therapist perspective and the client perspective. (Yalom & Elkin 1974). In many instances, what was experienced as most important for the client (Elkin) had been thought inconsequential by the therapist (Yalom), much to the therapist's surprise. In a similar vein, Maluccio (1979) found significant differences in clients' and therapists' evaluations of the overall effectiveness of therapy, with clients generally being more satisfied than their therapists with the eventual outcome. He also emphasised, as I have noted previously, that clients tend to see events and relationships in their life outside the therapy room as being important in triggering change, while therapists are less aware of these 'outside' factors, and placed more importance on what happens in therapy itself. Amongst others, Blaine and McArthur (1958), emphasised the immersion of the

therapist in the technique of therapy, while for the client it is a much more personal and down-to-earth process, that is, the chance to discuss themselves with an impartial, intelligent, 'safe' person. Similarly, Llewelyn (1988) reported clients as wanting solutions to problems and to 'feel better', whilst therapists were concerned with the aetiology of their client's problems and their 'transformation through insight'. She claimed that this reflected a difference in the degree of importance for clients and therapists of different aspects of the therapeutic process, rather than different ways of talking about the same aspects.

2.3.2   Review of research studies

A number of researchers have employed interview techniques with counselling clients. For example, Mayer and Timms (1970) conducted 61 interviews with clients at the Family Welfare Association in London; Maluccio (1979) collected interview data with 33 former clients and their counsellors from a Catholic Family Service Agency in the US; Brannen and Collard (1982) carried out 48 interviews with Marriage Guidance clients and clients of a hospital-based counselling service in London; Markova et al. (1984) interviewed 47 haemophilia patients and 29 carriers of haemophilia in genetic counselling; Timms and Blampied (1985) interviewed 50 clients from Marriage Guidance and the Catholic Marriage Advisory Council, and Hunt (1985) interviewed 51 former clients of Manchester Marriage Guidance Council. Of other methodologies employed, open-ended questionnaires were used with 63 clients in psychodynamic therapy (Feifel & Eells 1963) and with 40 therapist - client pairs, the majority of whom were working with 'eclectic' therapy (Llewelyn 1988). It is noticeable that this published research is with diverse client groups, and the form of counselling offered – psychodynamic counselling, marriage guidance, and genetic counselling, differs markedly in form and philosophy.

In all the above studies research data were obtained from clients some months after their counselling. Whilst participants may lose the immediacy of

the counselling and forget details, the delay also allows time for former clients to locate the experience of having counselling into their self-narrative, (McLeod 1990), and for it to be incorporated into their life-world.

From these studies a number of findings have been presented, for example, it was found that many of the clients interviewed had not confided their problem to anyone else prior to counselling, even though there were people close to them. (Mayer and Timms 1970). Maluccio (1979) devised a format of examining the client experience according to three phases, which he named as 'becoming a client', the middle phase, and ending. In the early phase, clients closely evaluated the counsellor's perceived competence (or perceived lack of competence), using phrases such as 'knew what he was doing' or 'too young, inexperienced'. (Maluccio 1979). Some of the findings appear to be contradictory, for example, according to McLeod (1990) one of the common factors in all forms of counselling and therapy is the expectation that the client will confront, explore, and work through previously avoided thoughts and feelings. However, Brannen and Collard (1982) found that clients enter counselling without clear expectations 'I didn't know what to expect....I really had no idea', whilst those who have been counselled before will often make assumptions about the new counsellor based on their experience of the previous one.

In considering endings, the main themes to emerge in research include emotional investment and dependence on the counsellor, ambivalence about ending and an awareness of impending loss of support. (McLeod 1990). However, again, findings were often contradictory. Clients interviewed who had found less benefit in therapy, and who experienced unplanned endings, were more likely to deny having any feelings about termination. (Maluccio 1979). In contrast, in Hunt's (1985) study, a significant minority of clients felt aggrieved or angry at the end because they felt themselves to have been 'let down' by the counsellor or the agency. One client accepted the invitation to take part in the study 'because she still felt so angry and wanted to complain'.

In researching helpful and hindering events in therapy, of unhelpful factors, clients identified aspects such as 'not daring to talk about some things.' Clients described general factors as being helpful, the most frequently cited included getting advice from the therapist, 'talking to someone interested in my problems', encouragement and reassurance, and 'talking to someone who understands'. (McLeod 1990 p.15). This has been used to support the existence of a set of non-specific helpful factors, common to all forms of therapy, for example, J.D. Frank (1973), as discussed earlier in this chapter. It also points to the lack of technical training on the part of the majority of clients, in that they don't 'speak the language' of the psy-sciences, but use a lay lexicon of both emotional troubles and of help received.

A meta analysis of studies

This is further underlined by the work of Howe (1993). Following a meta-analysis using secondary data from diverse client settings that included general counselling, a post-adoption agency, and family therapy, Howe (1993) illustrated that 'clients consistently say similar things about their experiences of being helped (and not being helped), no matter what school of counselling they have attended'. (Howe 1993 p.1). 'In doing so, clients appear to be identifying general, non-specific, processes and experiences that cut across different schools of intervention.' (Shaw 1996 p.61).

Howe (1993) drew on a mix of psychological theories and social construct principles, including attachment theories, cognitive development, and development as 'occurring within relationship with another'. He went on to theorize the understanding of self and other as being formed in the field of social meaning and relationship. He claimed that in order to reflect upon and change understandings, the client needs to return to the field of social meaning within the therapy. Self and situation are not seen as fixed or permanent, but are co-constructed, and talking to another helps give meaning to experience. Control over their experience empowers the client and in so

doing, enhances self-esteem. Howe identified underlying features that endure across all psychotherapies as 'accept me', 'understand me' and 'talk with me'. (Howe 1993).

According to Howe (1993), the counsellor tries to explain and treat, whereas the client wants to be understood and helped. Clients ignore strict theory and take what they need. Particular counselling procedures are simply a framework for holding dialogue. The things that clients say about therapy are the things that matter to them, for example, the personal attributes of the therapist, the quality of therapeutic relationship, and the personal understanding achieved. The technical orientation of the therapist does not matter to the client, nor do procedures associated with that school of therapy, except insofar as they affect the quality of the relationship. Howe (1993) outlined the sequence of therapy as being the 'therapeutic alliance' leading to 'talk and dialogue', which in turn leads to 'making sense', which then allows the client to 'control the meaning of experience', resulting in their coping better with life.

2.3.3   A detailed look at two studies

I will now offer a more detailed look at two studies, beginning with Oldfield (1983), who interviewed 52 former clients who had received psychodynamic counselling, six months after the end of their contact at a counselling centre. As co-ordinator of the centre, Oldfield had access to intake information regarding the clients, such as presenting problems and biographical data, and also data relating to the number of sessions attended. Using a structured interview schedule, her findings related to clients' hopes and expectations, what happened in the sessions, helpful and unhelpful factors, and outcomes. The results reflected a varied pattern of outcomes, from those who found the counselling useful, to those who were disappointed. The clients' comments reflected the psychodynamic theoretical underpinning of the centre, although inevitably, each counsellor brought their individual working preferences to the sessions. For some clients, the structured approach to scheduling a limited

number of sessions was considered invigorating, whereas for others, this led to their not really feeling engaged with the counselling, knowing it would end soon. In contrast, some clients appreciated having an open-ended contract, whilst others felt they were 'wasting their time'. Some clients felt un-nerved by a counsellor who guided them through a session, whilst others felt bemused or belittled by the 'silent' approach. In her conclusion, Oldfield commented that this type of counselling provision formed a new tradition, developing from its roots in psychoanalysis, yet offering a service to the general public. She stressed the need for counsellors to be flexible in two key areas. Firstly in explaining the rationale for their interventions. Secondly, she called for counsellors to be flexible in their approach, and not to relentlessly pursue their own theoretical goals, at the expense of leaving clients feeling confused and frustrated. (Oldfield 1983). Oldfield's findings point to the need for recognising individual differences in clients, and that to offer a 'one-size-fits-all' therapy will inevitably fail to meet the needs of some clients. This also supports the position of those clients mentioned elsewhere in this section, who felt sufficiently aggrieved by their psychodynamic therapy that they went into print with their experience.

In the second study under review here, Paulson et al. (2001) interviewed eight clients at a Canadian university counselling centre to ascertain their views on hindering experiences in counselling. Comments gathered from the interviews were then rated by a further 20 clients. The hindering factors were clustered as concerns about vulnerability, lack of commitment and motivation, uncertain expectations, lack of connection, barriers to feeling understood, structure of counselling, negative counsellor behaviours, insufficient counsellor directiveness, and lack of responsibility. Three core aspects emerged, that of counsellor behaviours, external and structural barriers, and client variables.

The counsellors at the centre were often gaining placement experience and were neither qualified nor experienced practitioners. Also, the counsellors

used a range of theoretical approaches, and either of these factors may have confounded the results. Where comments such as 'counsellor getting hung on a particular pattern and sticking to it' or 'counsellor dealing with the initial concern but not other concerns that emerged', it is not clear whether this is a consequence of rigidly working to a theoretical approach or due to practitioner inexperience (or indeed, both). Furthermore, some of the comments collected in Paulson et al.'s study may be a consequence of the particular research setting used. These include, for example, being video-taped, concern regarding the presence of a two-way mirror, of paying fees, and of having a trainee counsellor. Of being seen by a trainee, comments were made such as 'feeling like the counsellor was trying out a technique' and 'feeling like a guinea pig'. However, these context-specific comments can be used to demonstrate the importance to clients of safe boundaries, for example, through feeling contained by an experienced counsellor, and of not being watched or overheard.

2.3.4   Client voices from psychoanalysis

There are clients who have felt abused by their experience of psychoanalysis and who have published accounts, as a means of having their voices heard. Here I will briefly comment on the work of Rosemary Dinnage, Rosie Alexander and Anna Sands. All three witness failures in managing the transference and in boundary maintenance, with excruciating consequences for the clients involved.

Dinnage (1988) offered a collection of brief personal accounts. Many of her contributors present a view of the work as being unending, with clients visiting a succession of therapists, and of always being in need of further therapy. Many of the individuals appear to see themselves as unable to function without seeing a therapist. Alexander (1995) wrote of her experience of psychoanalysis in France. Her account contained examples of 'frame breaking', for example, a therapist who allowed his patient to kick him. When she (Alexander) went elsewhere to seek another therapist, she was

recommended to return to the therapist with whom she was experiencing the difficulty. Eventually she found support when she joined a group for those who felt they had been abused by their therapy experience. More recently, Sands (2000) wrote passionately of often cold and detached practitioners, and the adverse effect that this has on clients who, according to Sands, need loving caring support, and not pathologising analysis.

2.3.5   Section summary

In this section I have explored some of the published material relating to clients' experience of therapy. Studies often produced contradictory findings, but as noted, the research draws upon different client groups in different settings, and is conducted using different methods. Through these relatively small-scale studies I have noted particular findings, such as the recommendation for counsellors to be flexible in their approach (Oldfield 1983) and the need for clients to feel secure in the therapy relationship (Paulson et al. 2001). Such experiences as published in autobiographies and through qualitative studies, suggest there is much to be gained from a study of the client perspective. Such an examination can shed light about what clients say about what does and does not work, and what is important to clients in the therapeutic encounter. My study focuses exclusively on the client voice, achieved through narrative accounts collected via individual interviews. In meeting the objectives of this research, one element is to explore what seems to make counselling successful, as judged from the lay standpoint. Psychoanalysis is criticised for its insistence on pathologising the patient. (e.g. Dinnage 1988, Alexander 1995, Sands 2000). So both psychiatry and psychoanalysis are accused of abuses of power, whilst in contrast, counselling is often criticised for being ineffective or irrelevant, carried out by poorly-trained 'do-gooders'. (e.g. Persaud 1997, Ironside 2003). In this study I shall look for any evidence that supports either of these criticisms, of pathologising or of ineffectiveness.

2.4 SOCIOLOGICAL CONCEPTS

In conducting my analysis I plan to draw upon concepts from the sociological literature, in order to step outside the frame of a psychological viewpoint. This has the potential to afford fresh insight, through an alternative appreciation of counselling and therapeutic endeavour. In particular I look at society's concern with 'self' as an object of examination and inquiry, explanations and attributions as to why some individuals are thought to be more vulnerable than others, and therapy as an institution for containing and re-training disordered lives.

As seen in chapter one, there is an increasing rise in demand for, and provision of, counselling and related activities. Late modernity is characterised by both a concern with our emotions (how and why we feel the way we do), and by the development of strategies for managing such emotions (such as psychotherapy and counselling). In modern western societies, as McCarthy (1989) has noted, there has emerged a growing number of therapies designed to get us back in touch with our emotions and feelings. Emotions and feelings thereby come to be seen as things to be worked at or worked on. Periodically, one's emotional life is required to be disclosed and re-modelled in accord with therapeutically designed principles of emotional health and well-being. (Rose 1999).

Notions of self and identity have played a major role in the development of the social sciences. Thus self was a key focus for the work of G.H. Mead (1934) for example, and Goffman was long ago concerned with the presentation of self in day-to-day life. (Goffman 1971). More recently, Giddens (1991) has argued that the central feature of self in late modernity is that it serves as the site of a reflexive project, sustained through a revisable narrative of self-identity. That is, one has to construct and repair one's biography at regular intervals throughout the life-span. Giddens argued that the self requires 'psychic re-organisation' at many of the turning points in

one's personal career. In this light it becomes clear how central the work of the 'psy sciences' (Rose 1999) can be in the modern world.

This concern with emotion has been criticised by Persaud (e.g. 1997) and Furedi (2004), amongst others. They claim that such attention to the self promotes the maintenance of a victim culture, and that the mainstream acceptance of talking to 'professional strangers' leads to a lack of reliance on self and family.

2.4.1   The rise of concern with 'self'

Social constructionism posits that commonality among constructions of the world comes about as a result of the common social, linguistic and historical period that we share. (Polkinghorne 1992). The practice of psychotherapeutic counselling has developed from theoretical explanations of the structure of personality. This in itself has arisen out of a concern with the 'self' as a clearly defined entity, first posited by John Locke in the seventeenth century, in his Essay Concerning Human Understanding (1997). For Locke it was consciousness alone that makes 'self'. In the present day, symptoms of disease, unhappiness, and anxiety, amongst others, have been described as existential angst, as 'problems with living', or as resulting from poor childhood relationships or early experiences. Others look to biological explanations, expressed as 'imbalances in brain chemistry', or to genetic predisposition.

In one such view it is believed that adverse life experiences present challenges to change and adapt that cannot be met by vulnerable individuals. Social class represents a predictable correlate of mental illness. People who are economically disadvantaged have to struggle with the personal consequences of material deprivation. They experience higher stress from crime, diet and their physical health is poorer. They are more likely to be unemployed or to have less personal control at work, and to suffer lower self-worth. The proportion of 'positive' experiences is fewer for those at the bottom end of the scale. Therefore, this group has fewer 'buffering

experiences' against life's stresses, and are more vulnerable to mental distress (see, for example, Phillips 1968, Brown & Harris 1978, Pilgrim & Rogers 1993, Shaw & Middleton 2001).

As evidence of this, in a recent survey, more women than men reported having experienced the death of a relative or close friend, separation from a relationship, domestic violence and sexual abuse at some time in their lives, while more men reported having undergone redundancy, serious illness or injury, bullying, violence at work and serious money problems. (ONS 2000a). Nearly three quarters of those reporting a neurotic disorder were unemployed or economically inactive. Those with a mental disorder were far more likely than those with no disorder to be living in rented accommodation (38 per cent compared with 24 per cent). About half of those with a mental disorder were living in accommodation rented from a housing association or local authority. (ONS 2000b).

> 'Public education ...has convinced countless persons that what they had regarded as distress caused by the ordinary vicissitudes of life was treatable by something called psychotherapy. It was a great gain when the manifestations of mental illness came to be seen as signs of personal malfunctioning rather than manifestations of demoniacal possession or mysterious brain diseases. But this makes it impossible to draw a clear line between abnormal and normal distress, so that many persons suffering essentially normal responses to the wear and tear of life now see themselves – and are seen by others – as suitable candidates for psychotherapy.' (J.D. Frank 1973 p.338)

Such therapies, then, form part of a discourse of the disordered self, albeit a very different one from that which Foucault referred to in Madness and Society (1973), but one that can be just as capable of disciplining seemingly disordered lives.

2.4.2   The nature of therapy

Strategic dimensions of the therapeutic

Through an analysis of textual discourses, Rose (1999) listed four 'strategic dimensions of the psychotherapeutic'. These dimensions specify the factors that are called upon to explain psychological distress. Firstly the *subjectification of work*. Work confers identity, and a successful career forms the basis of a satisfied life. Lack of achievement in this domain is problematized. Second, *psychologization of the mundane*. Ordinary life events such as house-moving and childbirth are construed as the causes of 'stress' with individuals being considered lacking in 'coping skills'. Thirdly, the *therapeutics of finitude* encompass the grief and disappointment inherent in the human existence. Death is inevitable and loss in all its forms is a natural part of life. However, a resistance to acceptance of this basic condition, or an inability to adjust to loss, is considered a route to psychological disturbance. The crisis presented by loss is also considered an opportunity for personal growth. Fourthly is the *neuroticism of social intercourse*. Within this discourse, relationships are seen as the aetiology of dysfunction. Children are 'damaged', unhealthy patterns of relationship are repeated, and unsatisfactory relationships, whether as a child or adult, are considered to be at the root of personal unhappiness and social inefficacy. Understanding lack of achievement (or of appreciation) at work, commonplace (but difficult) life events, fear of inevitable mortality, and a perception of relationships as damaging, leads to an ever increasing demand for psychological services. It is in this broad cultural milieu that the practice of counselling has developed.

Technologies of the self

Rose (1999) drew on Foucault (e.g. 1973, 1978, 1979) in his analysis of psychotherapy, and the 'shaping of the private self'. He described 'moral codes' for how to lead a good life, which include esteemed attributes, in addition to goals to pursue. The presentation of these vary, and within psychotherapy there are different emphases and different vocabularies. For

example, from a psychoanalytic leaning the goal is to be less influenced by unconscious desires and fears. From a behavioural approach, symptoms can be removed or altered by direct training and practice. The humanistic perspective emphasises 'that one can be the Self that one truly is'.

Rose (1999) further described *ethical scenarios*, as contexts within which the moral codes are transmitted, for example, schools, courts, social work and medicine. In this case the ethical scenario is the primary care counselling service. He also described 'techniques of self' which are taught or modelled, such as self-reflection, writing journals and assertive communication. The various psychotherapeutic approaches are described as 'therapeutic systems', and each context has its own theory regarding the nature of humanity, and the structure and development of personality. Each offer a different prescription for changing a client from one way of acting and being, currently perceived as dysfunctional and distressing, to another, more satisfying way. The texts of psychotherapy are thus the instruction manuals in the techniques of self.

In delivering this prescription for change, Rose (1999) considered the 'spatial technologies of therapy', which, depending on the therapeutic system, may be the analyst's couch, or the circle of chairs used in group therapy. For clients in this study the special technology is the room at the GP surgery where the counsellor sees her clients. Rose described the 'technology of voices', which includes the way in which the therapist offers interpretations, or supportive sequences of words and gestures. The 'technology of transformation' is the mechanism for persuasion or change. Clients will move on from the therapy, but will take these self-techniques of therapy with them. The techniques include attending to different aspects of self, attending to thoughts and feelings, and of different ways of construing the self. These techniques for cure are expressed as, for example, the *purgative* effect of catharsis, the *liberating* effect of understanding, and of re-structuring and re-training thoughts and emotions.

2.4.3   The nature of power in the therapeutic arena

Derrida's work is at the heart of de-constructing discourses of power in society, (e.g. Derrida 1995), and Foucault (e.g. 1967) wrote, with regard to mental illness, of the many discourses in operation and of expert discourse, how those in power control which discourse is to be privileged. As Larner (1999) commented, power is not the name of some thing we possess, but emerges out of the social situation. Gergen & Kaye (1992) first drew attention to the way in which therapists' narratives are an abstract formulation, artificially divorced from cultural circumstances. That is, they frequently refer to theoretical interpretations, in preference to alternative explanations based on the client's individual social circumstances. The power imbalance within the therapist-client relationship derives not only from the expert role of the therapist, but from other sources, such as the nature of the emotional attachment that many clients make to their therapists, and clients' frequent membership of disadvantaged groups. (Fish 1999).

According to Newnes & Holmes (1999), it is possible for therapists to re-create the abuse of power of society, since the premise of psychotherapy places the blame within the individual, whereas critics of therapy point to the problems created by society and of living in society. As Kaye (1999) has noted, mainstream psychotherapy possesses assumptions that there is an underlying cause of pathology, and that this is located within the individual, by implicitly or explicitly positing that the sufferer is deficient or responsible in some way for their problem. It also assumes that the problem can be diagnosed, and that it can be treated by a specially designed set of techniques. The theories of psychotherapy focus on intra-psychic causes of problems to the relative exclusion of inequalities structurally ingrained in society, for example, but not exclusively, by class, race, gender, and economic deprivation. Placing the therapist in the role of expert, possessing superior knowledge and skills, disempowers the patient. In this way, therapy may be reproductive of oppressive practices of power. The 'receptive helper' approach to therapy involves the exploration and examination of the client's

story within the terms of the therapist's frame of reference, and from there attempting to engage the patient actively in the process of reinterpreting their narrative within the therapist's frame. Kaye accused psychotherapy of maintaining the inequalities of the social order by preserving the dominant culture. (Kaye 1999).

Counsellors determine the nature of the occasion. They ask questions and make observations through particular theoretical lenses. In this way, power resides with the counsellor in deciding what counts as relevant. (Davis 1986). The client's initial version of 'troubles' is transformed in the first session into a problem suitable for therapeutic work. The problem is viewable as a construction, and the client is persuaded to accept this. All utterances are accounted for within the counselling construct, and anything not within the construct is re-formed to fit or is ignored. (Howe 1993).

At the micro level, a lack of appreciation by the therapist of their choice of words, and the way in which language and paralanguage impact upon the co-construction of the therapeutic encounter, can lead to persuasive techniques conducted out of awareness. Language as the conveyor of meaning is not neutral, but filters experience through its particular structure. (Messer & Wachtel 1997). Analysis of discourse uncovers the ways in which norms and values are both constructed and transmitted. Using the method of conversation analysis, Silverman (1997) studied counselling in HIV clinics. His work demonstrated the way in which counsellors persuade clients, in this case regarding safe sex practices. Silverman commented on how this departs from definitions of counselling that privilege promoting the client's autonomy. For example, 'Counselling is the skilled and principled use of relationships which develop self knowledge, emotional acceptance and growth, and personal resources. The overall aim is to live more fully and satisfyingly'. (Rowland et al. 2000 p.222). It could be argued that 'counselling' in an HIV clinic is overtly persuasive. However, tapes of Carl Rogers have been analysed to demonstrate how a person-centred therapist rewards clients with non-verbal

verbal reinforcers. Inevitably the therapist has an agenda, if only for the client to be more autonomous, regardless of whether the client seeks this or not. It has also been claimed that therapists seek to educate their clients in the language of therapy, and in the techniques of therapy (Rose 1999). Farrell (1979) observed how the 'success' of therapy was measured according to the degree the client had assumed the therapist's 'Way of Talking'.

2.4.4   Studying accounts of counselling

Counselling itself is a social process, where cultural norms and values are affirmed within the therapeutic encounter. Counselling is a means of helping individuals negotiate their own relationship with these cultural norms, (McLeod 2001), and as a means of transmitting these values. As with any form of interaction, the process of therapy is co-constructed in the moment, in this case in the interactions between therapist and client. The therapist will bring to this interaction a construct of therapy gained through professional training based in what Rose (1999) called the manuals of the techniques of self. The client may possess a construct of therapy based upon cultural representations of disorders of self and their various treatments.

As has been seen, the majority of studies of counselling follow the positivist tradition of scientific inquiry that prizes objectivity. (Toukmanian 1996). By contrast, the methodologies of conversation analysis, discourse analysis and narrative analysis offer insight into the ways in which therapy is conducted or how it unfolds, and how the values and beliefs are transmitted within the therapeutic encounter. The client's perspective is the most direct source of information about client experience. Clients tell their own story, in their own words, and these descriptions of the counselling experience give us clues about how it works and why it works (Birtwistle 2002). Each therapy encounter is unique. Each therapy participant has his or her unique experiential history. Transactions have multiple meanings, some events within sessions are more important than others, and often therapy is only one of the

many possible client experiences contributing to positive outcomes. (Toukmanian 1996).

> '[W]hilst the *experience* of change is unique to each client, there are common or core processes underlying this phenomenon for all clients, and that without an understanding of the nature of these processes there can be neither a satisfactory explanation of how psychotherapy brings about change nor a fruitful search for the therapeutic ingredients that account for change in diverse treatments.' (Toukmanian 1996 p.185)

As Paulson et al. (2001) noted, clients hold privileged access to certain aspects of counselling. They are a critical source of information that is often overlooked in counselling research. This study is based on an analysis of interviews with clients who attended counselling sessions at their GP practice, some months after the completion of their counselling. My aim was to elicit clients' accounts of counselling. The accounts produced through interaction can illustrate the person's construction of the phenomenon in question, in this case, their experience of receiving counselling in a GP practice. A study of the accounts of former clients offer a means of accessing the cultural norms and values of counselling. In this way it is possible to gain insight into the life-world of clients, (Schutz & Luckmann 1973), scripted in the lexicon of lay people.

In this thesis, through an analysis of client accounts, I shall study the ways in which clients have integrated symptoms of emotional ill-health into their life-world. According to Schutz and Luckman (1973) the world of everyday practice is routinely described and accounted for according to the unique experiences, biographies and 'stocks of knowledge' of its individual members. In the context of psychological illness, such frames of meaning can serve to explain why psychological distress might occur in the first place, or may serve to suggest how symptoms are to be managed in the social worlds of everyday life.

In an account of any situation, individuals construct and present a version of themselves. Since it is what people say that gets reported and analysed, the account becomes the focal point in the investigation. (Bury 2001).

> 'A particular self is constituted through these narratives, occasioned by the presence of the listener, her questions and comments. Typically, the moral character of the protagonist is maintained.' (Riessman 1990 p.1195)

This notion is reiterated by A.W. Frank (1995). He described the self as being formed in the story that is told, to others but also to oneself. There is a moral imperative to present oneself and construct an identity as a person with morals and integrity.

There has been much interest in illness narratives in medical sociology, where they have been seen as an alternative to the biomedical voice by 'giving voice to suffering'. Whilst this is so, illness narratives cannot be taken as the 'one true voice', since, both the patients' and the medics' narratives are partial accounts of a subjective phenomenon. (Hyden 1997). For both, they are produced to serve a purpose, for example, to excuse or explain behaviour. From an analysis of accounts, a range of narrative forms have been identified, for example, Kleinman (1988) presented the illness narrative as a 'witness to suffering', especially for those with disabling chronic disorders, and A.W. Frank (1995) described three narrative plots, namely, restitution, chaos and quest, which I will discuss in more detail in chapter six of this thesis.

2.4.5   Section summary

I began this section with a consideration of the centrality in late modern society of the examination of the self with a focus on emotions, drawing on Rose, Giddens and Foucault, among others. I have noted the rise in psychological disorders and a growth in demand by the lay public for talking therapies. I have included criticism of the ubiquitous phenomenon of the psy-sciences in post-modern society, and a consideration of power within psychotherapy.

I have referred to concepts of the nature of the disordered self – aspects of mental ill-health and emotional distress. I have also considered technologies of the disordered self – the forms of therapy that have been developed to ease the distress of the disordered self. In my discussion I will look for origin factors, or strategic dimensions (Rose 1999) that are drawn upon by clients to account for their need for counselling. I will also consider how clients 'shape their private selves' by presenting themselves as abiding by moral codes, and I will investigate how clients refer to the technologies of transformation, that is, the counselling they have received. In this way I will examine how counselling and the technologies of self are incorporated into the life-world of clients. Given the steady criticism of the 'therapy culture' I shall also attend to discourses of power within client accounts. A number of criticisms have been levelled at the principles and practice of therapy, including abuses of power inherent in the therapeutic endeavour. In this study I shall note whether, and if so, how, these discourses of power are present in the accounts of counselling clients.

2.5 CHAPTER SUMMARY

In this chapter I have looked at debates relating to researching counselling and psychotherapy. In particular, I explored empirical research within the therapeutic endeavour, both the conduct of such research, and the philosophy that underpins its methodology. Criticisms of empirical studies appear to undermine their validity in attempting to identify any one therapy as being more effective than any other. Research into specific factors appears to point to the importance of generic factors in therapeutic change, with client factors and relationship factors the most important. In the third section, I have considered the voice of the client, and findings from research where the client's perspective of therapy has been sought. This has offered some perspective on what clients find important, and what they consider to be helpful or unhelpful. I will explore this further in the analysis of interview data

in this study. Finally I have introduced some sociological concepts which I shall draw upon in my analysis of client data. I will consider these under the headings of the presentation of the self, and the life-world of the client.

CHAPTER THREE

METHODS

I said to my husband I'll take part in the research - the study - because I found it so beneficial that if the option's there for other people, I think yeah, if there was a chance that all doctors' surgeries can offer this, then yeah, it'll benefit a lot of people. [Nikki]

In this chapter I will provide an account of the research process, including the research design, the procedure for recruiting interviewees, a detailed account of the process of data collection, and the decision-making processes of the analysis.

3.1 STRATEGY FOR DATA COLLECTION

3.1.1 Semi-structured interviews

In order to collect data for this research, I decided to use semi-structured interviews. I considered the possibility of holding focus groups (e.g. Bloor et al. 2000) with former clients, however, where sensitive issues are investigated in a group setting, it is possible that some individuals may be reluctant to disclose matters relating to such issues. Furthermore, if there is disclosure of a personal nature that results in emotional distress, the interviewer is in a better position to contain and deal with any such distress in an individual situation than if he/she has the responsibility of a group. I therefore chose individual in-depth interviews as the best method to access the clients' presentation of accounts regarding their counselling (see, for example, Fontana & Frey 1998). The interview is an informal, interactive process that utilizes open-ended comments and questions. I developed a set of questions aimed at evoking a comprehensive account of the interviewee's experience of counselling, aware that I may vary, alter or discard the questions as each interview progressed. (Moustakas 1994).

3.1.2 Counselling-style interview

I adapted and used the 'counselling-style' interview. (Coyle 1998). This technique is particularly appropriate for use when researching sensitive issues, and where the researcher is experienced at using counselling skills. Mindful to work ethically, (BPS 2000), the counselling-style interview is most suitable to contain and diffuse any emotional distress that may arise. The counselling-style interview comprises a semi-structured format, centred around a few open-ended questions, using a facilitative style to encourage reflection and exploration of personal experience. Core questions are decided in advance. The exact wording and presentation are left to the discretion of the interviewer, as she responds to the issues raised within the interview.

Counselling skills are used and conveyed throughout the 'counselling-style' interview, thus: *paraphrasing* is used to check understanding and spark further elaboration, also to refocus where the interview may be moving too far away from the core questions. *Reflecting* is used for clarification. The interviewee can confirm the reflection, or can correct and elaborate it. *Summarising* draws together the essence of the interviewee's communication in a brief sentence, emphasizing that the interviewer has been listening, and offering further opportunity for corrections to be made by the interviewee. *Empathy* is conveyed by means of non-verbal communication such as tone of voice. Empathy conveys to the interviewee that they have been understood. *Genuiness* can be expressed as not hiding behind a professional façade. This is not to express one's own opinion on an issue, which may shape and bias future responses from the interviewee, rather, it can be seen as a validation of the experience expressed in the interviewee's account. *Unconditional positive regard* is offered as respect for the person of the interviewee. (Coyle 1998).

3.1.3 The conscious use of self in research settings

Inevitably, an in-depth individual interview technique requires the researcher to become deeply engaged with the participant in the interview process.

Atkinson and Shakespeare (1993) noted the way in which a researcher with experience in the helping professions, such as a counsellor, or social worker, employs the conscious use of self in the research setting. These skills require self-awareness and the capacity to be reflective and introspective. In the collection of data I considered the influence of my interview style upon the interview, and in consequence, upon the choice and direction of the material that was offered by the interviewee. I was aware that through repetition of questions or emphasis on certain issues, it was possible to encourage clients to move in the direction I wanted, through my choice of words. I therefore endeavoured to be as neutral as possible in this respect, and monitored this by reviewing audio-tapes of the interviews.

There is also an argument that the researcher must maintain a social and intellectual distance in order that the proper analytical work can take place, (Hammersley & Atkinson 1995), and Coyle (1998) cautioned beginning practitioners against introducing their own values, interpretation and material into the encounter. However, where researchers are experienced in therapeutic work, they are practised at recognising their own material, and able to use the counselling skills to enhance and facilitate the interview. (Coyle 1998). As a professional counsellor of many years' standing I felt confident to use this technique without interfering or unduly influencing the interviewees' responses, other than in the manner that all social interactions are co-created, and shaped by both participants. (Wetherell & Potter 1988).

3.1.4   On being familiar with the research setting

On the question of professional distance versus over-involvement or over-identification, (Coffey 1999), there is debate as to whether prior, 'expert' knowledge of the research setting is of value, in this case, of being familiar with the shared assumptions of the world of counselling, or whether cultural naivety ensures a unsullied canvas upon which the researcher can study the field without bias. Atkinson (1997) wrote of the necessity of educating himself regarding the procedures of the medical practitioners he studied. I have the

advantage of possessing the professional identity and the personal manner of a counsellor, and as such, able to be recognised, accepted and trusted by the interviewees. I was aware that some talked to me as if I was in a role of a counsellor. Justifying subjectivity, Atkinson and Shakespeare, both health and social care professionals and researchers, commented,

> 'We look to our own world and our own knowledge to throw light on what we are doing......our autobiographies have had a role to play in the construction of our research.' (Atkinson & Shakespeare 1993 p.8)

In a grounded theory approach, researchers are advised to delay reviewing the literature until after data have been collected and analysed, whilst in phenomenological research, the researcher is required to adopt the position of epoche, that is, to bracket one's own values and assumptions. (Spinelli 1989). It is debatable whether this is truly possible, and perhaps it is best thought of as an on-going process, of both setting aside whilst also recognising one's implicit theories. (Cowie et al. 1998). Furthermore, when the researcher is working within their own specialist area, 'bracketing' becomes even more problematic. Whilst a deliberate attempt may be made at being neutral to the data, inevitably one holds opinions and assumptions. (Rennie et al. 1988). I arranged additional use of supervision to ensure this work was as free as possible from professional culture-based bias.

3.1.5   On validating the participants' stories

Transcripts, thematic analyses, and/or a synthesis can be offered to participants for their validation and adjustment, as 'member validation'. (Seale 1999). However, I chose not to do this, firstly in view of the sensitive nature of the topic, as I did not want to open up potentially distressing issues once again. Second, the time delay. Participants move on in their lives and my research is merely a snapshot moment. Further contact may have initiated further narrative making. Third, my concern to complete the research in the allocated time, since the recruiting and interviewing of participants had taken longer than I had initially anticipated.

3.2 RECRUITING PARTICIPANTS

I chose to interview people who had had more than one counselling session, and those for whom some time had elapsed since the counselling, in order that the counselling experience would be incorporated into their narrative identity. This was operationalised as those whose counselling had finished between three and twelve months prior to being contacted for this inquiry.

3.2.1   Access issues

As described by Flick (1998), access can be problematic when researching in counselling settings. He noted the difficulty of recruiting people to be interviewed who cannot be approached directly, because they are clients of the organisation, in this case, the NHS. Counsellor-client confidentiality can make it difficult to contact a representative sample of clients, since the researcher has to rely on the counsellor giving permission, to the point of the counsellor making the initial approach to clients to invite their participation in the research. (McLeod 1990). It is likely that my position as a counsellor in the project assisted in my being granted access in principle. However, there are different levels of regulation of access, as well as various people who hold responsibility, and some were more willing than others to assist me in accessing their clients.

I developed a protocol for the research and arranged informal discussions with the counselling services manager and the lead GP. Of utmost importance, I obtained the agreement and support of the manager of the counselling services, who was the informal gatekeeper, and who held the power to encourage or discourage the counsellors' help in contacting clients. (Flick 1998).

Each counsellor held their counselling records securely within their GP surgery, such that there was no central list of clients. I devised a procedure whereby initial contact with the former client would be through the

counsellor, thus preserving the client's anonymity until after they had agreed to participate. For this purpose I developed a recruitment pack that comprised a letter of introduction signed by the counsellor, a letter of introduction from myself, an information sheet about the research, a response form and a stamped addressed envelope. Copies of all documents are included in Appendix 3.

Eleven counsellors were employed in the two counselling services, working at a total of 17 GP practices. I excluded one counsellor who left her post during the planning stage of this study, and excluded myself. I could not interview my own clients without perhaps reactivating the counselling relationship which may be potentially distressing to the client, and/or obtaining a less objective interview because he/she may wish to praise the work and overlook any negative aspects to 'spare my feelings', or to present themselves as coping better than they would otherwise say. Of the remaining nine counsellors, five worked in more than one practice, and three of these worked in both services. I attended two group meetings, one from each counselling service, to introduce the research to the counsellors and obtain feedback from them on the recruitment pack. As a result of the feedback, a further letter was drafted, to introduce the research to the doctors via each practice manager, a copy of which is included in Appendix 3.

I gave recruitment packs to the counsellors, who then signed their name on the top letter, and addressed the envelopes. At this point I did not have access to the names of clients. Only when a former client returned the response form did I have any information about them, this being their name, contact details, and name of their GP, or the name of their surgery, since some did not identify an individual doctor at their surgery.

Upon receipt of the completed response form, I sent a standard letter to the GP (in Appendix 3), to inform them of the client's agreement to be interviewed for the research, and asking them to reply to me if they felt that

to take part would be inappropriate or harmful in any way to their patient. Where no individual GP was named, a letter was sent to the senior partner. This procedure recognises that the GP holds clinical responsibility for their patients, and that if the GP indicated disapproval, the interview would not be carried out. If no reply was received from the GP after a minimum of two weeks, I proceeded to contact the client by telephone.

The one exception to this procedure was Gareth. Upon receiving a recruitment pack he telephoned me to give his consent to be interviewed. During the telephone call I asked him the name of his doctor's surgery, explaining that I needed to send the doctor a courtesy letter. When we met for interview I obtained his written consent to participate.

No GP with-held permission, however one GP misunderstood my letter and wrote to inform me that he would require the patient's written consent before any medical records could be released.

3.2.2   Theoretical sampling

The extent of the basic population was not known and so a representative sample size could not be defined in advance. Since I was unable to use statistical sampling, I used a method of theoretical sampling, whereby 'sampling is finished when theoretical saturation is reached'. (Flick 1998 p66). That is, by conducting an on-going analysis of the data being collected, when the researcher is confident there are no new themes emerging, it can be said that sufficient data have been achieved. The recruitment packs were sent out in three batches, and decisions made after each batch of replies were received, as to whether to continue to trawl for further participants, following the principles of theoretical sampling.

Table 3.1   Accessing interviewees

date	counsellors approached	invitation letters sent	response forms returned	comments
February - March 2002	4	22	6	no replies from the clients of one counsellor who had accepted 10 invitation packs
May 2002	5	45	9	no replies from the clients of one counsellor who had accepted 18 invitation packs.
September – October 2002	4	26	10	replies received from clients of all counsellors approached
totals:	13*	93	25	

*n > 9 because four counsellors were approached more than once (see below)

I hoped to achieve a minimum of twenty participants. Since I did not know to whom the counsellors had sent recruitment packs, I had no opportunity to follow up non-responders. The number of packs given out varied, nominally six per surgery, with the final number being agreed in negotiation with each counsellor. Five of the counsellors worked in more than one surgery, and for these I prepared additional packs to recruit participants as widely as possible. One counsellor had only recently joined the service and had fewer previous clients to draw upon. I therefore asked her to distribute fewer invitations per surgery. The nine counsellors were approached during the first and second trawl. For the third trawl I approached counsellors who had produced responses from clients during the previous trawls.

3.2.3   Participants

In total I received 25 replies. Two were discarded; one because I recognised the name as being a former client of mine from another setting, and inappropriate for me to interview, and a second where it proved impossible to arrange a mutually convenient location and time to meet for the interview. This left a total of 23 people interviewed for the study.

Table 3.2   Procedure for recruiting participants

access resource	numbers involved	description
Manager of Counselling Service		informal discussion: support obtained
Lead GP		informal discussion: support obtained
NHS Trust Research & Development Board		formal application: permission granted
Area Health Authority Local Research Ethics Committee		formal application: permission granted
GP Practices	14	courtesy letters & information
Primary Care counsellors	9	meetings & explanation of the research; distributed invitation letters to former clients
Former counselling clients	up to 94*	received letters from their counsellor
Former counselling clients	25	returned response form
Clients' GP	24	received opportunity to withhold permission
Interviewees	23	arranged time & location of interview by telephone

*I cannot verify this number since I was dependent upon each counsellor to distribute the recruitment packs.

3.2.4   Demographic profile of participants

Since there was no central list or database of clients, I was unable to select participants, and was reliant upon the counsellors. Because of the low response rate, I interviewed all who returned a response form, with the exception of the two excluded people, as mentioned above. Ideally there would have more than sufficient responses and I would have been able to select a sample. Nonetheless, the mix of interviewees was comparable with the population presenting for counselling in respect of age and gender, as outlined in chapter three.

Table 3.3   Age distribution of clients

age range	no. of clients
under 29	2
30-44	8
45-59	9
over 60	4

Of the 23 participants, 19 were women and 4 were men, a ratio that is broadly reflected in the population of those attending for counselling. There were no interviewees from an ethnic minority. I did not inquire as to sexual orientation, but noted, through the narratives, that all except one interviewee presented a heterosexual discourse of family, marriage, and for some, divorce. There was no use in the interviews of 'indeterminate pronouns' to disguise the gender of a partner (see, for example, Morrish, 2002). The one exception was Gareth, a young man of 18 living at home with his parents. He made no reference to a partner, girlfriend or boyfriend.

The number of sessions attended by clients in the study was six sessions (mean), with a range of 2 – 12 sessions. The number of months since finishing counselling was 6 months (mean), with a range of 4 – 14 months. However, because there was no central data source this information was derived solely from the clients' accounts. Most interviewees were vague about the number of sessions they had attended, and of the time elapsed since finishing, and offered an estimate using holidays and other events, for example, 'I had my last session just after Christmas'. One was precise: 'the day of the attack on the World Trade Centre – it was on the screens in the waiting room and I said to the counsellor 'have you heard the news?'

3.2.5   Representativeness

Qualitative research does not claim to be representative, but to offer a portrayal of the sample in question. I approached all nine available counsellors to distribute recruitment packs to former clients. I requested that counsellors send to former clients within the specified time frame, but I could not confirm that this was done. There were no replies received from the former clients of two of the counsellors, which narrowed the range of counsellors from nine to seven. The lack of replies may have been coincidental, or there may have been factors unique to those counsellors' settings that made the clients less likely to respond. It is also possible that the two counsellors did not distribute the recruitment packs.

If either or both of these counsellors had declined to help with the recruitment of *their* clients for the study, there is the possibility that their clients may have been more negative (or more positive) than those who took part. It is also possible that these counsellors felt more negatively or obstructively towards the research itself, or to the inclusion of their clients in particular. My talking with *their* clients is potentially quite exposing, and particularly since I am a colleague in the counselling service. It is possible that only those counsellors who felt confident for me to interview their clients sent out the mailing, and perhaps others distributed the packs only to those considered 'good' clients with successful outcomes, and this may also have produced a skewed sample and biased results.

Table 3.4 below shows the response rate per counsellor and clients grouped according to their counsellor.

Table 3.4 Response rates per counsellor

counsellor	recruitment packs distributed	responses received	interviewees	comment
1	9	5	Angie Bridie Ffion Ruth Sian	
2	7	1	Christine	
3	12	3	Debbie Eileen Will	
4	6	-	-	
5	16	6	Gareth Heather John Kath Leonard Zena	
6	6	1	Irene	
7	18	-	-	
8	6	3	Marjorie Nikki	one excluded: unable to arrange suitable time & venue
9	12	6	Olive Pamela Tracey Victoria Yvonne	one excluded: a former client of mine
totals:	92	25	23	

A table detailing the participants' age, relationship status, symptoms and presenting issues is included as Appendix 5.

3.3 INTERVIEWING

The interviews took place between March 2002 and January 2003. Once the participants had returned the signed consent to be interviewed, my first contact with the participants was by telephone. The one exception was Leonard, whose telephone number was unobtainable, as since completing the

initial response form he had changed his telephone number. I wrote to his home address, enclosing a stamped addressed envelope, asking that he telephone or write to me. He telephoned me to arrange the interview.

All interviews were conducted on weekdays. Participants were offered a choice of time for the interview (daytime or evening), and a choice of venue. Where there was no preference, I arranged a daytime interview. The seven who requested an evening interview were Ffion, Leonard, Ruth, Sian, Victoria, Will and Zena. The majority chose to be interviewed at their home address. The three exceptions each cited family reasons for choosing to come to an office at the university (Sian), to a local NHS Clinic (Christine), or to my consulting room (Ffion).

The interview is a product of a shaping in which both participants are involved, interviewee and interviewer. (Bornat 1993). Interviews proceed as part of an interview relationship that is situated in time and place. (Radley & Billig 1996). The interview is a 'snapshot', in that the account produced cannot be said to represent a fixed attitude or permanent position. The presumed status of the individuals taking part, in this instance, supposed 'expert' interviewer and acknowledged 'person who needed counselling', underpin the co-construction of the interview, as do taken-for-granted assumptions on the part of interviewees, for example, that as a woman researcher I will share an understanding of my female interviewees' lives.

3.3.1   Development of interview - a subtle change in focus

In developing this research study, I began with an interview schedule that focussed on three core questions. What is counselling? What makes it work? Why does it fail? My intention was firstly to explore how former clients describe counselling. How do they account for counselling? Do the accounts differ from those who have received counselling in other settings according to the research literature, and if so, in what way, and why might this be? Second, what makes counselling work? What are the effective factors?

Counsellors train for many years to become proficient, according to the psychotherapeutic literature, in providing counselling and psychotherapy. How would clients describe this? Would they be aware of the intricacies of the therapeutic nuances that can be so prized by the practitioners? Third, 'how does counselling fail?' What factors may promote a less than successful therapy? How would clients put this into words? Would they be able to distinguish the effective from the less effective or downright unhelpful?

As I began to research the literature, I found reluctance within the profession to seek the opinion of the client, other than a rudimentary evaluation questionnaire completed at the end of counselling. I found few, but consistent, reports that when asked, clients identify generic features such as 'someone who listens to me'. (Howe 1993). Will the clients who have had counselling in primary care be any different? Department of Health policy seeks to include the opinion of the service user. If clients think of counselling as little more than having a nice person to talk to, can this be justified within the Health Service budget?

With the first few interviews it became apparent that the majority of clients were unable to describe counselling, or its effective and ineffective factors. Interviewees tended to be quite vague in their responses. Imposing the schedule was interrupting the natural flow of the interviewee's story, and despite my best attempts at offering probe questions, they offered instead detailed narratives of their life-world, their lives and troubles, and where counselling fitted within this. Answers to questions relating directly to the counselling were prefaced with long contextualizing narrative. In addition, questions directly about the counselling at the GP surgery were frequently answered by offering contrasting experience of other counselling, both before and since. In this manner the client's account of the nature of counselling, and the effective and non-effective factors, were but a small part of the rich data collected. Clients offered biographical accounts of which their encounter with counselling was only one element. My attempts to bring the client back

to the interview schedule either interrupted the client's narrative, or simply failed, as the client continued, ignoring my intervention.

Following consultation with my research supervisor regarding the first three 'pilot' interviews, I developed an interview schedule to follow a chronological progression. Before: What were things like before you came for counselling? What led up to your having counselling? Who suggested that you saw a counsellor? Did you have any expectations of what counselling would be like? During: What was the counselling like? Was it what you expected or was it different? What was helpful about the counselling? What was unhelpful about it? After: How were you after the counselling? Has it made a difference? What is different now? (Or isn't there a difference?). These questions facilitated the client's generation of narrative, whilst at the same time, allowed me to retain some control over the direction of the interview.

In developing this study, my original intention was to focus on the course of counselling received at the GP surgery. Since the primary care counselling service was designed to meet the needs of patients who did not meet referral criteria for specialist services, I had failed to anticipate that a substantial number of interviewees, 10 of the 23, would also have received some form of therapeutic contact elsewhere. As I have noted above, these clients brought in descriptions of previous counselling, and/or subsequent ones. Whilst initially I encouraged the participant to focus on *this* counselling, that is, at the doctors', I later decided to use the material referring to other episodes of counselling, as a rich source of contrast narrative. Consistent with my research approach, enriched by this contrasting material, whilst the focus of the inquiry remained *this* episode of counselling, it broadened to the *accounts of people who had had counselling* at their GP surgery, and who may or may not have had other encounters with counselling.

Table 3.5: Number of therapeutic episodes

interviewee	single therapeutic episode	prior therapeutic episode	subsequent therapeutic episode
Angie	x		
Bridie		x	x
Christine		x	
Debbie		x	x
Eileen	x		
Ffion		x	
Gareth	x		
Heather	x		
Irene		x	
John	x		
Kath		x	
Leonard	x		
Marjorie	x		
Nikki		x	
Olive			x
Pamela		x	x
Ruth	x		
Sian		x	
Tracey	x		
Victoria		x	
Will	x		
Yvonne	x		
Zena	x		
totals	12	10	4

n.b. n>23 as some clients had had more than one therapeutic episode

Table 3.6 below provides further detail as to the types of therapeutic support accessed by the interviewees in this study.

Table 3.6: Variety of therapeutic episodes

secondary care - psychologist	Christine, Debbie, Pamela*, Sian
secondary care - psychiatrist	Bridie*, Kath, Nikki, Sian
volunteer counsellor	Debbie* (Christian counselling agency) Ffion (community counselling agency Olive* (Cruse Bereavement Care)
independent counsellor	Bridie
private healthcare provider	Irene
Relate couples counselling	Victoria
groups	Debbie* (assertiveness group) Pamela (pain management group) Sian (bereavement support group)

* = therapeutic episode since GP counselling

3.3.2   The use of audio tape

Written consent (in Appendix 3) was obtained at the beginning of each interview for a recording to be made on audio-tape, using an unobtrusive portable recording device. At the commencement of each meeting I explained the consent form in detail. I invited any questions the participant may have had. The participant then signed one copy and returned it to me, and kept a copy for their future reference. After the consent form was signed I switched on the tape recorder. All interviews were tape recorded using a miniature audio-tape recorder and standard C90 audio-tapes. This provided satisfactory recording quality, with three exceptions: Ffion, Irene and Sian. At the commencement of the interview with Irene the recording device failed to engage. I noticed after approximately five minutes that the machine was not working, and successfully began the recording. I was able to recall the interview to that point, and repeated a summary of the discussion, for the benefit of the tape. I obtained Irene's agreement of my summary, and there was nothing of significance lost as a result. During the interview with Ffion the tape-recorder's batteries were running low. This resulted in a slowing down of the voices on the tape toward the end of side one, and unfortunately a few minutes of data were lost. Sian was a softly-spoken woman whose voice became even softer as she spoke of the distressing experience that had brought her to counselling. Unfortunately the interview with Sian took place at the university in a room unfamiliar to me, and I did not choose an ideal position to place the tape recorder. Outside my knowledge at the time of the interview, whilst the gist of her narrative had been preserved, sadly the recording had a number of inaudible moments throughout.

There is an assumption that interviewees will 'forget' that they are being tape recorded, (Flick 1998), however this cannot be assumed to be so. One never knows what is not said because the tape is running. (Aveline 1997). Of my interviewees, the majority were very open in their disclosures, for example, John discussed the impact of his depression on his libido. Ruth initially hesitated to talk critically about counsellors in private practice. Born in

England although now living in Wales, looking in the direction of the tape, she also made disparaging references to Wales. I made a point of repeating that no-one else would hear the tape, and that all material would be anonymised. However, two participants waited until the tape was switched off before introducing sensitive topics. Debbie intimated that she was currently seeing a counsellor in the voluntary sector and that she was not happy with the service she was receiving, whilst Leonard asked whether there were any men in the counselling service, and on my prompting, admitted that he would have preferred to see a male counsellor.

3.3.3   Fieldnotes

After each interview I wrote fieldnotes. I recorded demographic information, such as age, number of children, etc, and also noted my thoughts and feelings of the interview. I recorded any comments that were made off-tape, and any issues to note for my further attention during the analysis.

3.3.4   Transcription and equipment

I transcribed the interviews within days of their taking place, using an audio cassette transcribing system with foot controls and Microsoft Word word processing software. The process of transcribing afforded me an invaluable opportunity to immerse myself in the data. As one of the participants in the interviews, undertaking the transcription myself added to the accuracy of representation. It resulted in transcripts more faithful to the clients' narratives, as where there were ambiguities on the tape, I could refer to my memory of the interview itself and draw upon the meaning expressed by the interviewee. (Seale 1999). Aware of the constructionist approach to the co-creation of interactions, I included all of my questions, reflections, minimal encouragers, etc. in the transcription, thereby making possible later analysis of my role in the process of developing the narrative. For example, I could check whether an interviewee spontaneously introduced an issue, or whether this was a consequence of introducing it myself.

3.3.5   Poem-like structures

Whilst my analysis was later to be carried out on the content of client interview material, immediately after transcribing each audio-tape I constructed a poetic form of the complete interview. (Richardson 1992). Developing and structuring the data in this way, through the composition, the poem-like structures helped me to fix and 'hold' the essence of each interview in my mind. Using the words of the participant, the poem-like structure contains the whole of the participant's story in a concentrated form. It preserves the verbal quality and retains the pacing and pathos of the original. As Riessman (1993) noted, interviewees' narratives more naturally form poetic stanzas than formal, grammatical sentences. The spoken word is not the same as text, and textual presentation loses the individual's voice, such that the poem-like structure is 'truer' to the original. 'Poetry may actually better represent the speaker than the practice of quoting snippets in prose.' (Richardson 1998 p.357). They also permit a view of the whole story as presented in the interview, in contrast to the process of breaking apart data into smaller and smaller meaning units. (Coffey & Atkinson 1996). The poetic structures are not intended to be 'broken apart' as in code and retrieve protocols, but to be read for their ability to offer insight into the interviewee's way of presenting autobiography. Whilst I did not analyse these poems as part of the study, I include them as Appendix 6. They also form a contrast to the more conventional representation of participants in Appendix 5.

Table 3.7   Diary for data collection

date	details
Aug 2001	developed research question
Aug - Oct 2001	developed protocol, research strategy and materials
Sep 2001	obtained initial approval from Counselling Manager and lead GP
Oct 2001	introduced research to North Oaktown counsellors
Oct 2001	used feedback from initial meeting with North Oaktown counsellors to refine procedures and materials for recruiting participants
Nov 2001	submitted application to NHS Trust
Nov 2001	obtained approval from NHS Trust
Nov 2001	submitted application to Local Health Authority Research Ethics Committee
Dec 2001	obtained approval from Local Health Authority Research Ethics Committee
Jan 2002	introduced research to Ashville counsellors
Feb - Sep 2002	courtesy letters sent to GPs introducing the research
Feb - Oct 2002	individual meetings with counsellors and distribution of information and invitations to participate
Mar – Nov 2002	courtesy letters to GPs informing them of the participants' consent to be interviewed
Mar 2002 – Jan 2003	interviews with participants
Apr 2002 – Mar 2003	transcribed interviews

3.4 ANALYSIS

3.4.1   Computer software

I aquainted myself with the qualitative data handling software package ATLAS/ti. (Muhr 1991). I was working on two computers, one located at the university and one at my home address. As the process of analysis developed, because of the size of the files generated, I found it inconvenient and increasingly unmanageable to transfer the up-to-date analysis between computers. I therefore chose to perform the data analysis using the 'cut and paste' editing feature of Microsoft Word word processing software. Whilst labourious, this afforded further opportunity to engage in depth with the data,
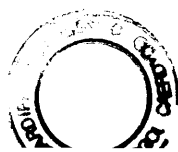
not merely on screen, but also in paper form that I could work with away from the computer. My preference is to work closely with the data, and to make notes on paper suited my preferred way of working.

3.4.2   Analysis of content

I carried out a thematic analysis, (e.g. Aronson 1994, Boyatzis 1998), as a method of content analysis of seeing and sensing themes, appropriate to this type of sensitive data. This firstly involved a process of reading through three transcripts, summarizing, and making an initial coding of the data using coloured pens. Identifying key themes, categories emerged from the transcripts. Twelve key themes were named, and codes were ascribed. Three further transcripts were read and summarised by my research supervisor. A broad agreement of codes was reached. The codes were then applied to the remaining transcripts. Subsequent work with the data involved sub-dividing themes, noticing connections and overlaps, and further breaking apart the data, using the constant comparative method, (e.g. Seale 1999), to test, refine and further develop the themes. Use of the 'cut and paste' facility of the word processing software allowed the handling, movement and re-organisation of the data. (Coffey & Atkinson 1996). I developed a matrix on which to record the process of this analysis, an example of which is included as Appendix 4.

In this way I worked with the themes that emerged from the content analysis of the data, and present the findings in the following two chapters. I have grouped the findings as firstly, the client's perspective of 'what works' in counselling, secondly, the expectations that clients bring to counselling, thirdly, how clients present themselves and the kind of people that they are, and fourthly, where and how counselling fits in the life-world of clients.

3.4.3   Confidentiality and anonymising data

I have changed identifying details throughout as a means of protecting the identity of the clients and their counsellors, whilst at the same time permitting

a faithful reproduction of the interview data and of the clients' stories. To anonymise the data, I gave each client a pseudonym, in alphabetical order, Angie being the first to be interviewed, followed by Bridie and Christine, and with a name that reflected the person in this Welsh urban community, in terms of age and gender. Thus, Nikki is in her 30s, Pamela in her 50s and Marjorie is in her 70s. Bridie is from Ireland. Ffion and Sian are Welsh speakers. Identifying details, such as names of family members or health professionals, have been removed, and replaced with generic descriptions ('my husband', 'my doctor'). North Oaktown and Ashville are also pseudonyms.

3.4.4   Storing data

Hard copies of all transcripts and analyses were kept in a secure, locked filing cabinet at my home address, as were the audio-tapes of interviews and back-up computer floppy disks. All materials stored electronically, both on my personal computer and at the university, were on password-protected accounts. The one original document, the response form, which contained the interviewees' identifying details, was linked to the pseudonym by a system of cross-referencing using coded notation, filed separately in a locked filing cabinet.

3.5 ETHICAL CONSIDERATIONS

Since the participants had received counselling through a counsellor employed by the NHS, it was necessary to obtain formal approval from both the NHS Trust and from the Health Authority's Local Research Ethics Committee. A copy of the letter of approval is included as Appendix 2.

Interviewing a client during the course of counselling may affect the process itself, whilst interviewing after the counselling has finished carries the risk of re-awakening unresolved emotional issues and causing distress to the interviewee. (McLeod 1990). Whilst I had offered the client's GP an opportunity to advise against proceeding with the interview, other than that, I

had no means of knowing the former client's current state of psychological functioning. I therefore took the view that it was possible that the discussion would cover sensitive issues, and the recounting of these may stimulate painful memories and feelings.

It is unethical for a researcher to address sensitive issues with interviewees, to re-stimulate painful experiences, record them, and leave. (Finch 1984). I ensured that I was aware of local resources available both within the NHS and through voluntary and community agencies, should it become apparent that this might be helpful for the interviewee. I was also aware of my responsibility to identify possible mental health issues that may need attention, and to be prepared to liase with medical staff if appropriate. The British Psychological Society's Code of Conduct, Ethical Principles and Guidelines, (BPS 2000), advise the offer of a 'debrief' session following participation in research. This I offered to all participants, verbally at the end of the interview, leaving telephone contact details on a printed sheet. None of the interviewees took up this offer.

Whilst data collection was the core of the work, I hoped the interviewee experienced their participation in the study as a 'sensitive and meaningful encounter'. (Coyle 1998 p.59). I kept in the foreground my role as researcher, and not therapeutic practitioner. It would have been unethical to engage interviewees specifically in therapeutic work, although interviewees may have valued the opportunity to talk through their experience.

Whilst participants gave their consent to take part in the study, I was aware that consent may be given without recognising the potential for re-activating memories. (Coyle 1998). I was able to utilize my skills as a psychological counsellor to deal with any emotional turmoil that emerged, to ensure as far as possible the psychological well-being of the interviewee. I made use of my own structures for support, both my research supervisor and the supervisor of

my psychotherapeutic work, to ensure both my psychological well-being and that I was working within my own competence. (Coyle 1998).

Many of the interviews were emotionally charged. Eileen and Olive both spoke of the death of their husbands in detail, and of their grief. Debbie retold the mental health problems and suicide of her husband. Angie offered the detail of the physical abuse she suffered at the hands of her former husband and other partners, whilst Sian recounted the very harrowing story of physical abuse and the later suicide of her husband. Some of the participants presented as emotionally vulnerable. Bridie, Irene and Kath were all very tearful during the interview, in a manner that suggested they constructed the interview as similar to a counselling session. Whilst I possessed counselling skills and an appreciation of therapeutic interventions, these participants had not consented to a therapeutic contract with me, but to participate in my study. I was aware of my responsibility not to leave a participant in a worse state than when I arrived. (BPS 2000). I employed techniques such as asking what the participant was going to do after I had left, as a means of seeking to focus them on everyday activities and away from their distress. I also enquired what sources of support they had, such as family or helping professionals, and whether these seemed adequate, with a view to exploring possible additional sources of support if this appeared to be required. Heather and Ruth were keen to do some psychotherapeutic work in a context other than the surgery, and I was able to offer contact details of reputable local counselling agencies. Debbie was in voluntary sector counselling, although this was not proceeding very well. Yvonne was already on the waiting list to see her GP counsellor again, and at the end of our interview, Irene thought she might request a re-referral to her GP counsellor.

CHAPTER FOUR

THE CLIENT'S VOICE ON COUNSELLING

Talking to somebody who's got nothing to do with it, who was completely on the outside, and me not trying to make out I was a saint or anything, y'know, 'cos I wasn't trying to do that. Just talking freely abut things, helped tremendously, yes. She did put things back in perspective, which is what I needed. [Tracey]

This chapter is concerned with what clients have to say about counselling. Firstly, what is it that makes counselling 'work'? In considering client opinion on 'why counselling works' I will examine factors cited by clients as responsible for the success of their counselling. Three clusters of factors emerged, that of relationship factors, therapeutic interventions, and contextual factors. In accounting for effective help, participants also offered contrasting stories of other forms of therapeutic input. I will then go on to look at the expectations clients had of counselling, and the changes they experienced.

In considering the 'before and after' of counselling, I was interested to explore the impressions that clients had formed prior to counselling, from what sources, and whether counselling matched their expectations. It was apparent that a few participants considered themselves or their lives completely restored or transformed. Most presented themselves as somewhat improved and better able to deal with 'ups & downs', whilst for some, counselling had seemed to make little difference. Finally, I will look at client accounts of successful counselling in primary care, as well as accounts of counselling as disappointing.

Quotations in this chapter are from all interviewees except one, Olive being the person who could not recall seeing the primary care counsellor.

4.1 RELATIONSHIP FACTORS

The factors in the relationship cluster include being in a relationship, having someone to talk to, someone who is outside the client's immediate circle of family and friends, a person who is perceived as having expertise, and someone who has certain personal qualities that enable the client to feel at ease.

4.1.1 The quality of the relationship

The majority of clients, 18 of the 23 interviewed, spoke of the importance of the quality of the relationship with their counsellor. The former clients spoke of the connection with a person perceived as caring, of feeling understood, the importance of that relationship and the disruption and loss when this connection is severed. Clients made comments concerning the nature of feeling connected with their GP counsellor and of getting used to a particular person:

> She was very nice, and we gained a rapport. She's a lovely lady, as I say. I think, possibly, if you don't hit it off with your counsellor than it's not going to do you so much good, is it? - whether you persevere in going, y'know? [Ruth]

Angie in particular commented on the importance of the relationship with a counsellor:

> Obviously if you're trying to bring out all your hurt and your fears and your feelings, you have to be able to relate to the person that's going to be there to help you. And I think that, um, y'know, that - if you've got the right person, then it can be a wonderful thing and work. Definitely. The only trouble is that if you've got somebody that went to somebody they couldn't relate to, then that would be, y'know, that could be, damaging, maybe. [Angie]

Angie went on to make this contrast with a friend who was receiving counselling:

> She was finding it difficult to begin with, to relate to the person that she was having counselling from. And she was having difficulty for quite a

few sessions, before she was actually able to sort-of relax and - and be okay about it. [Angie]

In this present study, Sian had been in a physically and emotionally abusive relationship. Of the clinical psychologist she saw previously, she said:

The guy was nice and kind and everything – but he wasn't on my wavelength and I couldn't relate to him. I only went once to him. This guy was the same sort of age as my ex-husband, which made it even worse. So I think, because I couldn't relate to him, I didn't take to the guy. It doesn't have to <u>be</u> anything, it's just the impression you get. I didn't find any warmth in him, let's put it that way. It was all sorts of things, but I couldn't relate to him. Full stop. End of story. [Sian]

Clients seem to recognise the importance of the person who is the therapist, and the relationship they have with them. Debbie described her dilemma at letting go the counselling relationship:

I was a bit upset when it came to an end, really, cos I thought, 'well, it'd be nice to go back, I dunno, every three months or something'. Um, but then maybe not. Because maybe it's not a good idea to hold on to that, really. I mean at some point you've got to go out into the big world and do it yourself. Um, it's the sort-of safety net at the time isn't it? When you feel safe, you feel like somebody's looking out for you. But no, you've then got to take responsibility for yourself. [Debbie]

Ruth also mused that the amount of time spent with the counsellor would never be sufficient:

Perhaps if the appointments could be an-hour-and-a-half, maybe. I don't know. Perhaps it would never be enough, would it? Who knows. [Ruth]

Victoria and Sian commented on the importance of 'fit' between client and counsellor. Victoria surmised:

I suppose sometimes people don't get on with their counsellors, or counsellors don't like their person. And I suppose they declare an interest then and say 'I don't think I'm going to be able to do this person much good'. [Victoria]

Whilst Sian declared of her counsellor:

She may not have been right for somebody else, but for me she was spot-on! [Sian]

Zena said of an acquaintance who is currently in counselling, 'she doesn't want to leave go of it. She still does see him'. By contrast, Leonard's account of the end of counselling indicated no such attachment:

There wasn't anything to say. It had all been said. I think that ultimately you can come to that position when there's nothing more to say. You can say something but you've answered that last week, or whatever. So when it comes to the fact that you no longer spend an hour together, you only spend ten minutes and you run out of conversation, then it's time to say goodbye. I think that's how it came to an end, is that both of us said there's no purpose really, 'cos there's nothing we want to talk about. It ended in that way. [Leonard]

4.1.2   Someone to talk to

The majority of interviewees named the importance of counselling as 'just to talk', whereas others were able to account for using the time purposefully and constructively. There were many comments such as 'it's good just to talk', 'to have someone listen to me', and 'to get it off my chest'. For example, Bridie was living with the aftermath of being harassed at work:

Talking about it, I think helps. I think I had a shortage of having someone to talk to about it. Um, I would say that for every week, once a week, whilst I've been going through this, I would probably have needed someone to talk to. I think it was helpful at the time. The counsellor can't change what's happened, nor can she alter the future, except to support how I'm feeling, or what I've felt because of what I've gone through. But apart from that I do think it's a vital service, going and off-loading to someone, your emotional concerns or apprehensions. [Bridie]

Doctors were often respected but 'didn't have time to talk'. When people tried to talk to family they were often silenced. Male relatives in particular did not want to talk about emotional subjects and friends were seen as hi-jacking the conversation to talk about themselves. For some, talking in a group did not meet the need for talk, with comments referring to not enough time 'for me'

because others dominated the group. There was also the anxiety of talking in a group.

4.1.3   Someone outside one's circle of family, friends and work

Talk as a core factor was closely linked with the theme of impartiality, of being able to talk with no strings attached, without the usual social rules for conversation, that is, a relationship with someone outside the client's immediate circle of family and friends. This was acknowledged by the majority in this study. 'The counsellor didn't know the other people in my family and could look at the situation with fresh eyes, without pre-judging'. 'With family you hold things back, but you can let it all out to a counsellor'. Family and friends were thought to either overly agree with the client, in an attempt to be supportive, or lacked training and understanding, and offered 'pull yourself together' comments, which were considered unhelpful.

> *How often do you get to sit down and talk about you, when it's not a two-way conversation, and you're not having to give care to your friend or whatever? So that in itself is brilliant. There's no 'give', you're just 'taking'. Which sounds an awful callous way of doing it. You don't walk into it and think 'I'm going to take as much as I can', but you only have to be aware of yourself. You don't have to worry about anybody else's responses to you, or what they think of you, even. [Ffion]*

With a stranger, one could be honest, with no need to maintain a good image of oneself:

> *We talked about things that I couldn't talk to my friends about. 'Cos I didn't want them to think I was under pressure, or – well I didn't want to reveal too much about my own family situation to them because, they are my friends, but I don't want them to know everything about me. [Yvonne]*

Participants in this study said that they could not be completely open and honest with friends, either not to hurt them or cause distress, or not for others to think badly of them. Of the two who had been offered counselling at their place of work, Tracey and Will both had concerns that a 'works

counsellor' would not hold confidentiality and would report back to their managers.

4.1.4   A person perceived as having expertise

The counsellor was presented as 'she knew what she was doing'. The expertise of the counsellor was considered important, with frequently a definite statement, such as 'She was good. Very good'. Counsellors were seen as trained, experienced and effective.

> *Everything does get dredged up. And I think if you have an experienced counsellor who can pick up on things and go back to them, yeah, it definitely helps. I think that helps a lot, actually, being in a safe environment. It's also safe to cry, as well, without feeling a total twerp, which you do. And I did cry, and I did feel a twerp {laughs}. But you feel safe doing it, because you know your listener is trained. [Ffion]*

The only exception in this study was Kath, who considered that counsellors should be expert at assessing the mental health needs of clients, and to recognise whether counselling will be sufficient, or whether a deeper or longer term therapeutic intervention would be more helpful. Kath thought her counsellor was inexperienced and not able to recognise that she (Kath) needed more help than she was being given.

Of the inexperience of others, friends were described as not possessing the expertise, or as too self-interested, to be helpful:

> *Not every friend is able to listen, and draw you towards the right things. I think sometimes you can perhaps make things worse, if you don't know what you're doing. A friend tells you to pull yourself together, and there's nothing wrong with you. And there is something wrong with you, and you can get help. [Zena]*

4.1.5   The personal qualities of the counsellor

More than a half of the interviewees spoke of personal qualities, such as kindness, being seen as contributing to the establishment of a good relationship. For example:

As soon as I seen her face. She had a very, very soft gentle face. And her accent. She's very, very softly spoken. And it just put me at ease straight away. [Nikki]

Clients appreciated what they considered an appropriate amount of personal disclosure on the part of the counsellor. Where this was mentioned, this was experienced as a useful part of forming a relationship with a 'real person', as opposed to someone who maintained a professional façade.

Leonard was concerned about the lack of similarity between himself and his counsellor. He was a man on the verge of retirement, in his eyes she was 'young girl' and he questioned, 'what does she know?' He also assumed that she would automatically 'take his ex-wife's side'. Ffion commented that both counsellors she had seen were not 'on the same wavelength' as her. They were older women, one used the term 'courting' to describe Ffion's relationship, and neither shared Ffion's New Age worldview.

Bridie considered the personal and professional experience of the counsellor to be important, that is, for her, to have worked in an education setting rather than the health service, in order to share an appreciation of the contextual pressures. Ffion thought that although counsellors have training, they still bring 'themselves', that is, their individual personality, into the counselling sessions. Christine said of counsellors 'they can get you to talk', and Angie's comment was:

They do make it easy for you, and you can just say whatever it is that comes into your mind, or whatever worries you have, or whatever, and it's helpful. [Angie]

Victoria, who had enrolled on a counselling course, spoke of the self-awareness of counsellors. Of being a trainee counsellor, she said:

You have to go through counselling yourself, as well, which is understandable, because I suppose you've got to understand yourself deeply before you can sit in a position of talking to other people. [Victoria]

Gender match between client and counsellor

All of the interviewees had seen female counsellors. With a couple of exceptions, gender did not figure as an important factor in the client accounts. Leonard commented off-tape that he would have preferred to talk to a male counsellor, and engaged me in a conversation regarding the scarcity of male counsellors in primary care. Sian was vehement that she did not want a male counsellor, asserting that a woman could understand her better. She had previously seen a male psychologist who had reminded her of her abusive ex-husband. Yvonne said she preferred to talk to a woman, whereas Ruth felt that the personality of the counsellor and the quality of the relationship were more important than the gender of the counsellor.

Debbie, Olive, and Pamela had worked with male therapists or counsellors either prior to or since the counselling. For them, gender was not brought up as a difficulty, indeed Olive and Pamela were both currently working with a male therapist, and were pleased with the help they were receiving.

Zena made of point of saying that if her problems were very distressing, the gender of the counsellor would not matter, whereas as it was, she was glad to have had a woman counsellor, who, she felt, would 'instinctively' understand her experience of being a woman and a mother:

> *I think that a lot of the things that I say, another woman would understand, where maybe a man wouldn't. If it had been a very fresh grief, or a husband passing, or a child, in that way, I don't think it would have mattered whether it was a man or a woman, because I think we all identify with a deep grief. But the loss that I had for my mother, I don't think a man would understand. [Zena]*

4.2 THERAPEUTIC INTERVENTIONS

The factors in this second cluster, therapeutic interventions, are relating to seeing things from a different perspective, doing things differently, exploring options for the future, expressing emotion, 'normalising' the client's experience, exploring 'deeper' issues, and books and other written resources.

4.2.1   Seeing things from a different perspective

Gaining a different perspective, of self, of people, and of the situation, so much so, that for clients, the concept of 'gaining new perspective' could be said to define counselling. There were accounts relating to seeing the situation, or for some, seeing oneself, from a different perspective, and also considering alternative explanations for another's behaviour or attitude. There were numerous and lengthy examples. Of oneself:

> *It did help, in so much as it allowed me to look at myself, perhaps, from someone else's point of view, that I wasn't doing before. Not that that was something I wanted to feel or see or say. But it did help me see myself from someone else's point of view. It helped me to see myself. Whether it helped my situation is another matter. You can look back and say 'well it really didn't change too much'. But it did allow me to see myself as others see me. It was useful. [Leonard]*

Of others:

> *If somebody says something and upsets you, it's not necessarily that they want to upset you. You don't know what's happening in their world, that they've been rude or ignorant, or whatever. And it just helps you put it into perspective, really. [Ruth]*

Of problems:

> *Because I've tried that, I've tried that, I've tried that! And that doesn't work. And then when you've got somebody then who says 'well, okay, you've tried all these things because you were looking at it from that angle. How about looking at it from this angle. Um, I thought, 'oh, didn't think of changing my way of looking'. {laughs} I was just thinking, 'how am I going to deal with this?' I wasn't thinking 'well try looking that way instead'. [Angie]*

Of habitual ways:

> *A different point of view. To say that you'd learned these things in childhood, and you accept them as correct and right, but they're not always, now, as correct as they were, for you. And that was quite eye-opening, really. I'd think 'oh, yeah.' Quite liberating. And that helps. Yeah, that did help. 'Why didn't I think of this before?' The light-bulb going on, thing, y'know? It really was a great weight. [Ruth]*

4.2.2 Thinking and doing things differently

Of aspects relating to teaching or learning, clients valued advice, information and suggestions for doing things differently. This category had the largest number of quotations ascribed to it, 19 of the 23, as to be almost universal. There were many references to learning different ways of thinking about oneself, for example, for Irene, who had been sexually abused as a child: 'the counsellor got me to think it wasn't my fault, but that I was the victim'. Nikki offered:

> *She explained to me I can change things. I didn't have to wait for anyone else to do it. I can do it myself. [Nikki].*

In the accounts of those who described the helpfulness of specific interventions, there was a considerable amount of apparently direct advice. This was often related to assertiveness, for example, for Ruth, in the relationship with her boss, the counsellor helped her with different ways of handling situations, voiced as 'next time you could do it like this'. Two clients commented on the helpfulness of cognitive techniques relating to thinking about things differently.

4.2.3 Exploring options for the future

This theme consists of developing and evaluating options, which had often been unexplored or assumed unattainable. It also includes focussing on plans, identifying preferences, and putting these into practice.

> *She didn't tell me what to do. She didn't even give me options. She, like, said a few things, and she said 'you <u>can</u> do this if you want to' or 'you <u>can</u> do that if you want to'. And it was just moreso the confidence boost she give me. And like I said, she didn't – she said 'I can't tell you <u>what</u> to do. I can't give you options'. But she made me give her the options, and then I realised, 'well, yeah, I have got options'. And then she said 'right, well, you've got options. You've just told me 'em, so now you go and put 'em into place. Or try to'. [Nikki]*

For this analysis I have taken into account interviewees' comments regarding other sources of help, such as family and friends. Considering plans and alternatives were only mentioned as part of counselling, and were not a feature of other helping sources.

4.2.4   Expressing emotion

Clients described their anguish and their relief at the release of tears and emotion.

> *She got it out of me how I was feeling about it. And, yeah, it was much better that time. I did end up writing a letter, to my grandfather, just to finally put the blame on him. Because I'd always blamed myself. And I didn't post it. I just read it, and bawled my eyes out, tore it up and put it in the bin. And felt better for it. [Irene]*

Where emotion was mentioned it was often located at the beginning of the counselling contact, for example:

> *Harrowing, the first couple of sessions, but it made me face up to it. Face the demons first, then you've got a chance of getting over it. [John]*

Victoria talked of 'needing people' to 'help to bring it out of you'.

> *It was the counselling that brought things to a head. Things that had probably been simmering for a while, or kept under wraps, whatever. It was probably a good thing anyway, in the long run. There were things that I was keeping under wraps and not letting out. And then once I did, that's when I actually was off work for a while, because I found it difficult to cope with. But I think it was a process that I needed to go through. Y'know, sometimes things need to get worse before they can get better. You actually need to admit there's a problem, or whatever, whether it be in your past, or present, or what combination it is, and actually deal with it. And as painful as it might be at the time, going through the process, it probably is beneficial. 'Cos it'll come back to haunt you at some time. In some way or another. It'll affect your relationships in other ways, later on, whether it be with partners, children, whatever. [Victoria]*

Ffion said, referring to her aromatherapist:

She confided in me that she was seeing a counsellor and she was asking how it was going. I said, 'oh I bloody bawled my eyes out yesterday! I felt a right wally'. She said 'oh my god you're so lucky! I've been going for years and I can never -', she said. 'It's in there {indicates her chest} and it's never coming out,' she said. 'And it needs to come out. She said 'you're so lucky. I don't ever feel I get to that place and I know I need to'. I think it's important to feel - talking, and letting it out, so that it doesn't build up to a place where it's going to burst forth, in an unpleasant way, like a panic attack, basically. [Ffion]

4.2.5   Processing trauma

Gareth, who had been the victim of an assault, said of the counselling:

Bringing it all back up. That made me feel ten times worse. 'Cos to start talking about it again, it makes you think about it. And it turned my stomach. [Gareth]

Angie spoke of her father:

No end of people have said to him 'why don't you go to counselling, cos that'll help you deal with all the trauma you've been through and sort these things out in your head and you'll cope better', y'know, 'and help you sleep and that'. [Angie]

4.2.6   'Normalizing' the client's experience

Clients appreciated finding that they were not alone or odd, through either information given by the counsellor, for example, of the effects of bereavement, and for Debbie, the normalising experience of being in a group setting of an assertiveness group:

Y'know, for people like me - and judging by the assertiveness course, there are an awful lot of people like me around. [laughs] I mean there were people there who were worse than me....It was weird, because you know how easy it is to think you're the only one who goes through this? And I thought, well, I actually felt not too bad compared to some of them. I thought, y'know, some of these people are actually worse than me. It didn't make me feel better, it just made me realise that there are so many - I thought, if there's - there were going to be eight of us there - if there's this many people in this small group, imagine how many there are in the country, that are struggling through life, trying to stand up for themselves, and stand up to bullies, even the family, y'know, and things. It sort-of made me feel not so alone as well. [Debbie]

4.2.7 Addressing deeper issues

Working on more than the presenting issue and going deeply into issues was valued in the client accounts. Those who explored older issues were more satisfied with the outcome of their counselling. Many clients explored their childhood relationships. Victoria, who went for counselling in the aftermath of her divorce, spoke of the usefulness of the counselling for her, working with issues from her childhood. During counselling Eileen re-constructing her early family relationships and noted that she 'always felt second best' and Debbie 'could never say 'no' to her sister'.

Debbie thought that she recognised different types of cognitive counselling, and asked me directly in the interview if this was so, seeking to settle the confusion she held regarding her previous therapy. Heather, Kath and Zena spoke of the depth of counselling. Kath was disappointed not to have explored childhood experiences. Heather and Kath were both disappointed because they wanted a deeper form of counselling. For Zena it was her choice to work at a surface level, but she recognised the distinction. She spoke of an acquaintance:

> *I know somebody who has been to deeper counselling than me. And I know that she would never have got through without it. [Zena]*

By contrast, for some clients, dealing with only the surface issues was not well received, and counselling was then felt to be 'not deep enough'. Several clients were left feeling disappointed and frustrated. Heather wanted to talk about the effect of the death of her mother when she (Heather) was a teenager:

> *That's what they looked at, my problems with socialising and going out. But I think it's more deep. I don't think that was the help I needed. She suggested, when I go to get the children from school, strike up a conversation with one of the mums, instead of waiting for them to come to me. Which, you know, on days, I can do. On other days I don't want to. In that respect, the counselling didn't really help in that way. That's basically why I stopped going. I didn't think it was really dealing with the problems that I had. [Heather]*

4.2.8   Books and other written resources

Books that were suggested or loaned by the counsellor were mentioned by only a few participants, but these were valued and considered useful. Recuperating after a breakdown, Will bought his own copy of 'Mind over Mood' (Greenberger & Padesky 1996) that his counsellor had used in the sessions. Whilst working on assertiveness, Angie used a copy of 'Feel the Fear and Do it Anyway' (Jeffers 1991) that had been lent to her by her counsellor. Christine read the pamphlets on self-esteem that had been provided by her counsellor. However, what suits one may not suit another, so for example, whilst Angie and Ffion found the self-help and assertiveness books helpful, Heather had read books prior to the counselling. She found them interesting but was unable to use the self-esteem raising exercises. Furthermore, Eileen was angered at the bereavement article she had been given by her counsellor. John had accessed material via the internet, which he found helpful.

4.2.9   Counselling and individual responsibility

In this section where I have considered therapeutic interventions, it is worth noting that in some client accounts, there is recognition of their part in the process. That is, concerning the client being the one who has to do the 'work', as in these three quotations:

> *Everything is down to me, anyway, isn't it? Nobody can wave a magic wand. And I either get over it, or I go under, y'know? [Kath]*

> *I think it's an exposure of where you're at. Helping you to look at the problems. To try and solve them yourself. I think that's the bottom line. It's not going to solve your problems for you. It's not going to get rid of the problems. It's just going to help you to see them. And to find your own solution. I think that basically is what you would say counselling is about. That's all. 'Cos some of the things you're told you don't like to hear, pretty much. And then you have to come to terms with that, and accept it. And look at it and say 'that's the problem - that's how someone else sees it'. [Leonard]*

I don't think the purpose of counselling is to go there and for the person to tell you how to solve your problems. That's not what it's all about. It's for them to empower you, and enable you to solve your own problems. Otherwise, they're going to have to be there, sitting by your side constantly through your life. Well you can't - that's not realistic, and that wouldn't be your own life then, would it? It's there really, I think, to enable you, to give you this new skill, so enabling you to sort out any – or deal with any, and manage these problems, future, or past, or whatever. [Victoria]

4.2.10   The language of therapeutic 'schoolism'

There is a richness in therapeutic approaches, as outlined in chapter one. The primary care counsellors whose clients participated in this study had training in a variety of these. There was little in the client accounts to suggest that clients had any appreciation that there are different forms of counselling. Three interviewees presented this as the 'depth' of the work, which can be said to approximate a psychodynamic focus on childhood issues, as contrasted with more practical, solution-focussed or behavioural approaches. Only Debbie included in her account an indication of there being different orientations within the psychotherapeutic domain, in her seeking to confirm that there were different kinds of cognitive therapy. Will explained that his counsellor had talked him through the cycle of how thoughts influence feelings, and Debbie spoke of 'faulty thinking'.

4.2.11   Unhelpful interventions

A few specific interventions by the primary care counsellors were experienced as unhelpful. There was one reference each to a counsellor's extended silences, a counsellor's 'normalizing' intervention that had the effect of making the client feel trivialised, an initial lack of specific advice, a counsellor's reflective, non-directive comments, and a book that challenged Eileen's sense of her late husband's presence as being 'in her imagination'. To flesh this out a little, Irene said:

I didn't like her silences, waiting for me to say something. I knew she was waiting for me to say something and I didn't know what to say {laughs} – yeah, that was awkward. I'm a bit sort-of, aw, twiddle my thumbs, and play with my fingers, sort-of thing. [Irene]

Kath reported:

I felt she told me she didn't think that I was depressed. I suppose, putting it on a level as she finds other people, I can't remember her exact words, so don't quote me, but I just felt that – I know she said 'well I don't think you're in a terrible decline. I see people worse than you, who can't function'. So that made me feel a little bit more inadequate than I was. I wasn't happy about that. [Kath]

4.3 CONTEXTUAL FACTORS

In the cluster of contextual factors located specifically in limited session work in primary care, the importance of having choice in the spacing of sessions and in the manner of ending the counselling emerged from the analysis of interviewees' accounts. This was mentioned by the majority of the interviewees. Of the location, for convenience and reassurance, the advantages far outweigh the disadvantages of seeing the counsellor at the client's GP surgery. Clients also cited the deleterious effect of a long waiting time to see a counsellor.

4.3.1   The spacing of sessions / endings

Most clients in this study found it difficult to name unhelpful factors in their counselling, but when pressed, would have liked more, that is, more sessions, longer sessions, or both. Fifteen interviewees commented on matters relating to negotiating sessions, either the helpfulness of this, or the desire to do so where this was not offered. Some clients commented that individual sessions were felt to be too short. This was expressed as they had just 'got going' or were 'in the middle of something' when it was time to finish.

I would have actually liked to have gone on and explored other things, but, y'know, there's only so many people that she can see at any one time. There were certain issues that we did sort-of develop that, y'know, I would have liked to have gone on, but we dealt with what was causing me to go there in the first place, I suppose. The panic, and the anxiety, and that sort of thing. But of course in doing that we touched on other things, which, me being curious about things, I thought, 'ooh, hang on, wouldn't it be nice if - my relationship with my mother, and the fact that she's quite a dominant influence in my life, feelings for her, and that sort

of thing. We did get as far as that, but we decided that we'd reached a point that it would take us probably a long time, if we went on again. Because she did explain at the beginning, it's only meant to be a short thing, because of the way it goes and how many people need it. [Ruth]

I suppose the only thing – a lot of people might say – sometimes you wish sessions were a little bit longer, but you had to stick to that, because, from a practical point of view you can't, they only afford so much for each patient. But as I say, that's not really a criticism, it's just, say, in an ideal world, which we're not in, yes it would be nicer to have had, say, sessions that came to an end naturally, rather than, 'well look, the time's up now, let's wind up' sort-of thing. You wouldn't want them going on and on and on, or whatever. {laughs}. Yeah, it would be a bit intense. But some time you think 'oh gosh there's a few more things' and you know you'll forget by next time. [Victoria]

Interviewees also commented on the loss of momentum and connection, when holiday breaks occurred, or when the counsellor was busy and could not fit the client in for a number of weeks. For example:

Rushing it a bit, yeah. Fitting in more patients. I don't know, that's the impression I got. She was a very, very nice person. Don't get me wrong. But I think she had certain commitments. I could always see her struggling with her diary, trying to fit everybody in. She double-booked on a couple of occasions. {Interviewer: What happened?} Um, well I got there first! {laughter}.....it's like she was trying to juggle too many people, I think. As well as trying to be as fair as possible to everybody. [Tracey]

Of those who were offered some say in determining the number of sessions they received, clients appreciated their autonomy in determining the spacing of sessions and the manner of ending the counselling. By contrast, those who experienced their counsellor as rigid in imposing structure experienced their counselling as less satisfactory, highlighting the importance of flexibility in counselling provision. People valued the knowledge that they could return to the counselling. 'She said the door is open - I can always go back if I need to'. And Ruth commented:

It was nice to know that you're not caste off and done with. [Ruth]

Two clients had very strong feelings that it was their counsellor's agenda to finish the counselling and described their disappointment at what was experienced as a loss of support. They expressed a desire for 'top-up' sessions, an opportunity to have an occasional session with their counsellor without needing to return to a lengthy waiting list. Christine in particular was troubled by this:

> *But after the counselling stopped, after I while, I found that one-to-one chat to let everything out - y'know, wasn't there. And I went back, y'know. I found I needed more of that. .....They see you for six sessions, and then they say, 'oh, you seem to be perking up now. You seem to be better, I don't think there's any need for you, but if you still need to see me...'. you say 'yes okay then, I'll try to be - y'know, not come any more. I'll try to be better now, and - y'know if you say that I'm okay, that's fair'. ...But then, when that stops, when you've got no-one, y'know, that one-to-one stops. But then when I got in touch with the counsellor, she said to me that I got to go through my doctor again. And there was a long waiting list. Which really is not a good position for someone who is depressed. Because they want to go and see someone - now!..... And y'know, I feel that there should be some sort-of way, that when you need it, you could be able to go back [Christine]*

4.3.2   Location at the GP surgery

The location of the counselling at the GP surgery was appreciated as familiar, convenient and reassuring by all who mentioned it, bar one. Angie anticipated the stress of travelling to the nearest city hospital. Ruth confessed that she might not have gone for an appointment at the hospital. Nikki was determined not to return to the CMHT after her prior poor experience there. There was also the assurance that comes with having counselling in the surgery with a counsellor who is 'professionally trained and trustworthy'. Victoria was reassured by knowing that her counsellor had direct communication with her GP, and placed importance on her belief that the counsellor was updating him of her progress.

> *I loved that fact that we were on 'home ground', so-to-speak, because it was in the doctor's surgery. Neutral territory, but somewhere that you are familiar with, rather than going to a centre, where there could possibly be some sort-of stigma attached to it. It's an awful thing to say,*

but it does come into the equation. Going to the surgery was just like going to the doctor's. [Sian]

The one contrary comment concerned the lack of anonymity at the local surgery. Ffion complained of her poor experience:

....walking through the waiting room of the surgery, which could have been full of people, with a big red blotchy face and sniffing. [Ffion]

4.3.3   Waiting time to see the counsellor

People in this study experienced very different waiting times, from virtually no wait because the service was new, to many weeks. Some said they were fine about the waiting time, because they knew they were in line to see the counsellor, and were able to withstand the waiting period. Often the importance of waiting time was dependent upon the level of distress experienced by the client at the time of referral. Some felt the urgency of needing to see someone quickly, and described the prospect of becoming more distressed, to the point of feeling suicidal:

I would have probably tried to fight it on my own, but I don't know that I would have got anywhere. And I think when somebody is at crisis point like that, to wait four months to see a counsellor, well it's ridiculous isn't it? Because you'll have either done something, or you'll have solved it yourself. You'll have either run into a tree, overdosed, hung yourself, or done something, or you've resolved it. [Eileen]

Those who had been informed of the probable waiting time by their GP were more accepting of the wait, although some had strong feelings that any wait was too long, expressed as 'when you need help, you need help *now'*.

4.3.4   Paying for counselling

The counselling in primary care is free of charge to patients, although a referral is required in order to access the service. Where money was mentioned, there were mixed feelings about paying to access counselling. Leonard had been willing to pay, and had initially asked his GP for a private referral. Heather was sad that she could not afford to pay privately: 'if I did

have the money, I would have booked in privately by now.' By contrast, Ffion declared that she would not have paid for the service: 'had I had to pay, I wouldn't have gone.' Ruth quoted her counsellor's opinion that counsellors in private practice charge 'unjustifiably expensive fees'.

4.4 CONTRASTING STORIES: OTHER THERAPEUTIC EPISODES

Here I look at other forms of therapeutic support accessed by clients and the ways in which participants account for their usefulness, or otherwise, in easing or resolving emotional problems. A therapeutic episode is defined here as contact with helping professionals or volunteers, for assessment and/or some form of therapeutic endeavour, for example, from psychologists or psychiatrists in secondary care, and/or from counsellors and other sources.

For the majority, 12 of the 23 interviewees, the counselling at the doctor's surgery was their only experience of counselling. The remaining eleven interviewees had had previous therapeutic input, and for four, since, the GP counselling. Table 3.5 in chapter three illustrates this pattern of accessing therapeutic support. Interviewees introduced a history of therapeutic episodes into their narratives, often to illustrate contrasting features with the GP counselling that was the focus of discussion.

4.4.1   Previous therapeutic episodes

Here I will look at what it is that clients say that made their previous therapeutic encounter unsatisfactory. The majority of those who had had previous therapeutic input elsewhere praised the recent primary care counselling. Frequently a comparison was made and for seven interviewees, the earlier involvement was described as unsatisfactory in some way. For example, Debbie, who had received cognitive therapy in secondary care some years ago, commented that although her previous psychologist said he was using cognitive therapy, it focused on visualisation techniques. She was delighted with her GP counselling, in which she learnt how her thoughts

influenced her moods, and declared 'I wish I'd had this years ago!' Ffion, whose earlier counselling was in the voluntary sector, did not feel that she and her volunteer counsellor were well suited. Irene had accessed counselling with a private healthcare provider, and spoke of the sexual abuse by her grandfather:

> *When I finally opened up and told her what we thought was the problem, the deepest problem, she told me it was a load of rubbish, basically. It was all abuse from my grandfather, and she basically gave him permission to do what he'd done. That was the feeling that I got from her. [Irene]*

Irene was further troubled by the attitude toward counselling that she encountered in the private healthcare sector:

> *She belittled the counselling as well. Told me I didn't need it. 'Oh you won't need that. That's a load of rubbish'. [Irene]*

Sian had previously been referred to a clinical psychologist at a Community Mental Health Team (CMHT), and later to group counselling in the voluntary sector. Of the clinical psychologist, she said that she did not relate well with him, not least because he reminded her of her abusive ex-husband, but also she 'wasn't happy with the advice or what he was saying to me'. She also complained of seeing a different person each time she went to CMHT, such that there was no continuity. Of the group counselling she said:

> *There was one family there, a lady whose husband had committed suicide. And she had a mother and father with her. And they sort-of domineered, controlled the meeting, because it was all about their anger, y'know. I went the first time. The second time the same thing happened. They were there – it was a Sunday afternoon – and the second Sunday then was exactly the same. They were still very angry, and it was all - again, and it wasn't for me. [Sian]*

Nikki had also had an unsatisfactory experience. She had been referred to CMHT, 'psyched herself up' to attend, spent two hours disclosing distressing material, only to be told that there was nothing the team could offer.

It was very in-depth, very personal, and it was just questions fired at me. I wasn't there to give what I was feeling. It was very traumatic. Terrible. I would have rather gone without. It was horrible. I was there nearly two hours. And I went back to my childhood. And nothing about why I was feeling this way. It was just, 'well we'll put you on tablets' which they did. It was just too much. I needed somebody to listen. Somebody to talk to. Not how it was structured. It was terrible. No offence to the doctor. I mean, she was wonderful, but – how can I explain without being horrible? – um, to me she didn't seem caring, counselling-wise. She was just there as a doctor. See what my symptoms were. 'Well, let's give you tablets.' She was more on the psychiatry level, than counselling, which wasn't me. [Nikki]

Victoria was aware of issues that had not been discussed, and said of her couples counselling at Relate:

That was with a man counsellor. He was very good, but I didn't feel it did a great deal for me in sorting out any personal issues that I had, maybe from the past. It was more, just, really, the situation, because it wasn't just me. And I don't think you can – you can't talk the same with your partner there, can you, really? I was still left with this feeling of how am I going to exonerate these guilty feelings I have? And those issues weren't addressed there. [Victoria]

For Kath, both her previous contact with a psychiatrist, and the recent primary care counselling were unsatisfactory. Christine presented a history of many referrals over a period of time, of seeing a counsellor from the CMHT, initially at her local health centre, then transferring to the CMHT's own centre, and, having been discharged from CMHT, later being referred to the GP counsellor's waiting list. Having had counselling in both primary care and secondary care previously, she had a constructed identity of herself as a 'weak' person who is in need of external support. In the interview she expressed the view that counselling is 'alright while it lasts', but that 'in the end you have to manage without them'.

4.4.2   Subsequent therapeutic episodes

Some interviewees described a series of involvements with various services, mainly through the NHS, though not exclusively, and this continued to be the

case for Bridie, Debbie, Olive and Pamela. Debbie and Olive had sought further counselling elsewhere since their counselling at the doctor's. At the time of being interviewed Yvonne was on the waiting list to return to her GP counsellor. Olive and Pamela were full of praise for their current counsellors. Olive was seeing a Cruse bereavement counsellor, with whom she felt she was working well, and he was able to 'get the emotion out of her'. Pamela was seeing a clinical psychologist who was using a behavioural approach. I explore both of these in greater detail in section 6.2.4. Two interviewees were less pleased. Bridie was seeing a psychiatrist, and asked rhetorically 'what can she do?' Debbie was seeing a counsellor with a Christian counselling agency, who she did not consider reliable in terms of keeping appointments.

4.5 EXPECTATIONS AND CHANGES

In this section I will examine client narratives for prior expectations and reported success, or otherwise, of the counselling.

4.5.1 Preconceptions of counselling

Participants' preconceptions were often offered as contrasts to how they actually experienced the counselling. Clients spoke of expectations regarding sessions, preconceptions about counselling from the media, and also presented a view of counselling as mainstream and acceptable, by comparison with how things were in the past.

The majority of clients were referred to the counsellor at the doctor's suggestion. At the time of their referral the service had only recently been introduced, and many did not know that there was counselling available at their GP surgery. There were expressions of pleasant surprise. Eileen thought referral to the counsellor was 'a brilliant idea', whilst Ffion said she would try anything. 'It might help. And if it helps just a little bit, it must be better than not trying at all'.

There was a view of therapy as being the 'norm' these days. Eileen approved of counselling and laughed that Americans 'aren't normal' if they don't see a psychoanalyst. John expressed regret that he was not automatically offered counselling after his brain haemorrhage, in the way that 'survivors of heart attacks' were. He considered that had this been the case, he may not have 'slipped into' his depression. Heather saw counselling as mainstream and acceptable now, by comparison with 'years ago, it wasn't the thing. Now, if you lose somebody, there's Cruse, and people like that'.

In terms of the amount of counselling offered, many said that they had no prior expectations, however Angie expected the counselling to be longer than six sessions, and Bridie considered the six or eight sessions that she was offered 'only a small number'. Of waiting times, there were mixed expectations, and different views of what was considered acceptable. Debbie assumed that she would be on a long waiting list, but waited 'only a few weeks', whereas Ffion thought the six weeks she waited was 'quite a lengthy time'.

Both Sian and Nikki had had poor prior experiences in CMHT and experienced anxiety prior to their first counselling appointment. Sian described herself as being 'apprehensive', and Nikki recounted:

> *The first appointment, I worked myself up into such a state, I was ill. I was vomiting. I had diarrhoea. When I got to the surgery, the counsellor had been taken ill. And I'm sat there and I'm thinking – I was shaking. I was sweating. And then my health visitor come down and she said 'she's been taken ill' and I thought 'oh thank God for that!' I flew out of the surgery. But then I had the next week to keep it – oh it was horrendous. I wasn't going to go. If it wasn't for my Mum. She said 'Go! You've got to go'. 'No, I'm not going'. 'You've got to go'. [Nikki]*

Many claimed that they had been open-minded and had had no particular expectations of the counselling. Irene said that she went along with an open mind, and was expecting just to talk. Nikki had also expected 'just to talk' and was delighted to have had the encouragement to develop alternatives and

options. Ruth said 'I think I was comfortable to explore it and to see what could be done'. Leonard's thoughts were:

I was quite open minded. I didn't have any anticipation of what it would do for me, if anything at all. I was quite open minded. But I thought 'I've got to do something'. So I made that approach. And see where we go from there. So I had no anticipation of what it was going to do for me. I know it was no magic cure-all. [Leonard]

Tracey was expecting advice:

I thought maybe the counsellor would have given me a bit more advice. But it's not about that. It's about coming to the decisions by yourself, and realising. [Tracey]

Not every counsellor saw their clients in the GP's consulting room. A couple of the counsellors had access to other rooms at the surgery. This was the case for Angie's counsellor, and Angie had expected more formality:

I wasn't expecting quite the cosy atmosphere that I had. I was expecting a table, y'know? Me sitting at a desk, like you do at the doctors, and somebody on the other side of the table writing notes. This woman is sitting on the edge of the chair leaning forward in a far more relaxed position, in an armchair opposite me, with a three-piece suite in the room and a coffee table, y'know? And she wasn't there writing notes all the time. She was chatting to me like she was a friend. [Angie]

Some clients had learned various counselling skills in their workplace, and made assumptions about their counsellor from this. Yvonne thought the counsellor would be checking her body language and evaluating her at the beginning. Will was expecting open questions, 'to get me to get the answers'. Victoria hoped that she would be able to build up some sort of rapport 'cos it makes it easier then'. Ruth had assumed she was not permitted to contact her counsellor between the sessions:

I was sort-of all excited, worked-up, one day. And I would have loved to have seen her and go through this and explore what happened. And of course I waited until my appointment, and then brought it up and she said 'oh you could have rung up and asked for an appointment'. But I didn't know until retrospectively, which was a shame. [Ruth]

Kath was disappointed that the counselling was 'too shallow'. Ruth had thoughts of counselling as regressing to childhood:

> *Sometimes you think 'oh counselling, most probably going to end up, y'know, regressing into childhood', and all that kind of thing. It was nothing like that, so it wasn't scary like that or anything...... I wasn't afraid of it. I suppose I did wonder what it was going to be like, but I didn't have any conception of what it would be like, really....although, obviously, there is the wonder about going to the unknown....{laughs} Y'know, all these horror stories that you read about occasionally. [Ruth]*

John talked jokingly of being hypnotised:

> *From what you see on the television. 'Look at this coin while I spin it about.' {laughs} Almost like a hypnotist. [John]*

Some participants described counselling as being a necessity – that people can *need* to have counselling.

> *I had a lot of trouble. I was beaten up, and mugged, but then we had a bereavement in the family as well as that happening, and a lot of stress with family. So I needed to have counselling. [Gareth]*

Yvonne said of her daughter:

> *She is quite depressed herself at times, and she's seen a doctor. I've said to her 'ask to see a counsellor. Perhaps, y'know, you need counselling'. [Yvonne]*

In answer to my question 'Was counselling something that you ever would have imagined yourself ending up doing?', Tracey was adamant 'No. Never. Not in a million years.'

4.5.2   Hopes of this counselling

Most held expectations that the counselling would be 'helpful', with many seeing this as receiving 'advice' or an expert opinion. Nine people offered the hope that the counselling 'would help' or would make them feel better, for example John:

I just wanted help. I would have tried anything to help. I was calling for help. In a big way. [John]

And Yvonne:

I just wanted something to get me through. And to be able to see the situation without going under, and having time off work, or anything. [Yvonne]

Zena's opinion was:

I thought I'll try anything. I mean, I had always wondered if there is some problem that perhaps needed deeper investigation. 'They are giving me this opportunity. I can only try. There's nothing to lose, and everything maybe to gain.' [Zena]

Leonard was more specific, in seeking an 'unbiased view':

It was just something I felt I needed to do. Or try. 'Cos I felt I needed help. I felt I need to go and talk to somebody else, who's unbiased. I felt I needed an unbiased view. And that's why I decided to go and seek some counselling. [Leonard]

Sian was determined not to continue as she had been:

I wanted to give it a try because I wanted to get it over. I want my life to move on. I don't want to be forever feeling the way I felt – I didn't want the rest of my life to be as it was, feeling such a failure. And this is what it was going through in my mind, churning around. [Sian]

Heather recognised that she had high hopes of the counselling:

The feelings of failure. Feelings of being no good. The insecurity. It's all those feelings that I want to get rid of. And that's hard. [Heather]

Three people spoke directly of wanting advice from the counsellor, for example, Yvonne said:

I thought if I could tell somebody else, perhaps she could give me some advice on how to cope with it. I needed advice from somebody who knew what they were talking about. Rather than just 'you ought to do this' or 'you ought to do <u>that</u>'. I really needed somebody who had been

– who had experienced these situations with people, and could tell me good advice. I didn't want sort-of, emotional advice, or what I should be doing. [Yvonne]

Sian wanted to be listened to without being labelled:

I wanted to be heard by somebody who would listen to me. Not because of my particular circumstances, or whatever led me to feel the way I did. But I just wanted somebody to listen to me. I didn't want myself to be slotted anywhere. 'Somebody who needs counselling because she's been ill-treated <u>by</u>...', d'you know what I mean? There was this women's crisis centre or something. I didn't want to be put into a category... If somebody could have talked me through it in the way - in the very early days. Down-to-earth. One-to-one. Very kindly. No pressure. Just as I'm chatting to you. That's what I needed. [Sian]

Heather wanted someone to explain why she feels as she does:

I expected them to be telling me, suggesting to me, what my problems might be - "why I feel like I do". Yes. I wanted – I expected somebody, after a week or two, to say, "okay, I put this down to going back to when your mum died". That's what I needed, I think. I'd like to see somebody where I can tell them everything about my childhood, and my life, and then they could say, 'well, I think it could be down to this. This is why you feel...'. D'you know what I mean? It would be nice to be able to go once a week and sit on a couch and let my heart out to somebody and then they can sort-of help me through, and say something, 'probably because this sort-of pattern in your life', and that type of thing. That's how I thought counselling would be. [Heather]

4.6 CHANGES THROUGH COUNSELLING

In this section I will present participants' accounts of the change, or otherwise, upon their symptoms and their lives, following their course of counselling. As discussed in chapter two,

'The overall aim *{of counselling}* is to live more fully and satisfyingly. Counselling may be concerned with addressing and resolving specific problems, making decisions, coping with crises, working through inner feelings and inner conflict, or improving relationships with others.' (Rowland et al. 2000 p.222)

Bearing in mind such 'mission statements' of counselling, I consider how things are different now for clients, and how they describe change. Comments

included 'I think about things differently' and 'I say what's on my mind'. For some, this included what has not changed. In terms of change, outcomes of counselling were expressed in the form of 'coping better', 'okay but I needed more', or 'not what I needed'.

Most people, 18 of the 23, made highly positive statements regarding the value of the counselling. Nikki recommended counselling to a friend, as did Yvonne to her daughter. Leonard put it this way:

> *It allowed me to carry on. And things continue to change – and time's a great healer anyway, regardless, I think. It certainly was helpful. It helped me get through that period because I was low, and depressed. [Leonard]*

If there had been no counselling available, Eileen commented:

> *I might have tried - I would have probably tried to fight it on my own, but I don't know that I would have got anywhere. I don't know that I would have got anywhere. More people ought to go to counselling other than taking tablets. I certainly agree with it. I really, really do think it's a good thing. [Eileen]*

Many made comparisons with medication, stating that counselling was 'better than taking tablets', or 'saved me from taking more tablets than I was taking already'. There were eight clients who expressed the view that medication may help people feel better, but it does not solve the problem, that underlying or pre-existing problems need to be resolved, and that one needs talking therapy as well. Victoria expressed this as:

> *I would definitely recommend it to people. The counselling, to me, is far more beneficial, than taking anti-depressants and things – because they're only masking things. You never get rid of the problem. Not the root cause, anyway. Better than say, going and just getting a prescription for some tablets, or some Prozac, or whatever, in the long run. [Victoria]*

Debbie was convinced of the benefit of counselling:

I'd say, if I hadn't have had that therapy, I think I can say this, hand on heart, that, that I would probably be on something else {medication} and a very strong dose. [Debbie]

Whilst Will expressed his appreciation of the medication prescribed following his breakdown, he also recognised:

Medication is fine, but at some point, hopefully, you're going to come off the medication and it's a case of, okay, if anybody's got any hints and tips, just so that you recognise 'hang on, I'm starting to feel this way, that way'. For you to be able to recognise any forewarning of it happening again. [Will]

Both Debbie and John commended counselling in conjunction with other helping input. Debbie appreciated the help she had had from the counselling in the first place, and the assertiveness group that her counsellor had recommended. John spoke at length of the support he received from his GP. Upon further questioning, this kind of contact may not have been as satisfying as it first seemed, and as Christine acknowledged, her GP's 'counselling', that is, time to talk with him, whilst appreciated, was less satisfactory than seeing the counsellor.

Eight aspects of change emerged: an overall improvement; change as an on-going process; counselling as a continuing process; life as consisting of 'ups and downs'; negative thoughts as recurring but manageable; confidence, self-esteem and assertiveness; thinking differently, and practical changes. There is a further category for those reporting no noticeable change. In some accounts there is little comment regarding the symptoms that were reported prior to counselling, and often it is by the omission of reports of symptoms that their relief or improvement is apparent.

4.6.1   Improvement

This category has the most number of quotations assigned, with 18 of the 23 participants speaking of there being some improvement, often in non-specific terms, but most made this point many times over. 'Once I'd done that, as I

say, it made things – life – a lot better' (Angie). 'Ten times better' (Eileen). 'Things are a lot better...I seem to be fine at the moment' (Gareth). John felt that, as a family, they had 'got back to normal'. Some spoke of being a 'different person':

> It turned my life around. I just feel a different person really. I wish that I'd had this twenty years ago, 'cos my life would have been totally different. [Debbie]

Whilst Victoria said that she was the same person, she just understood herself better.

Using a third person to validate improvement, two clients drew on the approval of their counsellor, 'my counsellor was pleased with my progress', whilst both married male clients offered, 'my wife will tell you', that is, would confirm the improvement. There was also a line manager drawn upon who had 'noticed the difference'.

4.6.2 Change as an on-going process

Clients made statements relating to the on-going nature of change, and the process of continuing to actively do the psychological work on themselves. Christine was perpetually trying to make herself 'stronger'. Nikki said that she'll 'get there, but it can't be done overnight'. Ffion said of managing bad days:

> I still get really bad days, and I took me a while to get used to it. At first I didn't realise. And I still do get bad days now. But obviously I know better how to ride them. [Ffion]

Yvonne remembered things the counsellor said and applied them, and Ruth used self-talk:

> It made me think, 'there's no such words as can't and should, and must'. But I still say it. I still tell myself 'I should' or 'I must' and then I think 'now what would my counsellor say?' {laughs} and in fact that worked - that, actually, was enough to help, on that particular occasion. I think 'now my counsellor wouldn't approve of me reacting like this or thinking

like this. I have to challenge these thoughts, and move on.' And that was very good. [Ruth]

4.6.3   Counselling as a continuing process

All the participants had finished their counselling at least four months prior to the interview, and for some it was very much longer. Victoria described the impact of her counselling as a long term, continuing process, and others, like Ruth, continued to 'hear' their counsellors. Yvonne described this as:

I keep remembering little sentences that she said to me, and I apply them to my life. I think some of the things that my counsellor said have stuck in my mind, and I can draw on things. Sentences, and things. And it helps me. [Yvonne]

Ffion described the change as being 'integrated' into her, but difficult to express:

What I find is if it's really working, you've got a good counsellor who's doing it for you, tapping into my buttons and stuff. I think maybe a lot of the changes are so integrated, so minute, but they do have huge impact on your responses, that that's a bit difficult to pinpoint. Definitely for me. [Ffion]

4.6.4   Life as consisting of ups & downs

Ten clients referred to 'ups & downs', with statements such as 'things are better' spoken in relative terms, that is, 'better than they were before' as opposed to problems having completely disappeared or being resolved. For example, Angie said, 'I get little moments, but nothing like I was before'. For Marjorie, 'it's not going through my head all the time, it just flares up now and again'. Nikki commented, 'at the moment it's just a blip. Some things are up and down. And I've just got to learn to cope with them'. Christine continued to take her tablets and felt 'on an even keel, neither 100% brilliant, nor under the weather with it'. Heather's problems continued to be very disabling. She said, 'I go up and down. A lot of days are better than others. It just sort-of comes and goes', and attempted to describe this in more detail:

I still feel it now, sometimes. Yeah, sometimes. Not as much. But I do. Most days are okay, but sometimes, yeah, I don't want to face the day.

And sometimes I don't go out. I just take the children to school and I'm sort-of, {miming agitation} 'I want to get back home, I want to get back home'. I go up and down. A lot of days are better than others. It's really hard to put into words. 'Cos its really hard to explain. It just sort-of comes and goes. It's strange. Some days I can be – well, I can be fine. I can go to the school. I can go to places I need to go. I can do whatever. And I think, 'yeah, I'm okay'. But other days, I get scared, even at the thought of picking the kids up from school. [Heather]

4.6.5   Negative thoughts as recurring but manageable

Interviewees continued to have 'negative thoughts' but used techniques to overcome them. Angie tried to 'think more positively', Christine tried to stop 'dwelling' on upsets. John had had a life-threatening brain haemorrhage which led to what he described as destructive thoughts:

Your mind is a powerful thing. And if you do let your mind take over, your mind can destroy you. And will destroy you, if you let it. And it's not a question of being mentally strong. It's a question of just try to get on with your life. And live for the present and the future, and not harp back on the past. That's what it's all about. Especially, live for the present. [John]

4.6.6   Confidence, self-esteem and assertiveness

Eleven clients included references to aspects of confidence. Some spoke directly of 'self-esteem', for example, Angie:

By the time I finished counselling, I felt a lot better about myself. By changing my way of thinking, the counsellor did it in a way that made me more confident and raised my – y'know – self-esteem. [Angie].

Others described the change in themselves, for example, Debbie said:

I don't feel like a doormat any more, and I've always been a doormat all my life'. [Debbie]

Whilst Will made this before-and-after comparison:

I went in there with the mind-set that, basically, I was just a failure at work. Yeah, the counselling just gave me a totally different mind-set. Very positive. Which was great. [Will]

When clients felt better about themselves, the higher their self-esteem, and in this study, confidence and self-esteem were presented as closely connected. Tracey said she had become a lot more confident now than she had ever been. Debbie linked this improvement directly to the cognitive therapy she received from her GP counsellor:

I always felt sort-of like a nothing, y'know. It used to frustrate me that I couldn't stand up for myself. And I didn't know how. Those times when I felt I was the most awful person on earth, y'know. And I didn't know how to tell myself I wasn't. Because I'd feel I was always letting myself down, y'know - realising through the cognitive therapy, that we do all make mistakes. None of us are perfect. [Debbie]

Assertiveness was the behavioural change associated with improved confidence and self-esteem. Angie said she was now aware of when people attempted to use 'emotional blackmail'. Christine said 'I'm still struggling not to let people walk over me.' Will, offered this, of being asked to work late:

In work, whereas before I probably would have said 'yes' and thought 'oh God, the wife's not going to be too chuffed now because I've done a full day and I'm going to work on and cover or something'. And it was a case of 'No, sorry. Not doing that job anymore. No, I can't lock the store tonight. Sorry.' It's like, 'Oh, right, okay, we'll find somebody else'. I mean, they still lock the store. Yeah, it was really good. And I mean everybody just said, the difference – it helped me be a lot more confident in going out. [Will]

4.6.7   Thinking differently

There were comments relating to cognitive change, often expressed as thinking about the situation differently. Some presented this as an active process on their part, others as part of a narrative of change. Angie demonstrated her new-found confidence:

I've changed my way of thinking about things. I know now, that even if this relationship doesn't work at any time in the future, I don't fear the fact of being on my own. I <u>know</u> that I can cope. [Angie]

Leonard expressed acceptance of his situation as a divorced man:

Deep down, maybe things never change, totally. I only can look at my own situation, and reflect on that. And it's not right. I can't put it right. It probably will never ever be right, again, in the way that maybe I thought it was. But you have to go on. Carry on. Move on. [Leonard]

4.6.8 Practical changes

Six clients spoke of specific practical changes they had put in place as a result of the counselling. For Irene, with two small children, she had re-arranged her week to include time for herself and with her partner. Tracey had made the first contact to repair the damaged relationship with her sister, and Victoria had enrolled on a counselling course. Leonard reported proudly, on showing me the alterations to his property:

I've completely re-vamped it, because it's now my house, not me and my ex-wife's house. [Leonard]

4.6.9 Supportive, but no change

The majority of interviewees described their counselling as helpful and as instrumental in promoting change or improvement. Whilst most claimed the counselling had been at least of some benefit, three clients felt their counselling was supportive but had not led to any lasting improvement, either in resolving the situation or in their adjustment to an insoluble life problem. Gareth felt that nothing has changed for him, Christine's problems with life were on-going, whilst Bridie said this of the experience of harassment at work and the lack of support she received from colleagues when she made an official complaint:

I feel I am still in a state of needing help because there hasn't been a resolve of - I think until something's done, there's no resolution to what has happened. It's just so difficult to accept that. Now I have no employment. I didn't appreciate how much I would lose - the only closure I'll have is when something's done about it. [Bridie]

4.7 PRIMARY CARE COUNSELLING AS DISAPPOINTING

Seven participants referred to their disappointment with the counselling. In the main this was due to insufficiency of some kind, for example, the counselling was not long enough or not 'deep' enough. Individual references

were also made to an initial disappointment with counselling, a need for rapid access to a counsellor, and a need for a specialist counsellor.

Tracey and Christine both expressed their desire for further sessions, and Ruth commented:

> *So that was not to say it wasn't useful, and beneficial, and took me further. I would have actually liked to have gone on and explored other things. [Ruth]*

Heather and Kath both wanted a 'deeper type' of counselling. They made a contrast between day-to-day difficulties and deeper, older problems, which is also reflected in the second section of this chapter where I look at clients' accounts as they refer to different types of counselling. Heather was disappointed and dropped out of the counselling:

> *Maybe it was the wrong type of counselling. Maybe I needed more sort-of, therapy, more than {pause} But I didn't know what I needed. She made a few suggestions of what I should do. Little steps, and things. But {pause} I suppose what I wanted was more of a psychology-type thing, where they can help me understand why I feel like I do. More than – I mean she was good, don't get me wrong. She was a lovely woman, and everything. But that wasn't the help I needed, I don't think. I think I needed something really deeper. [Heather]*

Kath attended for ten sessions, but left disappointed:

> *I felt a bit disappointed - I'd only skimmed the surface. Perhaps I was expecting something a bit too much. I don't know - because I didn't know what counselling was – I didn't like to go any further. Because I thought perhaps it was for 'there and then'. I didn't know. ...I came away, I suppose, feeling 'oh well, well that's it. There's nothing. That's it. That's as far as you go.' [Kath]*

Pamela did not get what she wanted from her primary care counsellor:

> *Basically she was listening to me and reflecting on 'well going back...' and 'how could you see things...?' and whatever. And although she was doing me good to talk to – what can I say? – it was good to talk to her, but I was still on the same level. [Pamela]*

Leonard was initially disappointed. The counselling did not meet his expectations, but he stuck with it:

> *I wasn't happy with it, in the first instance. I didn't feel it was giving me any assistance, help, or providing any solutions. You're looking for solutions. But I don't think counselling provides solutions. That's the bottom line. Doesn't provide solutions. Solutions have got to come from you - from <u>me</u>. In the first instance, it didn't seem to help my situation. It didn't improve it for me, I thought. 'Cos it wasn't giving or telling me anything that I thought was helping me. [Leonard]*

Christine thought there should be rapid-access to a counsellor, with no waiting list:

> *I think there should be more availability to a counsellor, y'know, not be put on a waiting list and have to wait for maybe months to see her. If there was more availability that would be helpful as well to somebody depressed, y'know. I mean it's very good, the situation, but a lot of improvements can be made. I think there should be more availability to a counsellor. [Christine]*

Disappointment with having to wait was a familiar theme:

> *I wasn't suicidal or anything like that, but possibly, counselling earlier in the diagnosis of my illness, might have helped me sooner. By the time I actually received it, I think I'd worked a few more things out for myself.* [Ruth]

Bridie thought a counsellor needed personal experience of the situation faced by the client. Bridie herself worked in an educational setting.

> *I need somebody who is a specialist in understanding educational issues and practices. And I think I would need someone who also is able to understand my feelings of how I've been treated. It's complex in education. I think it's difficult for someone who's had perhaps maybe, a caring background, for example, to appreciate the interactions of people in an academic environment. There doesn't seem to be any service for somebody who needs a specialist area of help, like myself. [Bridie]*

4.8 CHAPTER SUMMARY

In this chapter I have firstly presented client opinion as to the nature of what makes counselling work, and also contrasts between the counselling at the GP surgery and other therapeutic episodes. Interviewees cited aspects that point to the centrality of the relationship in successful therapy. Whilst some spoke directly of the relationship, others talked of the importance of 'being able to get on with' their counsellor. The opportunity to talk was valued very highly, with the crucial element being to talk to someone who was outside the client's usual circle of family and friends. The most commonly mentioned therapeutic interventions related to change, being helped to change one's way of thinking, and to change ones' perspective. Less frequently cited were aspects of emotional release and of psychological exploration of the client's historical relationships. There were contrasting evaluations. Two clients who had received cognitive counselling held this in very high regard. By contrast, for others, where 'deeper issues', that is, childhood issues, were not addressed, this was seen as a failure to achieve the desired outcome. Of the few who mentioned books and other written resources, these were mostly considered helpful. The importance of flexibility in determining the number and spacing of sessions emerged, as did the impact of waiting time. The location where the counselling took place, being at the doctor's surgery, was also an important factor.

For just under one half of the interviewees this was not their only therapeutic episode. Clients had accessed a variety of services, but these were mostly reported as being less helpful than the GP counselling. Two clients highly valued their current counselling moreso than the GP counselling.

Many clients held a positive expectation that counselling 'would help'. Most claimed to be 'open-minded', or lacked a clear understanding of what counselling was. I have explored clients' expectations and whether these were met or not, and for some, the hopes they had of counselling were not

necessarily fulfilled. However, for the majority, this lack of knowledge did not detract from their experience and appreciation of the process of counselling. Whilst counselling was claimed as helpful in varying degrees by most recipients, this was not so for a minority who found no benefit from the counselling. Of those who expressed disappointment, this related to both the short-term nature of the counselling offered, and the perceived lack of depth of psychological exploration.

CHAPTER FIVE

THE CLIENT'S VOICE ON SELF

I went to see the doctor and she said 'you've got depression'. I was in a terrible state. I'd been finding it really hard to get up in the mornings for months beforehand while all this was going on. Basically I'd given up. I wasn't really interested in anything, anything - and that's not like me. I didn't want to read – and I love reading. I just didn't want to do anything. It was just too much at one time, and I just couldn't cope anymore. All the things about not sleeping and anxiety and not caring about the way I looked or dressed or the house or the children. Literally anything, y'know. I didn't care if I ate or not. The doctor said it was classic depression. I don't know. I just thought it was me being stupid and thinking to myself 'well, come on, it's just another glitch here. Pull yourself together and get out of it'……at that stage I wasn't leaving the house. [Tracey]

The first section of this chapter comprises themes of the origins of participants' troubles that account for their becoming a counselling client. I will firstly explore client presentation of self, what clients describe as the origin of their problems, and examine clients' accounts relating to self-identity as a morally good person. How do former counselling clients construct their identities as persons of moral integrity? How might the fact of their having been a counselling client impact on the participants' presentational narratives? In these interviews, clients presented themselves as, for example, a good mother, with claims such as, 'even in the worst of my depression, I never neglected the kids'. As I analysed my research data, two separate strands of moral accounts and identity narratives emerged, that of, being a good person who possesses moral integrity and of being a good patient, which includes attitudes relating to medication and following the doctor's advice.

Next I go on to focus on the life-world of the client, that is, the experience of living with symptoms of mild–to–moderate mental health problems. I will examine the clients' accounts as they relate to symptoms. What symptoms did clients experience and how are these presented? What is the impact of

living with symptoms? Firstly I consider symptoms experienced by clients prior to their referral for counselling. People described their physical and emotional symptoms, and in most cases, but not all, these were offered as the reason for seeing the doctor. These include trigger factors, that is, reasons given by clients as to why their GP made the referral. Many clients presented the sequence of a build-up of symptoms, leading to, for some, a breakdown incident. With or without this breakdown experience, a referral from the GP led to counselling. Then I will look at client accounts of living with symptoms. These were presented as on-going ways of being that exacted a toll on the individual. They illustrate the ways in which clients had incorporated their symptoms into their life-world. (Schutz & Luckman 1974). For some, their symptoms remained part of their life-world as on-going difficulties to be continually negotiated or dealt with.

I will also explore how clients placed themselves in relation to family, friends and other forms of social support. How are family and friends viewed in relation to helping with problems? Comments about family and friends arose naturally during the interviews, often to illustrate a contrast with professional help. In the final section of this chapter I examine the way in which clients draw upon family, friends and other non-professional support, and look at what is considered helpful and what is not. In particular, holding in mind Furedi's (2004) criticisms, I was interested to note why the participants sought professional support, and why family and friends are not considered in preference to formal counselling.

5.1 ORIGIN OF PROBLEMS

A total of twelve origin factors arose from client accounts. These were divorce, contact with ex-husbands, abusive relationship, current family relationships, childhood relationships, childhood sexual abuse, ill-health, bereavement, miscarriage, stress and workload, workplace relationships and

assault. Some clients drew on many causal factors. I have indicated in brackets the number of interviewees who drew upon each factor.

5.1.1   Divorce (8)

Divorce was the most commonly mentioned individual origin factor in this study. For some the relationship itself was seen as detrimental to their emotional well-being, for example, Debbie's husband had had a diagnosis of paranoid schizophrenia. Ruth's marriage had been childless, and it was her choice to leave, but nonetheless she ascribed her symptoms of depression to not having 'worked through' the loss of her marriage. Leonard described his need for counselling purely in terms of finding a way to come to terms with his wife's leaving him. For others, for example Pamela and Ffion, the unanticipated desertion, at a time when they had babes-in-arms, was the crucial factor. Pamela's daughter was now in her twenties, and some nine years on, Ffion described it thus:

> *From my husband just saying he was going, with my best friend, and he upped and went, and that was just a total 'WHOA!' and with a nine month old baby, and I hadn't see it coming or anything. So that knocked me completely....I think I'm still grieving about my husband having gone. [Ffion]*

5.1.2   Contact with ex-husbands (2)

For Debbie and Ffion, it was the continued strain of contact with their ex-husbands that was considered the causative factor in their being unable to cope and needing to access counselling. The continued contact was considered unavoidable, on account of there being children from the marriage. Debbie's ex-husband had had severe mental health problems and Debbie had needed to protect her children and herself from him. He later committed suicide.

> *My ex-husband had mental health problems. I knew but he didn't know. He kept saying it's me that had the problem and not him. That was really hard to cope with. I could never look ahead at all, because all I ever saw was him trying to wreck our lives. He was ill. He was diagnosed with paranoid schizophrenia. He was very suspicious of*

everybody. He felt everybody hated him. He didn't trust anybody. He told me he didn't trust me. [Debbie]

5.1.3 Abusive relationship (4)

Angie's two husbands had both been physically abusive:

I became pregnant for the youngest one and he attacked me when I was seven and a half months' pregnant. Knocked me out. Put a hole right through my lip. So, y'know, things went from bad to worse. [Angie]

Similarly, of Sian's husband:

He started beating me up, burning me with cigarettes, and then when I said I didn't want anything to do with him any more, he committed suicide. [Sian]

5.1.4 Current family relationships (7)

Current difficult family relationships were drawn upon by seven interviewees. Gareth spoke of stress with his parents, Kath was greatly distressed because she had no contact with her daughter and grandson, and Tracey was troubled that she had fallen out with her sisters. Of the sexual abuse she endured at the hands of her grandfather, Irene came to counselling bitter that her mother had not noticed at the time, nor had they spoken about it since. Of her daughter who lived in another part of the country, and who was having problems in her marriage, Yvonne spoke of her dilemma:

I felt guilty that I wasn't going, d'you know what I mean? Part of me wanted to be <u>there</u>. Part of me wanted to be <u>here</u>. I didn't want to go down there and cause a scene between them, just in case it was just a row. Or just an on-going bad feeling between them, which would resolve itself, which sometimes it does, and then <u>you're</u> the ogre. So I really didn't know which was the best way to go. It was quite, sort-of, stressful. [Yvonne]

5.1.5 Childhood relationships (6)

Childhood family relationships were called upon by some as the foundation of present day difficulties. Victoria thought her lack of self-esteem stemmed from her mother's emotional coldness. Debbie considered that her lack of confidence resulted from her older sister's criticism. Heather described her

mother being ill, her father as unsociable, and her older sisters as excluding and criticising rather than encouraging her. Eileen described her childhood history:

> *My brother died when I was eleven, and I actually believe that's when my problem started. My best friend died of leukaemia when I was fifteen, but I think the problems had already started, but they were probably deep rooted, if you can understand. Something that I had buried. Because I was left as an only child, but I always remember thinking that my parents, and my mother particularly, didn't love me as much as my brother. And yet I've got no reason to say that she didn't, she did! When my brother died, I was promptly moved out of the house. Literally, moved out of the house. I suppose maybe in those days they did, to protect me. But I didn't see it as that, you see. I think in my young mind, that I was pushed out. [Eileen]*

Kath was sure that she needed to explore early family issues, including the high expectations her father had of her, as this was the root of the unrealistic expectations she held of herself:

> *When I think back, whatever I did for my father wasn't good enough. I could always have done better. If I came fourth in the class, I should have been top. ....And rejection. I was an only child for seven years. I had both doting grandparents at the time. When my brother came along I was pushed aside. [Kath]*

5.1.6   Childhood sexual abuse (2)

Irene had been sexually abused at the age of twelve by her grandfather and she identified her feelings about this as the cause of her depression. Marjorie, now in her 70s, spoke in detail of sexual abuse by a stranger at the age of nine. She had spoken of this in the counselling, and it was on her mind even more now because of the press coverage current at the time of the interview, of the murder of the two girls in Soham:

> *I had to go to court when I was nine. I was out blackberry picking, and this man just grabbed me, and started messing about with me. He just – started fiddling about. And I ran and told my uncle, and he went out and caught him...And it's thrown me back then to what happened. {pause, continues sadly} I often wonder if that's why I couldn't have children after he mauled me about. [Marjorie]*

5.1.7   Ill-health (7)

Ill-health was drawn upon as a factor to account for psychological distress. Pamela suffered from fibro-myalgia, a form of chronic fatigue syndrome, and had previously experienced the frustration of not having her condition recognised:

> *I was getting chest infections, feeling ill all through the time, well more often than not, going to bed when I came home from work And that was it. I just couldn't do anything. Everything sort of aches. I could just lift my arm up like that {demonstrates}. It absolutely killed me. Just stupid things. All weak. Everything sort-of went. 'It's a virus' they kept telling me. 'It's a virus. It'll go'. Nobody knew what it was. Eventually I went private......It's brought on asthma. Anything I do, I get out of breath. I can't do any elbow-grease work. Or very slowly I've got to do it. They told me that on the pain management course. They said 'do a little bit and stop. Do a little bit and stop. You don't have to do it all at once.' That's basically what I got to do. Just let it all go over my head. [Pamela]*

Kath had spondulitis plus damage to her shoulder following a road traffic accident, and exhaustion, which continued to cause major difficulties in her life. She was troubled by the effect of physical disability, and more importantly, to her, the conflict with the DSS over her inability to work, which she believed was not fully recognised by the doctors at the surgery. Olive had undergone brain surgery many years ago which continued to impact upon her day-to-day life. Her response to being widowed may have been exaggerated by her brain condition. She claimed her memory was a total blank for the first year of her bereavement, and that she could not remember meeting with the counsellor. John had suffered a brain haemorrhage, adjustment to which had led directly to his depression and to the counselling. John said of this life-threatening event:

> *To go to bed most nights and think that you might die. {pause} Fear of death is easy to talk about 'til you're faced with it. But when you're actually faced with it, then you realise how – I wouldn't say it's cowardly, but how vulnerable you are. How much you don't want to go. How much you don't want to go into the unknown. Or don't want to end your life. [John]*

Tracey had had major surgery:

> *I had to have a radical hysterectomy three years ago. I have a scan once a year. I've come to terms with it <u>now</u>. I thought I had but I hadn't at all. I hadn't - it was just like one more loss again. I think to myself 'oh well, you've got two children. Don't be greedy. Some people have had a situation and they've got no children'. I was trying to, y'know - rather than sitting back and thinking about it properly. There's a history of breast cancer and ovarian cancer in my family. My mum died at forty-two of breast cancer, and my sister had a mastectomy, and she's two years younger than me, for breast cancer. And obviously my scare was, it was developing into ovarian cancer. So, it was lots of these things. I didn't even think about the fact they took my ovaries away because they might have been cancerous signs, or something. I didn't even think about that, y'know. It's only later when you sit down and you think 'they don't normally take your ovaries away for absolutely no reason. There's got to be a fairly good reason, y'know'. But I didn't want to know too much at the time. [Tracey]*

The stress of close family's poor health also featured in client narratives. Both of Angie's parents had been treated for cancer, her father currently so. Nikki's husband had chronic asthma and her middle daughter was investigated for leukaemia prior to Nikki coming for counselling.

5.1.8 Bereavement (6)

Participants spoke of losses of close family members. Three were widows. Marjorie was widowed many years ago, although she spoke of still missing her husband. Eileen and Olive had been widowed within the past two years and it was symptoms of their grief that brought them to counselling:

> *When I lost my husband last year, I didn't know anybody. I just zonked through ... I miss every hair on his body. [Olive]*

Other bereavements were introduced as part of clients' narratives, in particular, the death of the client's mother was called upon by three people. Tracey considered her mother's death, when Tracey was 17, to be a pivotal factor in determining the direction of her life, as she had been unable to

continue her education. Heather cited a number of bereavements, beginning with her mother:

I was only twelve. I know she died, and it wasn't her fault, but sometimes I feel like she left me. And see, when I was nineteen, my brother died. He committed suicide, he did. That was another one. Then I lost a baby in between my two children. Then years later my father-in-law died, then my brother-in-law died. And it just seems to be, everyone leaves. [Heather]

Brown and Harris (1978) cite the early death of one's mother as a predisposing factor to later neurotic disorder. Zena, now in her 60s, was an adult when she lost her mother, but referred to concurrent life events as being at the root of her recurrent depressions:

I never accepted the death of my mother. I was only thirty-six. It was at a time in my life when my marriage had broken up, and I had the children to look after. So I never grieved properly. And I know all of those things are part of it. [Zena]

5.1.9   Miscarriage (2)

The pain of miscarriage was spoken of by Heather and Marjorie. For Heather it was one more in a list of losses in addition to her mother and brother, that also included her father-in-law. In her narrative, Marjorie did not name an individual origin issue, but carried out a life review that included four miscarriages and the sadness of not being able to bear children:

You know when you see people around and they're ill-treating children - then they're groaning and saying they're getting on your nerves and that sort of thing. And I thought 'I've never had the pleasure'. ....The last one I lost was in nineteen-fifty-four. [Marjorie]

5.1.10   Stress and workload (6)

The stress of caring for family, and also work-related stress, featured in client accounts. The stress of caring for children as a single parent was called upon by five of the interviewees. Pamela was acting as full-time carer for her father who had heart failure and increasingly, mental confusion. Pressure of work was cited, although not as a causative factor, more as adding into a situation

of overload when other factors were making life difficult. Tracey was adjusting to a new job at the same time as being 'between houses' and living with her sister's family. Ruth, formerly a catering manager, said of work:

> *I wasn't enjoying it any more. It was more of a chore to go, rather than a joy. You know, if you're working fifteen hours a day, you've got to love it. And I did, for so long. And then, just in the last couple of years, it wasn't really suiting me. Standards are higher and higher because that's what the public expects. Staff say they will and they don't turn up, and what do you do? You've got six people to serve a hundred and twenty, and it's hard work. So in the end I just thought 'I don't want to do it any more'. [Ruth]*

5.1.11   Workplace relationships (4)

Workplace relationships were cited by Bridie, Gareth, Nikki and Will as key causal factors. All except Gareth spoke of having had a 'break-down' as a direct consequence.

> *What brought me to the counselling was I experienced harassment and bullying in employment. Making a complaint against my Head of Department and another colleague - it wasn't the process of what they had done, but it was how they had treated me, and when I made complaints against how they were treating me, I was ignored, or it was covered up. [Bridie]*

5.1.12   Assault (1)

One interviewee, Gareth, had been the victim of an assault, which he described as the precursor to his anxiety and loss of confidence.

5.2 BEING A GOOD PERSON

In this section I will explore the constructed identities of former clients as they make moral claims of being a good person, for example, 'I acted fairly but others didn't'. I will also look at claims for being seen as a good mother, for example, 'I never neglected the children', of being a strong person, presented as, 'I have to fight not to get so low again', and of being relieved of responsibility because one has an illness, constructed in the form, 'I tried to commit suicide but it wasn't my fault. It was the depression'. Themes that emerged from the analysis were of being a moral person, of being a good

mother, of being a strong person, of suicide, 'it's an illness not a weakness', and the relationship between counselling and mental health.

5.2.1   On being a moral person

More than a half of the interviewees in this study offered a presentation of themselves as people of good morals and integrity. Bridie said that she had always tried to treat people the way she wants to be treated herself. Ffion spoke of going to work in a nursery school 'on her death-bed' rather than leave the young children with 'total strangers' (that is, supply teachers). When speaking of her intense grieving for her late husband, Olive claimed 'I still done things. I never neglected anything.' Debbie found living on income support shameful, and rationalised her situation with 'it could happen to anybody':

> *Sometimes I get angry at the situation we're in now. I hate being on benefits. I'd always worked from when I was fifteen. I gave up when I had my daughter because I thought 'I want to bring the children up myself'. And I was lucky not to have to go to work. I never dreamt I'd be on income support, struggling, y'know, with two children. But it could happen to anybody. [Debbie]*

Kath presented this image of the kind of person she is:

> *I've always worked extremely hard, and always given a hundred and ten per cent. Thought that I was doing the right thing, giving a hundred and ten. But when I looked around me and saw my colleague only giving fifty per cent, and picking up the same wages - but I am who I am, y'know. I can't come down to their level, because I am who I am. [Kath]*

Whilst of sexual morality, Ffion declared:

> *I'm thirty-seven and I've only slept with two people in my whole life and I loved both of them dearly. [Ffion]*

5.2.2   On being a good mother

Debbie, in dealing with the suicide of her ex-husband, said her priority was to support her children through their bereavement. Tracey talked of loving being a mum so much that she wished she did not have to work outside the home

in order to supplement the family finances. Nikki spoke of 'having' to get better for the sake of her family, whilst Angie described her life's priorities as to be a wife and mother:

> *I was desperate to be married, have children, in a relationship, and that was really what I wanted most of all. As far as career's concerned, that was the added bonus. Instead of putting the career first and then marriage and children, I was the other way round. I know that my children are three children to be proud of and I can take them anywhere. [Angie]*

Heather spoke of her depression:

> *I did things I had to do. I didn't neglect the kids or anything. I did things I had to do.... When you mention psychiatric help and things, [pause] – I don't want to go down that road, see, 'cos I've got the children. [Heather]*

In the accounts of the mothers who had experienced suicidal thoughts, the fact of their having children kept them from putting the thoughts into action. Tracey described the process of her thinking:

> *'Wouldn't it be easier if I just had a tablet and go to sleep for ever?' I was feeling like that. And that is not the way to feel with young children. And y'know the only thing that stopped me from doing something about it at times was the fact that I wouldn't leave the children alone. I know they would be fine with their dad – and then to hear in my own mind, saying that to myself, 'oh they'd cope okay. It wouldn't make any difference'. I took a step back and I'm thinking 'what are you on about?' Y'know, I just shouldn't have been feeling like that. [Tracey]*

5.2.3 On being a strong person

More than half made assertions relating to mental strength and the work or effort it required to remain 'strong' since the event that brought them to counselling. Some also provided a contrast of 'before' and 'after', with interviewees seeing themselves as weaker now. John described himself as being 'a very strong character' prior to his brain haemorrhage, emphasising, 'mentally, very, very strong'. Christine, who had seen several counsellors, spoke of trying to manage without a counsellor, and of 'picking herself up'

rather than wait 'three months' to be re-referred for an appointment with her GP practice counsellor. The concept of 'being able to cope', and 'being a 'coper' were frequently set out as signs of strength. This was contrasted by Victoria, who since counselling had sought training as a counsellor herself. She said she had previously felt 'strong enough to cope' without addressing her deeper issues. She declared 'I wasn't this super-person that could do anything', and that 'strength doesn't come from coping with everything, but from addressing what needs to be done'.

Debbie, of having a husband who was diagnosed with paranoid schizophrenia, described an inner strength that remained intact throughout the ordeal of her marriage:

> *A horrible experience, being with somebody like that. I'm absolutely amazed I've come through it because I could be in a mental hospital by now, really. - Let's hope I can carry on. Y'know I keep thinking at some point surely I'm going to crack. Just break down or something. I've still got that fear that one day it'll just all kind-of get too much. I'll think, 'I just can't do this anymore'. But I know I've got this survival instinct. Y'know, I can get really down, but then I'll always start coming up again. And I do have a happy disposition, basically, and he never managed to get rid of that. [Debbie]*

On the matter of self-respect, Ruth said:

> *Edge of a nervous breakdown - There were days when I used to think it would be just nice, if I just stopped holding on to my sanity, and just let my brain flip that little bit further, then I wouldn't be responsible for myself any more. Y'know, someone would have to take care of me, because I would just – go. I consciously used to think that at times, that if I just let go, then I won't have to care any more. {sounding distressed}. There's the self-respect thing that's tied up in it. You don't want to let that last bit happen. [Ruth]*

And Yvonne:

> *I didn't want people to feel sorry for me – 'cos I feel I'm a 'coper'. I didn't really want to say to the girls at work that I was going to counselling. I think it's a private thing, at first. You don't really want to*

share – especially because it is emotional, and you don't want to break down, because it makes people uncomfortable. [Yvonne]

As a contrast, Christine did not see herself as a strong person:

What you've got to realise is some people are stronger than others. Some people can cope with things you can't cope with. Y'know, it depends on how strong you are. Some people, they go through a lot, and they can cope with it because they're stronger. And there's people who can't cope with it. And there's some - that's the people who get the depression. [Christine]

5.2.4   On suicide

Eight interviewees spoke of suicidal thoughts and I have recorded these thoughts as symptoms in sub-section 5.4.4. The references to suicide that appear in this section are couched in terms of value judgement. Suicide was presented by four of the participants as beyond moral acceptance. Kath in particular was insistent that I should not consider her to be suicidal. 'Don't think I'm suicidal. I'm not.' Heather claimed, 'there's people on the verge of suicide - I'm not like that'. However, Zena appeared comfortable reporting her thoughts of it 'being okay if I don't wake up in the morning'. Heather and Tracey both reported thoughts of suicide but claimed they would not take this further because of their children.

There were claims of not wanting to take the time of the helping professionals because there were others who were more in need of help. For example, Heather said:

I was tempted to phone the Samaritans once, but I thought there's more people out there that need them. I'm not that sort-of desperate. I don't want to waste their time with me. [Heather]

Concern for family was offered as the reason for not carrying out suicidal fantasies, as described in this example by Eileen:

I felt as if I was ready to overdose or something. I don't think that I would have done anything, um, silly, um, because I absolutely adore my son, and I just think for them to have found me doing something stupid

would be mortifying for them, because that would then lead to them having problems. 'She didn't love me enough to stay'. Those things did go through my mind. Everything did go through my mind. [Eileen]

As noted previously, Christine did not have children, and she was the one person of my respondents who moved the fantasy into reality, with three attempts at suicide.

5.2.5 An illness not a weakness

Five respondents accounted for their depression as an illness. Kath made sense of her experience by identifying different kinds of depression, some within herself and others of chemical origin. She had developed a means of accepting her depression as inevitable:

Sometimes I feel that some of my depression is what I call chemical – I don't know how – that there's something in my body. And there's other depressions where it's your head. I think this is more a combination of the both at the moment, the body and the head. Whereas if it's my body that's making me, I just accept, 'right, you're going to have depression' and I just shut myself away for two days. Wallow in it, and then I'm back. [Kath]

Tracey had previously thought of herself as stupid:

I just thought it was a glitch. But I got told it was a sickness. I was ill. Although I didn't see myself as being ill initially. I saw myself as being stupid, and saying to myself 'pull yourself together'. But it didn't make any difference. You're sitting there and crying for no good reason. You do really, really stupid things. I mean, it was just so silly. But I just couldn't stop myself. Literally. [Tracey]

Christine bemoaned society's lack of understanding of depression as an illness:

Until somebody is depressed, they don't know. They can't. They think you're being silly. In the end they can't be bothered, because they don't understand. There's no sympathy, y'know. They don't class it as an illness. It's your own doing. [Christine]

Pamela did not identify herself as having depression but fibro-myalgia, and accounted for her problem as being physical and not a character weakness. Pamela was also happy to claim her diagnosis of fibro-myalgia, in other words, it is not *just* ME (myalgic encephalomyelitis), but a named, recognised condition. She accounted for the origin of her illness with a quote from her psychologist, 'with all you've done over the years, your body's just worn out'. Pamela placed great trust in the psychologist, describing him as 'wonderful' and 'expert', and she trusted him to 'sort her problems'. Pamela was following his treatment plans, and the anti-depressant medication that she was taking was prescribed, she stressed, to correct the chemical imbalance in her brain. It was not to lift her mood, she insisted, because she was not depressed. The treatment plan also included a stepped programme of activity such as walking and Tai Chi classes.

5.2.6   The relationship between mental health and counselling

There were a number of comments concerning the perceived relationship between counselling and mental health. Will and Nikki both commented on the distinction between having counselling and receiving psychiatric services.

> *There wasn't any connotation as to 'oh my God it's going to be a psychiatrist' or something. And fair play, my doctor, he said 'we're not sending you to a shrink. It's not in a hospital. We've got the room upstairs. It's all quiet.' [Will]*

Being identified as having mental health problems was perceived by many as stigmatising and shameful. In some accounts there was indication of a lack of discrimination of difference, with any emotional or mental health problem feared to be construed as 'being mad'. Sian thought it 'stigmatising' to be channelled through a women's crisis centre, and Heather said of her doctor:

> *I don't want him to think I'm mad, y'know. I don't want him to think I'm ill. 'Cos I don't think I am. I don't think I'm mentally ill or anything. No, I don't. I can control my thoughts. [Heather]*

Of the stigma in disclosing mental health problems to others:

*Although my boss was very nice, and I could have gone to him more –
but I couldn't. There is the stigma about mental health. I wasn't very
relaxed, really, to broach it, although I think he sort-of understood.
[Ruth]*

Heather's account contained confusion over the provision of mental health
services:

*I don't know how things like that work. When you mention psychiatric
help and things, I automatically think of – I don't want to go down that
road, see, 'cos I've got the children as well. And I don't want people
thinking – or the doctors or whatever thinking – yeah I've got a mental
illness, or whatever. Because I know I haven't. I think it all goes back –
but when you say psychiatrists, automatically you think of {name of
disused psychiatric hospital}, that type of environment. So I didn't
assume there was anything in the middle. You're either very mentally ill,
and you need that sectioning, that help. Or you've got the basic
counselling. [Heather]*

John had changed his position on the matter since suffering a brain
haemorrhage, and was glad to have the 'excuse' of his illness as this made
the counselling acceptable:

*In the past, the thought of anyone thinking I had a mental problem - in
a way though, it was easier now, because I had an excuse. If I hadn't
had an illness, I would have probably found it hard to say to people I
had a mental problem. I just felt, you know, it would be pretty difficult.
Whereas, I did have a reason to have mental problems, which I thought
were justifiable. Yeah, that was okay. I was never embarrassed about it.
I told all the people that work for me, and the people I worked for. I
told them straight. 'Oh I'm having counselling'. [John]*

Others couch their opinions in terms of the judgement of others, for example,
Ffion:

*Many people baulk at the idea. 'Oh there's nothing wrong with me. I
don't need a psych.' [Ffion]*

Whilst Kath said:

Because, really and truly, nobody likes to think they need counselling. It leaves a bitter taste in your mouth sometimes, doesn't it? I'm sure lots of people feel like that. [Kath]

Also drawing upon the reactions of others, Angie said her friends could not understand why she wanted counselling:

In fact I don't know any others that have been to counselling. There were gasps of horror when I was saying to people, 'I'm going to counselling' {laughs}. And there was like {intake of breath} y'know like, 'why, what's your trouble?' When I said that I was going to counselling, it was as if it was such a big issue, as if I'd completely lost my marbles or something. I had comments like, um, about a psychiatrist being involved. 'Do you need to see a psychiatrist?' One minute they'd be saying 'there's nothing wrong with you' and 'what are you going to counselling for?' 'what do you expect them to do?' I don't know whether they imagine that once you go to counselling, there's obviously something wrong in your mind and you end up seeing a psychiatrist or something. [Angie]

Angie also spoke of her father, who had had major surgery for cancer:

No end of people have said to him 'why don't you go to counselling, cos that'll help you deal with all the trauma you've been through and sort these things out in your head, and you'll cope better, and help you sleep'. And he would not do it. As if there was like a stigma. Cos he's sixty. It's like 'oh God, no, if I admitted I went to counselling, it means I'm weak or something, or I've got a mental problem'. [Angie]

For Nikki it was very important that the counselling should not be located within secondary care. She quoted a neighbour 'I'm going up the nutty farm today!' Of the CMHT Nikki said:

Some places have got a stigma attached. We deal with them with our residents {in a care home}. So to go there for counselling, it's not an option. One of the ladies up the street she said 'oh I'm going to go to the nutty farm today'. And I thinks 'oh, no, I went there'. We've got a lot of mental health patients in work, so when you see them coming in, you see what they're going through, and you think, oh, you don't want to be associated. Because, to me, it doesn't say 'counselling', it's a psychiatric unit. It's just a big difference. [Nikki]

5.3 BEING A GOOD PATIENT

All interviewees in this study accessed counselling at their GP surgery, and were thus construed as being in the role of 'patient'. For some, in describing their symptoms, anti-depressant medication was called upon to legitimise the severity of their symptoms and their misery: 'I was so bad I had to have tablets'. Furthermore, some went into great detail of the dosage of their medication: '20mg wasn't working so we had to up the dose to 40mg'. Ten people who had accepted the medication drew upon their GP's direction as justification for their decision: 'the doctor wanted me to try it'. Nine expressed concerns over dependency and withdrawal, fearing they would feel worse without their tablets, 'will I go downhill without them?' Whilst the majority presented concern over the taking of prescription drugs, and justified their use of medication, only two interviewees rejected the offer of prescribed psychotropic medication. Themes that emerged in this section were of medication as beneficial, as legitimised by the GP, as a measure of distress, fear of dependency on medication, side effects of medication, medication justified as treating other symptoms, the client's decision to stop medication, of other prescribed medications, and the deviant cases of those who did not want medication.

5.3.1   Medication as beneficial

There were positive statements about anti-depressant medication. For John, the anti-depressants alone, that is, before the counselling, 'changed his life'. For Ruth, 'if they make you better, they make you better.' Many described anti-depressants as being useful, 'helping you cope'. Heather said they help, if only a little, to get back some 'get up and go', whilst Ruth offered 'they did help, and brought me to a certain level'. As an example of the positive effects reported was this comment from Victoria:

> *At the time I felt I would have taken anything. They calm you down – they calmed me down. They might give your brain a bit of a rest for a while. [Victoria]*

Negative effects were minimised in favour of the benefits experienced. For Will, taking medication 'is a small price to pay':

> *If it ends up that I've got to stay on them for the rest of my life, well so be it. But if it means that I've got my life back, then that's a small price to pay. I've not felt any stigma or anything. I've got no worries about being on the tablets. [Will]*

And from Yvonne:

> *The tablets subdues this feeling. Unless you're really, really stressed, you don't experience that any more. It makes you a bit dull. But I don't care. {laughter} I'd rather be duller. It's keeping me steady, and keeping my mind happy. [Yvonne]*

5.3.2 Medication as legitimised by the GP

Clients legitimised the use of drugs by citing their doctors' encouragement and direction, for example, in this quotation, Christine indicated her concern by using the phrase 'they're non-addictive' three times:

> *Eventually my doctor said that he thought it would be best to put me on Sertraline, which was a non-addictive antidepressant. And he wasn't, um, concerned about me going on them at all, as they were non addictive. The doctor said that he didn't mind me being on them for another couple of years - they're non-addictive. [Christine]*

I will comment on this further under the sub-heading 'fears of dependency'.

5.3.3 Medication as a measure of distress

Patients offered histories of co-operation with GPs of their trial-and-error experiences to achieve an optimum dose for relief of depressive symptoms. The amount of medication required was used as evidence of amount of suffering endured. I never prompted for the dose of medication currently or previously taken, but this was offered spontaneously, and this level of detail is quite significant in the clients' accounts. For example, Nikki said:

> *They put me on Seroxat. I went on ten. And the doctor upped me to twenty. And one of the doctors then upped it to thirty, and things started to − not level out, it took a long time, but I could feel the*

difference. And about two months ago I come back down to twenty, because my doctor said he doesn't want me come off them straightaway, because I'd been on tablets before when I was ill in work. It's just like he said, I'm prone to it {depression}. So I've been on the twenty now for a couple of months. And things are okay on that. [Nikki]

Tracey had a similar account:

I tried to come off them. I tried to cut the dosage, but it didn't work. I'm on the highest dosage, anyway. I'm on forty milligrams, not twenty. The doctor tried me on twenty but it didn't do much at all, so she increased it. I'm on forty now. And I tried to come down lower but it didn't work. But I do have a stressful job. And I think I see it as a bit of a crutch, while I'm taking it... It didn't have the effect she thought it would have, as quickly. I was just as bad the second time I went to see her, as I was the first time. So she increased it to try and get it into my system a bit quicker. When I tried to take a tablet every other day, instead of every day, it didn't work. Um, so the doctor says she hasn't got a problem with me staying on them. They're not addictive. And I think I'll just do it in my own time. Because obviously, I think I was more depressed than I originally thought. The doctor said I was very, very depressed. [Tracey]

Some interviewees continued to take what they called 'a maintenance dose' with their GP's approval, expressed as 'she doesn't want me to come off them yet'.

5.3.4   Fear of dependency on medication

There appeared to be shame regarding taking medication. There were many contradictory statements of 'they're non-addictive', but also 'I can't do without them'. Sian was attempting to wean herself off them, recognising 'I get very addicted'. Christine had concerns about dependency and emphasised through repetition, her GP's advice and his description of the medication as non-additive. She was 'dreading' the doctor saying it's time to come off them, whilst making a point of stressing 'even though they're totally non-addictive', the doctor's 'gonna sort-of do it slowly'. Of her attempt to discontinue her anti-depressants, Christine commented:

I'd stopped taking them, cos I was a bit scared taking them for so long. But eventually I got so bad I took another overdose and I had to go back on them. [Christine]

Whilst Will was concerned over media reports which were being publicised during the final stages of this study.

The only thing that's interested me is some of the reports that you hear of Seroxat, where people coming off them - not that it's addictive, but they get like these electric shocks going through the body. So that's – interesting {laughs} [Will]

5.3.5 Side effects of medication

Leonard talked of drowsiness and of feeling rotten the next day, Zena of diarrhoea, Sian of liver problems, and Debbie of dizziness and a rise in prolactin causing her to lactate. For some, these side-effects were given as reason to discontinue the medication. Victoria described her position:

I was never really entirely happy being on them. They made me feel like a zombie. I'm the sort of person that does feel things more sensitively, there's no point damping that down, 'cos that's your natural personality. I thought 'well it's not really me'. [Victoria]

Of the various side-effects to their medication, for two interviewees toleration of these had been an achievement and evidence of compliance with the GP's treatment plan. Such toleration and endurance was spoken of with pride, for example, John reported his doctor's advice:

'Try them, it'll take a month to get into your system'. He said 'if you persevere with them, the first week will be terrible'. And it was. The first week was worse than without them. [John]

5.3.6 Medication justified as treating other symptoms

Three clients were taking anti-depressants for symptoms other than depression. Ffion reported taking them to control her panic attacks, and Zena believed taking Prozac was helping with the pain of arthritis. With regard to Pamela's fibro-myalgia, her symptoms included fatigue. She was prescribed an anti-depressant, not because she had depression, she insisted, but to help

'get the right kind of sleep – to go into the third stage of sleep - cos of the seratonin in the brain.'

5.3.7   The client's decision to stop medication

The three clients who had stopped taking anti-depressant medication spoke with pride, recognising the usefulness of the medication on a temporary basis, and measuring the discontinuation of the drug regime as a strength of character. Victoria cut down gradually and felt fine. She was proud of her decision to quit, going against doctor's advice:

> *I think the doctor was keen for me to stay on them for a little while longer, because I think he was just concerned – he didn't want me to take any backward steps. But I was quite keen, so I came off them very gradually, and reduced the dose very gradually, and I haven't taken any since. I don't feel that I want to or need to. [Victoria]*

John described his relief at knowing the anti-depressants were there as a contingency.

> *I had made the decision to come off, myself. And once I'd made that decision – a couple of times I nearly went back on them. I've come off them, and I <u>know</u> that I can go back on them. So, if someone said to me, 'right you're coming off them, but you can never use them again,' I might not have come off them. But knowing that I could fight it, and go back on them if I needed to – yeah, was a big help. [John]*

5.3.8   Other prescribed medications

All clients in this study who were on medication were on anti-depressants, and some had tried several different preparations. Some drugs were identified by name, such as Cipramil or Prozac; others were named generically as anti-depressants. Of the six interviewees who spoke of other medication, four had taken anxiolytics, ('tranquillisers') such as Diazepam or Valium, one had been prescribed Temazepam ('sleeping pills'), and Olive was on an anti-epilepsy medication. There were mixed feelings about these other medications. For Will, the tranquillisers 'really calmed him down', whilst Olive, who was taking anti-epileptic medication following her brain surgery, was experiencing what

she described as side effects of feeling 'fuzzy'. Zena was prescribed Valium in the late 1960s, prior to the death of her mother and her divorce:

I think the Valium suppressed my grief - the grieving over my mother, and the grieving over my broken marriage. I took that final step and stopped taking them. A short while after that, I started my grieving. While you were taking the Valium, it would be difficult to really get down to thinking about it. But afterwards, I could see what it had done. [Zena]

5.3.9 Deviant cases: those who did not want medication

Whilst many expressed concern and several were proud to finish taking medication, only two interviewees expressed strong views against psychotropic medication. Gareth, who was 18, drew upon his mother's reluctance for him to be medicated. Eileen made a point of claiming 'I didn't want them and I didn't take them', and I note her approval of a 'natural' (herbal) preparation as acceptable:

I didn't have anti-depressants - I didn't want anti-depressants, y'know, I don't want to go down that road. I don't get depressed these days. I take St. John's Wort, only one a day. I prefer the herbal than the actual drug, and not only that, it's good for you anyway. [Eileen]

In this example Eileen has presented herself not as morally good for being a good patient and following the doctor's advice, but being morally good according to a different value system. She is being a person of strong character by refusing to medicate her body with artificially created chemicals, and places high value on 'natural' complementary medicine.

5.4 SYMPTOMS

When a GP refers a patient to the primary care counselling service, reasons for referral are recorded on a 'GP referral form' which is forwarded to the counsellor. This referral form may or may not include a formal diagnosis, for example, 'depression', and/or may offer a brief summary of current difficulties, such as, 'marriage breaking up'. In the research interviews conducted for this study, the majority of symptoms cited were psychological

rather than physical in nature, although some psychological or emotional difficulties were somatised and presented as physiological, for example, as chest pains (Angie) or stomach problems (Bridie), with no physical cause identified. Some participants had long-established physical problems but these were not offered as the cause of difficulties requiring counselling, for example, Zena had heart trouble. By contrast, others were greatly troubled by their physical difficulties. Kath suffered the combination of physical and emotional problems, as did Pamela with her previously unrecognised fibro-myalgia, the symptoms of which were indistinguishable from depression.

In the analysis of client narratives, a number of themes emerged of psychological symptoms, namely, depressed mood, problems with thinking, paranoid thoughts, suicidal thoughts, anxiety, panic attacks, nightmares, intrusive memories, and of having a breakdown when things got too much. Those with symptoms of anxiety spoke of having difficulty sleeping and panic attacks. I have commented within the text where the interviewee uses medical terminology and where the narrative is purely descriptive. I have recorded the number of clients who cited each symptom.

5.4.1   Depressed mood (16)

The most frequently mentioned symptoms, cited by 16 of the 23 interviewees, related to 'depressed mood', and were mentioned many times over, in 29 separate quotations. This category includes feeling low, crying all the time for no apparent reason, having no energy, not wanting to go out, not wanting to face the world or other people. It also refers to a sense of being 'shut-down', wanting to stay in bed under the covers, and of time passing them by. For example, while his wife was at work, Will would spend all day in front of the television, not moving for hours.

Most people described their symptoms in behavioural terms, in what they did, or did not do, for example, Heather:

I was getting very low. I didn't go out. Didn't like speaking to people. Things like that. I just wanted to be in. I only felt safe when I was in. Last summer, it was pretty awful. Things just got too much. And I just got fed up. And I ended up just doing nothing, probably about two weeks. ....Dragged myself out of bed in the morning. That's another thing I feel, as well. I'm safe in the night. See, I go to bed, and I feel like, 'I'm safe here, nothing bad can happen now'. 'Cos it's the night. But then, the morning comes, and then letters come through your door, and just things happen, don't they, in the day? So I don't want to get up in the morning. Sometimes I just wish it was night. When I'm just getting into bed and just going to sleep, I could be there quite happily for ever, that time of the day. [Heather]

Accounts frequently call upon the GP's diagnosis with a discounting claim 'I'm not that bad <u>really</u>'. Depression was often qualified, for example, Zena 'I've had several episodes of depression. Not the very worst sorts'. Or Heather, who said, she was 'definitely not depressed. Not as the word depressed means...cos I wouldn't call myself depressed with a capital D'. For others, receiving a diagnosis from the doctor was presented as a justification of their symptoms. For example, Tracey had experienced financial and family turmoil, and finally broke down at work. As the quotation at the beginning of this chapter illustrates, her GP then labelled her symptoms as depression. Zena was an exception to this form of narrated account of troubles, and spoke of depression as a very familiar and long-term condition:

The longer it goes on, the less easy it is to ask for help. You realise more and more that you're not well, but it's more difficult to go and ask for that help. Depression becomes so much part of you, it's almost a friend. It's comfortable. It's warm. And you don't push yourself to get out of it. [Zena]

5.4.2 Problems with thinking (14)

Problems with thinking were described by 14 of the interviewees. Classed as a symptom of depression, it is not surprising that it was called upon so frequently in these accounts. Ffion was unable to use her usual strategy of affirmations: 'I'd get into a rut and forget how to feel positive about things'. Olive said: 'I didn't know anyone', Ruth described having 'short-term memory loss', and Will said he had 'always had a good memory, now there are gaps

Chapter 5

everywhere'. Tracey said that she was unable to think as she normally did, and Angie found herself confused 'because everything seemed as though I was bashing my head on a brick wall'.

This theme includes a lack of usual cognitive ability and also problems with putting things in perspective, 'seeing things clearly' and acting on misinformed beliefs. Interviewees described thinking thoughts that were untested or unjustified, but nevertheless, were troubling and influenced their thoughts, feelings and behaviour towards others, usually closest family members. Examples include this from Heather, who lost her mother and brother when she still a teenager:

> _It's the same with my husband really. Sometimes I feel like, I'm gonna be nasty to him, because he's gonna leave me anyway. We get along alright. Our marriage is okay. But it could be a lot better, on my part. .....Because if I let him in, and then he goes, y'see. But, y'know, he probably will never leave me. But I still think, at the end of the day, he's gonna go. Go off with somebody else, or something. Deep-down, that is. That's how I feel, really, with life. Y'know, I keep everything at a distance, because if I get too attached or too happy, they're gonna go. [Heather]_

And this from John, recovering after his brain haemorrhage:

> _After about eighteen months it started to affect me. It affected our home life. It affected our sex life. It affected everything. So, because of what our marriage was going through – it wasn't my wife's fault, it was my fault. Which I can see now. Then I couldn't. I just thought everybody around me should have been doing more for me. [John]_

5.4.3   Paranoid thoughts (7)

Paranoid thoughts relate closely to 'problems with thinking', and some participants used the term 'paranoia' loosely. Angie spoke of anticipating criticism from others and 'becoming paranoid', and Eileen, whose brother died when they were children, said, 'I still have this little paranoia that I'm second best'. Bridie also used the word paranoid referring to her experience as a college tutor, following criticism of her, and of work having gone missing:

It didn't stop me wondering, 'had my work been sabotaged?' to bring me to that point. And that sounds paranoid, but the way that I'd been treated, I think, made me feel questionable about everything. So I lost trust in people. [Bridie]

Others described paranoid thoughts but without using the word. Ruth said 'you feel everyone's out to get you. Of course, that isn't true.' Debbie spoke of imagining that people were thinking bad things about her. Christine also described her paranoid thoughts and their impact on her:

Your mind don't work properly. Your mind's thinking all things that you wouldn't normally think. The depression, you feel everybody's against you. You feel nobody understands. If someone ignored me I'd feel 'oh!'. Y'know, it was devastating. I'd think 'oh, why are they ignoring me? Why are they doing this to me?' and I'd get upset. [Christine]

This was also illustrated by Heather when she spoke of the other mothers at her children's school:

I feel that people don't like me, or they don't want to know me. Very insecure. No confidence. 'I'm not the same as any of those', y'know? They've all got better lives than me. Y'know, everything's better, than me. But it's as though, sometimes when I go to the school, it's as though they know all my secrets. D'you understand? Like, they know things about me. [Heather]

5.4.4 Suicidal thoughts (8)

Thoughts of suicide included both taking direct action, and also hoping not to wake the next day. 'It does cross my mind sometimes, cos that'd be an end to everything then', said Heather, but she then remembered the children and claimed, 'I couldn't do that to them'. Eileen made plans to kill herself, after the death of her husband. Tracey described her detailed plans:

'Wouldn't it be easier if I just had a tablet and go to sleep for ever?' I considered various options. 'But what if the children find me first?' - I couldn't have gone any lower, I don't think, without actually doing something'. [Tracey].

Angie described an emotionally charged scene from many years ago:

When I was pregnant for the youngest one, I was going to take my own life, and I came so close, and the middle son was the one begging and crying for me not to do it, and telling me how much he loved me. And he was really hysterical you know, cos he just knew that I was so down that I might do something stupid. And, um, he was begging. I was going to go out of the house, y'know, leave. I was jumping in the car. I was going to drive somewhere, I didn't know where. [Angie]

On thoughts of suicide and opting out, Ruth said:

You hear about people who have this electric shock treatment, and there were times when I thought I would love someone to just do that, and clear my brain. Thank goodness I don't have to go down that route. But I could understand why people might want it. There was just that feeling that I wish somebody would shoot something into my brain and I wouldn't feel this miserable and fed up. I wouldn't say that I was suicidal ever, but looking right back, to even before I was diagnosed, there were times when I used to think, 'well, you know, what would it be like, just to not have to be responsible any more?' Not necessarily to kill myself, but to opt out of society. [Ruth]

Christine had made three suicide attempts using an overdose of prescribed medication. Her narrative suggests that she had no control over her actions.

It's something inside you. Like a force inside you, driving you to do it. Something's pushing you, you know? Something's pushing you to do it. It's like a cry for help. If somebody answers that help, well all fair and good. But if nobody's there and nobody answers that help, well it's too late, you just do it. [Christine]

I have discussed suicide as a moral issue earlier in this chapter.

5.4.5 Anxiety (11)

Symptoms of feeling anxious were mentioned by eleven interviewees. Nikki had thoughts of planning her daughter's funeral when she was ill, Gareth was scared of returning to the shop where he had been assaulted, and Kath described being too frightened to leave the house. Irene reported being anxious about future nebulous events, for example, when winter comes, or when her children become teenagers. Heather experienced anxiety in many

contexts, whilst Will felt so anxious he could not face answering the telephone or opening the door:

> I didn't want to go out of the house. If anybody, even friends or family were going to call me, it was a case of they would ring, I would be able to do a one-four-seven-one, recognise the number – it was little things like that. I needed to know who, what, where and when. Whether I felt up to dealing with them, speaking with them or not. Somebody unexpectedly knocked on the front door, like the double glazing salesman, the heart would go racing. Yeah, it was like 'my God, who's this?' And you'd go into a bit of a blind panic. [Will]

5.4.6   Panic attacks (5)

The term 'panic attack' is used in different ways by different people. John claimed to suffer panic attacks when under stress, such as at the time of the interview, when his mother was in hospital. Marjorie spoke of panic attacks in the morning with her 'stomach, terribly tense and nervy'. Yvonne described waking up with panic attacks – palpitations – 'I wasn't aware it was a panic attack'. Bridie described distressing panic attacks prior to meetings at work, and Nikki described freezing with panic:

> The more I thought about work, I used to wake up with terrors, and nightmares. And I thought, 'no I just cannot go back'. I went out shopping once – my husband took me out shopping. He said 'come on we'll get out. Out and about'. Mum had the baby. And we got to Asda's and I just froze. I just stood there and I said 'just get me out'. It was horrible. It just got worse and worse. [Nikki]

5.4.7   Nightmares (4)

Nightmares are considered by some to be symptoms of anxiety that are suppressed by day. Angie had nightmares of a dreadful accident happening to her son, as did Bridie have nightmares involving her children. Irene spoke of nightmares of the abuse when she was a child.

5.4.8   Intrusive memories (5)

Symptoms reported included unwanted memories. Gareth used the term 'flashbacks' to describe his vivid memories of the assault he suffered. Sian says of the suicide of her ex-husband:

It comes back to haunt me every year. Particularly this sort-of time. {the anniversary of his death} [Sian]

Prior to counselling, Irene had nightmares and intrusive thoughts concerning the sexual abuse she suffered as a child. In talking to me she commented 'the thoughts are fresh again'.

5.4.9   Breakdown (6)

A breakdown was portrayed as the culmination of an untenable or unsustainable position. Clients claimed they were unaware of what a highly stressful situation they were attempting to manage, and the breakdown event was perceived as a 'wake-up' call. For Bridie, Ffion and Nikki, the breakdown event they described was in the past, and not an immediate precursor to this counselling. Both Bridie and Ffion had had counselling elsewhere following the breakdown event. Bridie described her experience of her breakdown at work:

It was a breakdown, but I didn't know I was having a breakdown. I couldn't speak in the meeting. I was so exhausted. I couldn't speak, I just felt sick. I just really couldn't talk. And the overwhelming anxiety was horrendous. It caused physical experiences that I've never experienced in my life before. [Bridie]

Also at the workplace, in a care home, Nikki said:

I went to work one day and I was fine. I was the making the bed for somebody. And I just literally started shaking. I was crying. I was vomiting. I was in a terrible state. Someone had to bring me home. And I just went to bed for three days and I refused to get out of bed. I wouldn't eat. I wouldn't drink. I just refused to get out. [Nikki]

For Eileen, Tracey and Will the breakdown they described became the trigger factor to accessing GP support and counselling. Will described having a gap in his memory, but knew that he did not complete his usual journey to work on the morning of his breakdown. Eileen remembered sobbing uncontrollably at work. Tracey used the term nervous breakdown:

I just went to pieces, basically...I had a nervous breakdown...one day in work, my eyesight went, spots in front of my eyes. And basically I said to somebody 'get me somebody!' and I just <u>went</u>. They took me down to the nurse on the site. My blood pressure was through the roof. They had to get a car to drive me home. [Tracey]

5.5 LIVING WITH SYMPTOMS

In this section I present a snapshot of the life-world of counselling clients, prior to their counselling. Clients spoke of their symptoms such that they were incorporated into their lived experience. Themes emerged of living with emotional problems as an on-going condition, of the difficulties of keeping up appearances, of questioning one's sanity, of feeling stressed, of lacking confidence, and of living with physical problems.

5.5.1   Emotional problems as an on-going condition

Symptoms were often presented as part of an on-going condition, comparatively enduring, and as something that had to be coped with. Christine referred to 'this see-saw thing', meaning that her mood goes up and down. John said 'I'll never be as strong as I was, mentally'. Ruth: 'this is something that I'll have probably for always now'. Sian: 'now I could cry very easily, since I became a weaker person'. Zena: 'it's something I've learnt to live with'. Ffion said, referring to her earlier breakdown:

I picked up quite well, eventually. I still get really bad days - obviously this is something I do need to put up with. [Ffion]

Kath said she has had periods like this off and on over the years, and described her day-by-day coping strategy:

Finding one thing that made the day worth living. And if it was eating a Mars Bar, then that'd be it. And if I don't feel any better by – say, Easter - I'll do myself in. [Kath]

5.5.2   Keeping up appearances

The theme of keeping up appearances includes references to the effort of 'putting on a front', and the claim that others did not know what the client

was truly feeling 'inside'. People were in emotional turmoil, yet no-one seemed to notice, or to pay attention. Clients also reported not talking to others, or of not saying how bad they were feeling. For example, Eileen, who had been widowed for two years, thought of herself as lacking self-confidence, but that people outside did not think it because they saw her as coping well. The experience of feeling 'not known' to others highlights the difference between how people felt about themselves and how they perceived others to perceive them. For example, Leonard offered:

> *People thought 'he's okay'. Go to work. 'Nothing wrong with him. He looks okay'. But they don't know what's going on underneath. [Leonard]*

Christine felt that nobody understood her pain and took overdoses of pills to draw people's attention to her distress. By contrast, Zena, who is at ease with what she calls her mild recurrent depressions, would tell disbelieving friends 'I'm not unhappy, I'm just depressed'.

The comments above refer to family and friends. Bridie said of health professionals 'I feel it's very difficult for people to see the pain without seeing the depression'. I take this to mean that she thinks that professionals label her as having depression, and that distances them from recognising the emotional pain she is experiencing.

5.5.3   Questioning one's sanity

Both clients who had been recently widowed described questioning their sanity. Eileen said: 'I thought there was something wrong. I thought I was going crazy.' Similarly Olive sometimes wondered 'am I going nuts?' Heather was concerned in case her GP 'thought she was going mad', although she herself did not think she was 'mentally ill'. Ruth felt her self-respect kept her from 'tipping over the edge'. Kath spoke of isolation and the need to hear her symptoms construed as 'normal':

I thought I was going mental. And I needed somebody to tell me that the symptoms were typical of somebody going through this. I thought I was the only person who ever felt like this. [Kath]

Angie offered this example of one of her nightmares and night-time hallucinations:

Another one I used to get a lot was rats running all over me. I hate them, and I was laying in bed, and I'd imagine them going over the bed. And I couldn't sleep at night, and I'd be laying there, wide awake, imagining that they were there running over me, even when I was wide awake, and even think I could feel them. So I'd have the covers all over me, so they weren't touching me, and I would think that I could feel them, running over the bed. And I found that particularly worrying. Cos I thought 'my mind's so disturbed now I've really lost it now. I really need help'. [Angie]

5.5.4   Feeling under stress

Clients offered their experience of stress as a symptom of problems, rather than a causal factor. There were references to feeling under stress and to the effects of stress. John found that he could not cope with as much stress as he used to, and that some stresses were beyond his control. Nikki described making the house and children perfectly clean and tidy before the midwife would come to visit, and staying up all night to achieve this. Leonard said that although he had slowed down considerably from how he used to be when he was younger, most nights his mind was 'racing ahead'. Angie said of dealing with a troublesome neighbour:

I was getting so wound up that I felt like I wanted to grab him by the throat and I was going to pin him against the wall any-day. And I thought 'this is becoming scary now, because I can feel myself getting to the stage where I'm so stressed out and really not coping, that I am going to grab him and overstep the mark'. The family were saying 'gosh you'll have a nervous breakdown the way you're carrying on'. I was getting pains in the chest and I went to see a specialist. And they did tests and said it was stress related. So, in the end, I went to the doctor. And I was in tears. I said 'I really just can't cope with all of this'. [Angie]

Gareth described the feeling of escalating tension:

I get very stressed. I just find that everything gets on top of me. Once one thing starts, everything else follows. I get very frustrated and very, very stressed out. And of course sometimes then I get irritated. I don't get aggressive as such, but I just get uptight. It starts annoying me. [Gareth]

5.5.5   Lack of confidence

Low self-esteem was often described in terms of lacking confidence. Debbie: 'If I did the slightest thing wrong, I'd beat myself up about it, I'd give myself a really hard time'. Some described this as a permanent state of affairs. Christine said 'I never feel really good with myself', and there were six separate quotations from Heather under this heading, including comments referring to 'people don't like me', 'people don't want to know me', 'I'm very insecure', and 'I have no confidence'.

I've never felt like I'd be good at anything. I always fail. It's as though if I do something and I do some little thing wrong, I've failed the whole thing. I'm a failure. [Heather]

In contrast, others spoke of loss of confidence or loss of personality, explaining that they had lost their old, confident self, as a result of a recent and identifiable event, for example, Bridie, following her dispute at work:

I lost my identity. The gifts of life. Of happiness. Of joy. Of having no fear. Y'know, all that's been taken away {distressed, continues tearfully}. I think I'm angry, now. Angry that I've been let down. That my personality's been changed. It feels almost like my mind's been affected, and my body's been affected, without choice. [Bridie]

Also Sian, who was recovering from an abusive relationship and the subsequent suicide of her husband:

Feeling such a failure. And this is what it was going through in my mind, churning around......It's been very difficult for me. As I say, I think I have suffered – I think my personality has suffered because of it. From being somebody who'll get up and talk in front of two thousand people at the drop of a hat, to then go to not wanting to talk to even my colleagues. In many ways, it changed me. [Sian]

5.5.6   Living with physical symptoms

Physical problems were drawn upon as symptomatic manifestations of emotional distress, and also part of life's problems which in turn were the cause of distress. Physical symptoms were often investigated to eliminate physical illness prior to referral for counselling. For example, Angie had 'pains in the chest'. The tests did not find anything, and the doctor concluded the pains were caused by 'stress'. Bridie had an 'irritable bowel'. Again, investigations showed up nothing, which was both a relief, in that there was nothing 'seriously wrong' and a disappointment, because it was due to an unresolved situation and would therefore continue. In her grief, Eileen felt physically ill:

> *I really felt bad, y'know. I felt physically ill. I seemed to have a pain all the time. A pain. I felt like my life was a pain. [Eileen]*

Both Kath and Pamela considered their long-standing physical problems to be a major factor in their difficulties, as I will discussed in chapter six. Some had long standing physical or medical problems which were not presented as part of current difficulties or as the reason for referral for counselling. For example, Marjorie described her symptoms as 'irritable bowel and diveticulitis'. Olive lives with the aftermath of her brain operation to remove a cyst, and this was presented as part of who she is, rather than a symptom prior to counselling. Zena had multiple health problems, including a heart problem, thyroid deficiency, and more.

5.6 FAMILY, FRIENDS AND OTHER SOURCES OF SUPPORT

In this section I will look at the ways in which participants describe their family and social support, their availability, and their value in terms of reducing or protecting against emotional distress.

5.6.1   Family and friends

From the analysis of interview data in this study, it appears that most people felt they were unable to talk to family or friends. For some, talking about their

problems or their difficulty was presented as shameful. Still others chose not to talk to family or friends, out of consideration for others, for example, Sian:

> *I've got some good friends. I didn't want to burden them with my problems. My husband doesn't want to hear nothing. He's a little bit better now, because after speaking to my counsellor I did try and explain to him that I did need to speak to somebody about the way I feel. But if I ever try to say to him, he becomes very, very angry. Not with me, but angry because he wasn't in a position to do anything. [Sian]*

Some tried to engage family and friends in conversation, but the listeners did not know how to be helpful to the client. Some listeners offered encouragement which was discounted by the client. Both of these quotes are from men:

> *You can talk to your friends, and I have spoken to some of my friends prior to this - and that's helpful. And that's counselling as well. But your friends tend to be on your side. What ever they tell you, usually, they support you, because they are your friends. You unburden yourself. And then you tell them the problem. And they're usually all sympathetic, or perhaps they've had similar experiences. But they're biased. [Leonard]*

> *Okay, I had people in the family, and my wife, saying 'it's not you're fault, it's the company and the people that you've worked with that have done this to you. You've not been managed very well, and that's it'. But it was still hard to take. [Will]*

Both Angie and Eileen spoke of friends who 'hi-jacked' conversations and talked of their own troubles. Angie said:

> *They wouldn't hear me out. Y'know if I start talking, they'd be butting in, wouldn't listen, or they'd come up with ideas that I knew wouldn't work for me. They weren't trying to understand where I was coming from. [Angie]*

Friends were sometimes considered not experienced enough to help, for example, this was how Zena saw the situation:

If you have friends that you can talk to, that's marvellous. But not everybody is able to talk to a friend. And not every friend is able to listen, and draw you towards the right things. [Zena]

Nor did Kath experience friends as helpful:

But other people don't understand. When I had the nervous breakdown, I was sick of people saying 'pull yourself together'. What a stupid thing to say! [Kath]

Some clients felt that they did not have friends to talk to:

I didn't have any person to talk to, so I didn't talk to anybody. The counsellor, I think, was the first person really. [Sian]

Where friends were presented as helpful, most referred to instances of 'normalising'. Irene described her friends as offering opinion that she found helpful:

It was a little bit strange really, because I was still feeling like I was the guilty party. And I would tell people. But luckily, they turned round and said 'Oh, no, that's bad. That is abuse' or whatever. Because I was just belittling it, and saying, 'oh it wasn't much, it was only...'. But they were saying 'oh no, no. That's abuse. It's wrong'. They were really good. They were really helpful. [Irene]

And John gained great comfort from a friend who shared a similar though different experience:

A friend of mine had testicular cancer. He came to see me because he was suffering, mentally. He came to see me and said he remembered what one doctor said to him. He said to the doctor, 'why d'you think it happened to me?' and the doctor turned round to him and said, 'well why not you? Why should it happen to someone else?' And that stuck with me. That stuck with me. That stuck with me and I thought, 'yeah, why should I wish it on someone else? Why should someone else have to put up with it? Why not me, y'know?' You start to realise you're not that important. Your importance is only to yourself. Your importance is only to yourself. It's not to everybody around you. [John]

5.6.2   Other sources of support

In addition to the professionals, family and friends, there were other resources cited as helpful or supportive. These included, for Ffion and Ruth, self-help books discovered prior to the GP counselling, and for John, pages on the internet. Spiritual support was appreciated by two respondents. Ffion found her New Age spiritual beliefs sustaining, whilst Olive appreciated the social support of her friends from a church-based lunch club, and from a clairvoyant's reading following her bereavement. Of animal companions, both Heather and Sian spoke of the comfort and companionship of their dogs. Their relationships with their pet animals were presented as being as close if not closer than with humans.

5.7 CHAPTER SUMMARY

In this chapter I looked at the way interviewees presented themselves and their life-world. Interviewees accounted for their problems using a number of events, some located in childhood, some in more recent, or current, relationships, both in the family and at work. On 'being a good person', clients presented themselves as 'copers', 'good mothers' and 'strong people'. Being a good patient was represented as compliance with the GP's treatment plan, which for the majority involved psychotropic medication. Despite expressing concerns, most complied with the regime, although those who discontinued the medication were proud of this achievement, and two interviewees were adamant not to commence the drug therapy in the first place.

The life-world of counselling clients was glimpsed through accounts of their situated experience prior to receiving counselling, and the experience of living with these symptoms. Clients described symptoms such as low mood, lack of energy and anxious thoughts that are consistent with the common neurotic disorders of depression and anxiety (APA 2000). This is as one would expect, given the nature of the client group that is seen for counselling in primary care, that is, those with mild to moderate emotional problems. (Referral

guidelines are in Appendix 1). Symptoms such as lacking in confidence and questioning their sanity, amongst others, were incorporated into everyday life. They illustrate the types of problems that people take to their GP. For the majority of interviewees, and for a variety of reasons, family and friends were not considered helpful. They did not know the right things to say, and in some cases, were seen as the source of difficulties. For some interviewees, problems were considered too shameful to disclose. Professional therapeutic support was able to offer something not available from family and friends.

CHAPTER SIX

DISCUSSION

It wasn't something whereby you could say 'right as soon as I've had this counselling, I feel better, and I feel a little bit better every day'. You don't. Like if you take antibiotics, each day - it's not like that. Sometimes it doesn't hit you, inasmuch as, it could be months and months ahead, and you look back and think about certain things, and you think 'mnn, yeah, I can see now where it all fits in the jigsaw.' [Victoria]

The structure of this discussion chapter follows the issues raised in the preceding findings chapters. The first theme concerns successful counselling, and the factors that clients in this study drew upon, clustered according to relationship factors, therapeutic interventions, and contextual factors. This is followed by a consideration of contrasting stories relating to other forms of therapeutic assessments and/or episodes. These were accounts of sources of support outside the counselling service, such as therapeutic input from secondary mental health care services and in the voluntary sector, both prior to the GP counselling and since. I looked at why, according to the client accounts, apart from two, these were described as disappointing or unhelpful, and even damaging. The second section considers 'before and after' accounts, and comprises expectations and changes. It includes preconceptions and hopes, and whilst the majority of interviewees present an account of their counselling as successful in varying degrees, I offer a detailed examination of four clients in the study who presented negative experience from their time in primary care counselling. The third section focuses on client presentation of 'self', on the origins of their troubles, and what has led to this person becoming a counselling client. It also includes aspects of self-identity that may impact upon how that person is offered therapeutic services, and the way in which they may make use of such counselling or other intervention. The fourth section examines the life-world of the client, the lived experience of symptoms, and how lives may be peopled by others. According to the interview accounts, friends and family are not considered a substitute for

professional help. From the discussion of the themes, throughout this chapter I will highlight issues that arise. I will go on to further refine these in the concluding chapter as implications for practitioners and service providers.

6.1 WHAT CLIENTS EXPERIENCE AS HELPFUL

As I have explored in chapter two, there is a debate regarding specific effective factors versus generic features of therapy. There have been many years of empirical research, for example, as presented by Roth and Fonagy (1996). Conclusions from such research are drawn upon when recommending treatment options, such as the Department of Health's Treatment Guidelines (2001). These have been critiqued by those who claim quantitative, modernist methods are inappropriate and unsuited to measuring an inexact craft (see, for example, Seligman 1995). Critics point to the uniqueness of the therapy encounter and the importance of client variables and relationship qualities. In this study, themes emerged that illustrate both the specific and the generic, and also contextual factors unique to the primary care setting.

In chapter four I analysed the interview data on client evaluation of counselling. Three clusters emerged, these being relationship factors, therapist interventions and contextual factors. The wide range of factors that emerged in my analysis supports the published research (e.g. J.D. Frank 1973, Asay & Lambert 1999) that a number of factors are predictors of success, particularly the quality of the therapeutic relationship. Techniques associated with specific therapeutic orientations are only one part of this. According to Asay & Lambert (1999) unique client factors play the most important role in determining whether counselling may be successful. In chapter four I also examined the accounts of unsatisfactory counselling and other therapeutic services.

In discussing essential factors in counselling, clients in this study made comparisons with previous and subsequent therapeutic encounters. Of clients

who had come to GP counselling with a history of mental health interventions, the counselling in primary care was successful for some and not for others. Some described their previous therapeutic encounters as 'not being right' for them and were delighted by the connection they made with their GP counsellor and the change to which this had led for them. Four had found counselling in primary care disappointing, although two of these were currently in successful therapeutic relationships elsewhere.

6.1.1   Relationship factors

This first cluster includes those issues raised by the interviewees that refer to their one-to-one connection with their counsellor. In the client accounts, the uniqueness of the therapeutic encounter was of central importance, as was the impact of unchangeable qualities of the counsellor, such as gender or age, on the establishment of the relationship and the progress and outcome of the work. The importance of having time and space to talk was paramount, which supports previous findings, for example, Howe (1993). Also, my interviewees told me insistently of the importance of talking to someone outside their family and social circle. The majority spoke of not wanting to worry their family and friends, and some of not wanting them to know their business, and that in counselling they discussed issues and problems that it would not have been seemly or possible to discuss with family or close friends.

The quality of the therapeutic relationship

Clients seemed to have little regard for theory or technique, but recognised the importance of the person who is the therapist, and the relationship they had with them. According to Elliott and Williams (2003), clients endorse the view that it is the relationship rather than particular ways of working. 'It is necessary for the counsellor and client to construct an emotional bond and to have some agreement over how they are going to work together.' (McLeod 1990 p.9). For example, J.D. Frank wrote of a client attending a three-year follow-up appointment. The client did not remember his (Frank's)

interpretations, instead attributing her improvement 'to the fact I had made her "feel like a real person"', (J.D. Frank 1973 p.232), whilst Timms and Blampied (1985) described clients toward the end of therapy beginning to take more interest in the counsellor as a person rather than as someone playing a professional role.

Paulson et al. (2001) commented that a sense of connection allowed the client to enter the therapeutic process whilst a lack of connection had a negative impact. In this study Heather dropped out of the counselling after two or three sessions. As McLeod (1990) noted, on some occasions a good enough bond is never created, and although clients may pretend that one does exist to 'save face', counselling in these cases is rarely satisfactory or effective. Kath stayed for ten sessions but felt that the counsellor did not truly get to the heart of her problems. She did not express her disappointment to the counsellor. In a previous study, Rennie (1985) observed that clients were reluctant to disclose their disenchantments with their therapists, to their therapists. Instead, when there was a misunderstanding on the part of the therapist, the clients sometimes withdrew somewhat and withheld important information.

According to Maluccio (1979) becoming disengaged from a therapeutic counsellor is in some ways more complicated than becoming engaged, although this may be more problematic in longer-term counselling. In the primary care setting the counselling is contracted typically as six sessions, and this is made clear from the outset. In earlier studies, clients have commented on their fears regarding their emotional investment and dependence on the counsellor, their ambivalence about ending and an awareness of impending loss of support. (McLeod 1990). Tracey expressed her sense of abandonment at the end of her counselling with the feeling that she was not ready to finish at that time. The importance of relationship was further emphasized by interviewees in this present study who experienced a change of counsellor. Three clients had been affected by a counsellor going on extended sick-leave

and a locum taking her place. All three commented on the disruption on the counselling of their counsellor leaving, and the unwanted premature closure of the initial counselling relationship. In addition, Christine told of being passed from one professional to another, through a series of changes in service provision and of her distress at this lack of continuity.

According to the interview data, the majority of clients found it difficult to find anything critical to say of their counsellor. Paulson et al. (2001) noted that clients found it hard to articulate negative or hindering experiences, and that this was particularly troublesome where the counselling had been experienced as successful, such that finding fault implies criticising the therapist. Two clients in my study had found counselling in primary care disappointing, (Pam, Olive) but were currently in successful therapeutic relationships. Clients recognised the importance of working with the 'right person'.

Someone to talk to

The majority of clients foregrounded the importance of the time and space just to talk, as highlighted by Howe's (1993) meta-analysis, where the three essential aspects were identified as 'accept me', 'understand me' and 'talk with me'. This is one feature of counselling that was absent in accounts of other forms of helping relationships, and clients presented many comparisons to demonstrate the importance of talk, often that GPs were 'good but didn't have time to talk'. People felt frustrated, or thwarted by being unable to talk in other settings or in other relationships. The need to talk has been described as a need for recognition, reciprocity and understanding, in other words, the need for a 'conversational listener'. (Ribeiro 2002 p.193).

Someone outside one's circle of family, friends and work

The majority of clients privileged the importance of talking to someone outside their family and social circle. This is in contrast to the critics of counselling, such as Furedi (2004) who claim that people need to talk to family and friends, and to 'pull their socks up' rather than engaging in

introspection and self-obsessing. The majority spoke of not wanting to worry their family and friends, and some of not wanted them to know their business, or for people not to think badly of them. And for some, their problems were located within the family. Some commented that they disclosed issues to the counsellor they had never disclosed to anyone previously. Similarly, many of the clients interviewed in an earlier study had not confided their problem to anyone else prior to counselling, even though there were people close to them. (Mayer and Timms 1970). Confidentiality was thought to be paramount. Yvonne did not want her colleagues to know she was attending for counselling, and this was mentioned in particular by Will and Tracey who had both been offered counselling at work. This feature was also found in a study of Employee Assistance Provision (EAP) clients, where there were mixed views of talking to colleagues about their counselling. Whilst some were enthusiastic, others were concerned 'it might be on my record somewhere'. (Goss & Mearns 1997). It has also been noted that men are more likely than women to keep quiet at work regarding the common problems of mild anxiety, depression and stress, out of fear that it may affect their career prospects. (Norwich Union Healthcare 2000a).

A person perceived as having expertise

Maluccio (1979) noted how clients tended to evaluate their counsellor according to their perceived competence. Interviewees in this present study also described their counsellor as being good at their job. Exceptions here were Leonard, who thought his counsellor lacked experience, and Kath, who considered that counsellors should be expert at assessing the mental health needs of clients, and to recognise whether counselling will be sufficient, or whether a deeper or longer term therapeutic intervention would be more helpful. Kath thought her counsellor was lacking in this respect. This supports Frank et al.'s (1959) findings of the importance of the client's belief in the therapist. According to the researchers, the therapists who most help their clients are those whose clients have confidence in what they do. Roth and Fonagy (1996) also point to the experience of the therapist as being an

important factor. In a study of 23 therapists, working with 143 clients, they commented that 'therapists with more than 6 years' experience showed greater efficacy' than those with less than six years. (Roth and Fonagy 1996 p.346). This was particularly marked for psychodynamic therapists.

In a previous study conducted by Paulson et al. (2001) negative counsellor behaviours raised certain concerns, including the counsellor 'not listening', 'having too many other things on their mind', 'trying to tell me what to do', and 'feeling the counsellor wanted to get me out of the office as soon as possible'. None of such negativity is reflected in the interview data in this present study. It is worth noting that Paulson et al's study included trainee counsellors, whereas the primary care service where my study was based employed only qualified practitioners.

The personal qualities of the counsellor

Clients in this study commented on the personal characteristics of their counsellor with phrases such as 'she was kind'. According to Maluccio (1979), the attitude and personal characteristics of the therapist is crucial to the development of the therapeutic relationship. However, the impact of unchangeable qualities of the counsellor, such as gender or age, on the establishment of the relationship also emerged from the client accounts. The greater the client-counsellor congruence in terms of age, gender, and social status, the greater the client satisfaction, and this is supported by Paulson et al. (2001) in their study of unhelpful factors in counselling. Included in their cluster 'barriers to feeling understood' were themes of 'someone who doesn't have a shared cultural experience', and the counsellor 'not being close to my age'. Ffion did not connect with her former counsellor who was middle-aged and middle class. Sian could not bear to work with a man. These barriers to an effective working alliance may not be permanent. Client preferences may change with time, such that issues that may make a relationship unworkable may change. Particularly in healing work, described, for example, as that which is offered within the reparative relationship (Clarkson 1995), perhaps

following abuse, after initial work with a female counsellor, it may be beneficial for such a client to work with a male counsellor.

Issues arising from relationship factors

(1) In examining clients' evaluation of successful counselling, there was support for previous research (e.g. Asay & Lambert 1999) that relationship and generic factors matter most to clients, more importantly than specific interventions. In other words, it is *being with* the client, and the counsellor's *way of being* with the client that matters, more than what the counsellor does. (Woolfe 2002).

(2) Whilst qualities of being 'present' are paramount, age, gender or some other feature of the counsellor may make it impossible to establish an effective working alliance at the present time, in which case it is in the client's interest to be referred to a counsellor more suited to that client.

(3) Where a client comes with a long history of therapeutic input, this does not mean they will be unable to make use of counselling. In the previous encounters they may have not found the 'right' person with whom to connect and form a successful therapeutic alliance.

(4) Counsellors should not underestimate the importance in the client's life of the opportunity to talk about themselves, that is to say, it may not be of utmost importance to the client to focus on activity, solutions or change.

(5) If a counsellor is perceived by the client as lacking experience this can have an unhelpful effect on the counselling.

6.1.2 Therapeutic interventions

In the main, clients found it difficult to articulate precisely what the counsellor had done in the sessions. In their accounts, clients spoke of a wide range of interventions as playing a part in the success of their counselling. Specific

interventions, for example cognitive techniques were highly evaluated by some clients, but dismissed by others. For some, 'time for me' and 'time to talk' were highly valued, whilst for others, reflective counselling was deemed insufficient. For many clients, the therapist's adherence to specific interventions was experienced as unhelpful, pointing to the importance of flexibility, that is to say, meeting the needs of the client's agenda rather than the counsellor's.

Seeing things from a different perspective

The majority of clients spoke of gaining a different perspective. Such insight into self and/or situation was so universal in the client accounts as to define for clients the outcome of successful counselling. This theme of different perspective is about becoming able to see with improved vision, a vision that has more clarity, and is from a wider vantage point. Without this, the counselling fails. For Gareth, Kath and Heather, nothing really changed.

Thinking and doing things differently

Nineteen of the 23 drew upon such difference or change in thinking and doing things, such that counselling is defined in this way. Indeed, without some form of 'difference' before and after, there would be nothing gained from the counselling. In thinking about things differently, there were some direct references by Will and Debbie to cognitive therapy techniques. When speaking of doing things differently, clients referred to behavioural change, demonstrating that the counselling has been integrated into the client's lifestyle. This illustrates a behavioural approach to the work (see, for example, Scott and Dryden 1996), that prejudices a change in behaviour over internal change, or this could be behavioural change as the evidence of intra-psychic movement.

From the client perspective, participants' accounts reveal some quite direct advice offered by counsellors. This was also found in Paulson et al.'s (2001) study, where clients liked direct advice, and insufficient counsellor

directiveness was expressed as 'the counsellor not telling me what to do'. McLeod (1990) noted the client perception that advice-giving is helpful, whereas often counsellors portray themselves as reluctant or unwilling to give advice. It is possible that what the client perceives as advice my be deemed by counsellors as problem-solving or offering structure. It is also important to note that this study considered only client accounts, in contrast to, say, conversation analysis of actual counselling sessions, for example, Silverman's (1997) analysis of sessions at an HIV clinic, which revealed the interactional process of HIV counselling.

Exploring options for the future

Clients valued the direct support in exploring options, a feature that was only mentioned in relation to counselling, and not to other forms of support. Exploring options is at the heart of a counselling model such as Egan (2002) which involves an exploration of desired options, followed by working toward removing any blocks to putting the preferred options into place.

Expressing emotion

In experiential approaches to therapy, acknowledging, accessing and expressing emotion is central to the work. Whilst expressing emotion appears here as a helpful factor, it is absent from many of the accounts in this study, with only a minority of clients who mentioned counselling as a place where they expressed emotion. This is possibly a consequence of the focussed nature of short-term therapeutic work in the primary care setting, with its pragmatic focus on change as opposed to catharsis. With an earlier sample of clients who had received a cognitively oriented therapy, researchers failed to find 'catharsis or emotional release' cited as a helpful factor, (Murphy et al. 1984), which points to the diversity in the understanding and practice of therapy, so inevitably there will differences in such findings. Since this present study is of short-term counselling, it is perhaps understandable if less attention is paid to emotional release and more to practical change. Or

perhaps this highlights individual differences, in that not all who come to counselling need to ventilate emotions.

Processing trauma

A couple of interviewees spoke of counselling as a place for working through the psychological aftermath of a traumatising event. Gareth had been a victim of assault, and Angie referred to her father who had undergone radical surgery as part of his cancer treatment. In neither case did this refer to immediate debrief or diffusion, but as helping later to process and resolve the psychological impact of the traumatising event. Neither of the primary care counselling services from which I drew my interviewees were set up to offer emergency or crisis intervention.

'Normalising' the client's experience

Normalising as an essential therapeutic factor points to the comfort and relief gained from knowing that symptoms and feelings are 'normal' or 'I'm not the only one, there are other people like me'. Being 'not normal' brings a sense of alienation and fears of mental illness. The passing-on of information regarding the symptoms of depression was valued, for example, 'I thought I was just being weak but the counsellor said I had all the classic symptoms of depression'. Normalising is not an intervention clearly identified within the various therapeutic approaches, but is highly appreciated by clients. It serves to minimise the sense of isolation and lack of knowledge about matters. Normalising also came about through group activities such as Debbie's assertiveness group and John's internet support, although groups were not found useful by all who tried them.

Addressing deeper issues

Deeper issues refer to older problems, with their roots in childhood and earlier relationships. On addressing deeper issues, those most satisfied with their counselling felt they had gained significant insight into their intra-psychic process, and had re-structured their understanding of past relationships.

Some counselling was considered unsatisfactory because the counsellor failed to address what the client described as 'deeper', 'older' or 'underlying' issues, and stayed with 'surface-level' interventions. Exploring earlier relationships and experiences is an intervention most commonly associated with a psychodynamic approach whereas the 'surface-level' practical solutions offered by counsellors may illustrate a solution-focussed type of approach, as, for example, in this study Heather recalls her counsellor suggesting 'try starting a conversation with the other mothers'. This approach intentionally looks forward and seeks solutions, as does Egan's (2002) model, rather than looking back to the past and focussing on problems. Kath was also disappointed not to have explored childhood experiences, and both Heather's and Kath's views mirror clients in previous research. 'Not having enough in depth discussion' was cited by Paulson et al. (2001) as one of the unhelpful factors in a college counselling service, as was 'having more to say but the counsellor not asking' and 'not being pushed enough'.

Books and other written resources

There were only a couple of references to reading matter such as self-help literature. Angie found one book in particular extremely helpful, whereas Heather did not, so again, there was a mixed evaluation of such an intervention. Of interest, after the period of my data collection, the combined Oaktown and Ashville counselling service later introduced a bibliotherapy scheme, comprising a range of self-help material to the client 'on prescription' from the counsellor, GP, or other health professionals. (see Frude 2005).

Counselling and individual responsibility

Victoria made reference that regardless of the intervention it was the client who has to 'do the work'. Recognising individual differences, Ruth commented that whilst counselling was successful for her, for some people 'it might not be the right time'. In other words, that where a person is, psychologically, in the process of their problem or situation, can be an important factor in whether they can make effective use of counselling.

The language of therapeutic 'schoolism'

Other then Will and Debbie, there is little reference to technical counselling language. That is, the clients did not describe their experience using a psychological lexicon, but used lay terms to express themselves. All the counsellors in this study were experienced to at least the standard for accreditation by the BACP. It is interesting to note that a study of taped interviews revealed experienced practitioners of different schools offered psychotherapeutic relationships that were more similar than those created by experts and novices of the same school. (Fiedler 1950). Other than those who offered specific techniques such as cognitive re-structuring, which was experienced by both Will and Debbie, there may have been a similarity in the approach of the counsellors to the work.

Unhelpful interventions

The specific interventions mentioned by clients as unhelpful suggest that these interventions 'missed their mark' in some way, or otherwise did not have the effect intended by the counsellor. Silence may have been held in order to facilitate intra-psychic reflection, but Irene found silence awkward and unproductive. Kath's counsellor may have attempted to minimize her (Kath's) distress by using comparison with others, whereas this was experienced as the counsellor not appreciating the difficulty facing her, and she reported feeling worse, and 'even more inadequate'. From her research in a primary care setting offering psychodynamic counselling, Oldfield (1983) notes the need for 'flexibility' in approach on the part of counsellors.

Issues arising from therapeutic interventions

(1) Specific interventions were named and appreciated by those who had received cognitive therapy, as was 'time to talk' for others. However, for some clients, the therapist's adherence to specific interventions was experienced as unhelpful, which points to the importance of flexibility, meeting the client's agenda rather than the counsellor's. It is clear that not one form of counselling is going to suit all clients. There is a need to recognise individual

differences between clients, and that to offer a 'one-size-fits-all' therapy will inevitably fail to meet the needs of some clients.

(2) Even in short-term counselling, deeper issues can be successfully explored, and that it is dismissive to the client not to do so.

(3) Findings in this study highlight the importance of facilitating exploration of future options within the counselling.

(4) At referral it may not necessarily be the right time for a client to be ready and able to engage in psychological work. This may have implications for a counsellor at the time of assessing for suitability for short-term work.

6.1.3   Contextual factors

Issues emerged in the client accounts that related to the context of short term counselling in the GP surgery.

The spacing of sessions / endings

In the primary care setting where the number of counselling sessions is limited, clients emphasized the importance of their having choice in determining the number of sessions, and when and how to finish. This would be, for example, to space out the sessions or the opportunity to hold a 'follow-up' session. In previous research Hunt (1985) noted that clients were angry when they felt the ending was not of their choosing, or not the right time for them, whilst Paulson et al. (2001) identified unhelpful factors that included 'not having regular sessions' and 'having long spaces between sessions'.

From the client accounts in this present study, when a counsellor appeared to be managing too many referrals, or to have too many open cases, the counsellor was perceived by the client as too busy to be able to fit the client in, and sessions were spaced further apart than the client felt was optimal.

The client did not feel 'held', and this had an adverse effect on the counselling. Those with symptoms of depression and suffering low self-esteem, such as Tracey, did not feel as if they mattered to the counsellor. The unavailability of sessions acted as evidence of their lack of worth. Paulson et al. (2001) commented on this with clients in their study finding unhelpful 'an hour is not enough', 'not having enough sessions', and 'not being able to have sessions more often when I wanted'.

Location at the GP surgery

Rose (1995) wrote of the spatial technologies of therapy, which for these clients was the familiar location of their doctor's surgery. The majority of clients in this study expressed their preference for seeing the counsellor in a familiar and convenient location. This was by comparison with either a unfamiliar setting, or a secondary mental health care setting, whether this was in a community based clinic or hospital, both of which would require an emotional strength to both find and access. For those clients who expressed an opinion, such mental health settings held a shameful stigma, and for some, a previous poor experience. For some it was also important that the venue was not overly exposing, such that anyone would be aware that the client was 'coming for counselling', an issue that Keithley (1995) also found in her study in primary care.

Waiting time to see the counsellor

Clients expressed different opinions with regard to the time spent waiting for a first appointment. Clients who were informed of the likely waiting time expressed themselves as more content (and contained) than those who were not, which suggests that the uncertainty in the length of waiting time increases anxiety and dissatisfaction. Individual client factors emerged and it appeared that the more distressed the person felt at the time of the referral, the less able they felt to wait.

Inevitably, some interviewees expressed the view that any waiting list was unacceptable. In a recent survey, two-thirds of those questioned thought counselling or psychological services should be provided within two weeks of referral, and 86 per cent said they would worry that their condition would worsen if they had to wait a long time. (Norwich Union Healthcare 2004a). Sian commented that counselling is needed 'at the point when it's happening rather than later'. However, this is not merely concerning waiting lists, but about the lack of availability of services. In Sian's account, she had waited many years before accessing the newly established primary care counselling service.

Paying for counselling

Within the psychodynamic perspective, paying for sessions is taken as an indication of the client's motivation and degree of valuing the therapy. However, contrary to Buckley's (1999) findings in his evaluation of counselling in primary care, (see chapter two), there was no indication within these accounts that because the clients did not pay for the service, that they did not value the counselling, or were any less committed to it. The overwhelming majority expressed gratitude that the service was available. Only Ffion made a comment to the effect that 'I only went because it was free, I wouldn't have bothered otherwise', and she had been disappointed by her previous counselling. Of my interviewees, the general view was expressed that had counselling not been available at the surgery, they would not have accessed an alternative, either because the cost was prohibitive, or through lack of knowledge of suitable low-cost services available.

Issues arising from contextual factors

(1) Even with short-term counselling, involving clients in negotiating the ending process can have a beneficial impact on the satisfaction with the counselling process.

(2) Case loads need to be managed to ensure the availability of appointments for current clients.

(3) If a waiting list is inevitable, it is better to inform client of approximate waiting time, and to keep them informed.

(4) The location or venue for the counselling can impact on the acceptability to the client, and on the likelihood of their attendance.

6.1.4   Contrasting stories: other therapeutic episodes

Some counselling received in other therapeutic settings had been helpful only in part, for example Ffion, for whom there had been a poor fit between herself and her counsellor. Debbie had considered her previous therapy to have been beneficial at the time, but had since re-evaluated its effectiveness by contrast with her recent GP counselling. Victoria had attended for relationship counselling as a couple, and had felt that her issues had not been addressed.

Others, who had been referred in the past through the secondary mental health system, reported that this was unsatisfactory and had not met their needs. Many years ago Kath had been under the care of a psychiatrist, but found his challenging style unhelpful and dismissive of her problems, and she did not feel understood by him. Sian described being assessed by a psychiatrist and then being referred on to other professionals and to other services, and found this lack of continuity unhelpful. More recently Nikki had a similar experience, and felt let down by disclosing her story and feeling left 'high and dry'. She was told that there was no service that would be offered to her.

Nikki's story, and also Sian's and Kath's, illustrate how it can be detrimental to the well-being of clients to go through the assessment process in a community psychiatric setting, and whose needs for a therapeutic

intervention are not met. Goldberg & Bridges (1988) comment how clients who are unable to meet their needs often make inappropriate use of health care services and repeatedly attend for GP appointments, which was Kath's pattern. Both Sian and Nikki felt helped by counselling, and it is questionable whether the referral to secondary mental health was suitable. Anecdotally, such inappropriate referrals are made when there are insufficient counselling resources available, and McBride (2002) records the fall in referral to secondary services once the primary care counselling service was in operation. Whilst Nikki and Sian both later received help in the primary care counselling service, it is not known how many do not accept referral due to poor prior experience elsewhere.

In other counselling settings, Debbie's current counsellor was a Christian counsellor contracted to work with Debbie's bereavement issues. Debbie was dissatisfied with this counsellor's repeated cancellation of sessions and her lack of reliability.

Issues arising from contrasting stories

(1) Inappropriate referral to secondary services can result in a damaging effect for clients, and may result in their not accepting referral, or of not attending a subsequent counselling appointment.

(2) As an assessment issue, it is important to ensure the appropriateness of the context and form of therapeutic intervention for the individual's needs at that time.

6.2 EXPECTATIONS AND CHANGES

In the second half of chapter four I examined interviewees' expectations and hopes with regard to counselling, and whether and how these hopes were met.

6.2.1 Preconceptions of counselling

Those participants who had not had counselling before appeared to have developed preconceptions based upon TV and other media representations. A small number knew of others who had been to a counsellor. Some presented an image of counselling as 'the norm', thus giving credence to Furedi's (2004) claims of the pervasive nature of the 'therapy-culture' of society. There were a couple of references to counselling as a 'necessity', which is an example of the beliefs that are criticised by Furedi (2004) and Persaud (e.g. 1997), which place the individual as unable to deal with the 'ordinary' problems of life, and needing to rely on 'professional' help and support.

Prior et al. (2003)'s findings questioned whether GPs were considered a legitimate source of help by people experiencing emotional difficulties. It was suggested that there is a difference between what symptoms the lay public may think of as appropriate for help in a medical context, and the health professionals' views of what constitutes mild to moderate mental health problems. My sample was drawn from those who sought help at the doctors. In this study some patients, but not all, took psychological symptoms to their GP. Of my interviewees, there was no indication that the GP was thought of as an inappropriate source of help, although only a few were specifically seeking counselling. Of these, Yvonne worked in a doctor's surgery, and knew it was acceptable to take emotional problems to the doctor, and Debbie, Gareth and Leonard specifically requested a referral to a counsellor.

6.2.2 Hopes of this counselling

Clients expressed a variety of hopes. Generally the expectations were vague, but that counselling 'would help' in some way. Some were looking for advice or direction with a problem. Many interviewees claimed not really to have any fixed expectations of the counselling, much as was found by Bannen & Collard (1982). However, as Frank et al. (1959) reported, anticipation of success, or a belief that the counselling will be helpful, is a key predictor of positive

outcomes in psychotherapy. My interviewees did have some sense that it might help, or at the least, they were willing to 'give it a go'.

A factor that emerged from the client accounts was the importance of clear contracting at the beginning of the counselling. The majority of clients in my study offered statements of not truly knowing what counselling was, other than to have some vague notion that it would be helpful to them. They were mostly satisfied with the counselling they received, and described outcomes in terms of improvement in symptoms and feeling better able to deal with life's problems. However, a minority held a view of themselves as needing a deeper intra-psychic re-organisation. They sought explanation and working through of earlier life-problems, and expressed disappointment with the counselling. From their accounts, it would seem that they had not had a discussion with their counsellor about the nature of the counselling, either to express what they wanted, or for the counsellor to discuss if there were any unrealistic expectations.

Leonard found counselling a struggle initially. As noted by Elliott & Williams (2003), there can be an initial clash in perspectives between client and counsellor. The client may expect 'problem-solving', and the counsellor offers perhaps 'personal development'. Dissatisfied clients include those hoping for expert diagnosis, advice, and recommendations. For many, hopes were not clearly defined prior to the counselling, the most typical response being similar to 'I didn't really know what to expect. I really had no idea, no experience to go on', which is a quotation from Brannen and Collard's (1982) study of marriage guidance clients. It is interesting to note that this study was carried out over 20 years ago, and the comment is still offered today, despite counselling having a higher media profile, and being available to a greater proportion of the population than previously. This highlights the importance of transparency in a clear explanation of what counselling is, and what it entails, set out at the beginning of the counselling encounter. This also supports the necessity of Clarkson's (1995) 'working alliance' as an effective joint

agreement to work together, and J.D. Frank's (1973) 'culturally congruent narrative', which is a shared understanding of the problem and its course of treatment.

6.2.3   Changes through counselling

The counselling was presented as having one of three outcomes. Firstly, a significant improvement and the problem was resolved or no longer an issue. Secondly, some degree of improvement, but the problem was not fully resolved, or where the client felt more able to deal with the problem. This included a recognition or acceptance of the problem as 'enduring', a life problem such as a death or an unwelcome divorce that does not have a resolution. In this second outcome, the client came to view such a life problem in a different light. Thirdly, where the counselling was not satisfactory, did not meet expectations, or was not what the client wanted.

Many participants, Angie, Sian, and Will, amongst many, were pleasantly surprised at what they were offered, in terms of the process and progress of the counselling, and its outcomes of change and improvement in their lives. The majority of participants presented the counselling as greatly appreciated. As seen in previous research, both large-scale randomised controlled trials (e.g. Boot et al. 1994 and Hemmings 1997), and on a smaller scale, (e.g. Bourne 1999 and Buckley 1999), the majority of clients in this study expressed satisfaction with the counselling received and a lessening in severity of symptoms experienced.

Many interviewees gave examples of how they continue to utilize lessons learnt in the counselling, or, for example, would ask themselves 'now what would my counsellor say?' Those who referred to change as an on-going process in this way are offering illustration of Rose's (1999) concept of 'self technique', by which techniques learnt in the counselling are continued by the client after the contact with the counsellor is over.

The language of counselling

In the first chapter of this thesis I presented an overview of the predominant theoretical approaches to counselling. Rose (1999) described the languages of the various therapeutic approaches as a 'lexicon of therapeutic change'. Given that the primary care counsellors had trained in a variety of approaches I was keen to note any evidence of theoretical difference that may emerge in the client accounts. In their presentation, would clients use a linguistic code indicative of a particular school of therapy? If so, this would support the work of Farrell (1979), who described the clients' linguistic accommodation to the counsellor's theoretical lexicon, and noted that 'successful' clients are those who learn the 'Way of Talking' of their therapist's tradition.

The client accounts of counselling illustrate a broad appreciation of diversity within counselling, formed as it is within the unique synthesis of client, counsellor and counselling approach. There was less indication that clients were aware of there being different theoretical approaches to the work. With the exception of four interviewees, counselling was presented as an undifferentiated, generic activity. The cognitive approach specifically teaches clients new terminology. Debbie talked of letting things fester in her head. 'Thinking I'm a terrible person. Faulty thinking, isn't it?' The term 'faulty thinking' is a concept she has drawn from cognitive therapy, and indicates the degree to which Debbie has adopted a way of conceptualising her difficulties according to the theoretical propositions of her counsellor's approach. (Farrell 1979). However, other than Debbie and Will, who used the language of cognitive therapy to describe their characteristic negative thinking, and the connective cycle of thoughts, feelings and actions, there was little to support Farrells' argument. It must be remembered that the clients had received short-term counselling. Perhaps it may take longer for this phenomenon to emerge, or perhaps it is seen in some psychotherapeutic traditions more than others. That said, Victoria's description of the counselling process as an 'enabling' process may illustrate her reading of counselling texts prior to

beginning the counselling training course upon which she had enrolled. Angie's account also contained ideas that may have come from a counselling textbook, for example she described her counsellor as 'leaning forward in a relaxed position'.

6.2.4 Primary care counselling as disappointing

The counselling in primary care was successful for some and not for others. The majority of client accounts contain a set of symptoms prior to the counselling that are resolved, lessened or transformed, as a result of the counselling. The majority were satisfied with the counselling they received. However, not all hopes were met. Others remained disappointed that the counselling had not addressed what they considered the 'real' problem, for example, Kath, Heather and Pamela. As Seale (1999) has pointed out, deviant accounts often offer an insight into various processes being played out. The accounts of four clients, Olive, Pamela, Heather and Kath, are deviant from the majority, in that none claim to have experienced the primary care counselling as beneficial. I will examine the four accounts in some detail, to identify possible factors that militate against successful counselling for these clients.

Olive

Olive had had a brain tumour many years ago and was on medication for epilepsy. She described the timing of the primary care counselling as being wrong for her, as during the first year following her bereavement, she was 'out of it'. She claimed to have little recall of events of this time, and no memory of seeing the counsellor at the surgery. She had recently begun seeing a Cruse counsellor, and described this as being very useful. In her account, this new counsellor has normalised her feelings, and she claimed he was able to 'get it all out of her', that is, her feelings. Perhaps without the cognitive deficit that she suffered at that time, Olive may have been able to make use of the GP counselling, and may have experienced a similar sense of

effectiveness. However, such was the effect of the bereavement, her cognitive impairment and/or the medication, this was not so.

Based on Olive's inability to recollect, there are questions that may be asked regarding the appropriateness of her referral for counselling, and for the counsellor's decision to offer counselling sessions. It would appear that there was a lack of psychological contact between counsellor and client, the first of Rogers' necessary conditions (Rogers 1957).

Pamela

Pamela is unique in the study as she did not describe her problems as stemming from an emotional source, but as biochemical in origin. At the time of interview, she had prescriptions for three different psychotropic medications to correct the 'chemical imbalance in her brain', and help her get what her clinical psychologist called 'the right kind of sleep'. She described the counselling at the doctor's as 'just talking about things', which was pleasant, but did not solve her problems. From Pamela's perspective, talking was not considered useful because it did not address the physiology of her problem. Her attendance at the ME clinic (for myalgic encephalomyelitis) has given her a language with which to account for her problems. As Banks & Prior (2001) noted, doctors and patients account for chronic fatigue syndrome (CFS) symptoms using different terminology. To the patients the problem is physical, whereas the doctors speak of 'chemicals in the brain' as a means of obtaining client compliance with treatment, which in the setting of an ME clinic, consists of a form of cognitive behavioural therapy.

Davis (1986) and Howe (1993) point out that it is the counsellor who defines the nature of the problem and the focus of the work. From Pamela's account, it would appear that there was a lack of agreement, or working alliance (e.g. Clarkson 1995) between counsellor and client. There was no joint understanding of the nature of the problem and therefore no agreement to work.

Heather and Kath

The accounts presented by Heather and Kath are similar in that both speak of wanting 'something deeper', and I shall discuss them together. Kath had been under the care of a psychiatrist many years ago. Heather had not had any previous connection with mental health services. As they reported, neither found the possibly solution-focussed style of counselling they received at the GP surgery beneficial, describing it as 'good as far as it went'. They both presented as wanting something, as they understood it, more akin to psychotherapy. Heather wanted an interpretation as to the cause of her unhappiness, hoping to hear 'you're like you are because this happened in your childhood', whilst Kath claimed of her counsellor, 'she didn't get deep enough', and indicated that she wanted her counsellor to delve further into her childhood experience. She offered the example, 'my father made me feel I wasn't good enough'.

Paulson et al. (2001) commented on clients not articulating their needs, and cautioned that this is a component of counselling that needs to be responded to. If overlooked, it will impact negatively on the therapy. In this present study, Heather dropped out of the counselling after only a couple of sessions, and made no further contact with the counsellor. By contrast, Kath had stayed for ten sessions, and I inquired whether she had said anything to the counsellor about her expectations. She had not, believing that the counsellor should have known what to do and what she (Kath) needed. She concluded 'I think she (the counsellor) was inexperienced'.

Both Heather and Kath had the same counsellor, identified as counsellor 5 in this study, who had also counselled Gareth, John, Leonard and Zena. It is possible that Heather's and Kath's disappointment is a factor relating to the counsellor, or it may be purely coincidental. Both John and Leonard found the counselling beneficial, although Leonard initially formed the impression that his counsellor lacked experience. Zena valued 'having time for me' but felt she

already knew the practical advice she was given. Gareth found the talking helpful but admitted 'nothing really changed'.

Oldfield (1983) stressed the need for clear contracting such that clients are not left feeling confused regarding the counsellor's way of working. Of their study, Paulson et al. (2001) further commented that failure to provide an orientation to the therapeutic process, that is, explaining the client's role in the counselling, resulted in clients retaining unrealistic expectations of the endeavour. For Kath and Heather, where counselling was thought to have 'failed', there is an aspect in their accounts of both waiting to be 'given the answers', or of the counsellor 'doing the work'. This suggests a lack of clear explanation of how counselling is conducted, that is, that the client needs to be active in the process. By way of contrast to illustrate this, Leonard actively challenged this counsellor, and, following his challenge, reported his experience of counselling as having improved.

In summary, Olive had previously had a brain operation, and had no memory of seeing the counsellor, possibly due to a cognitive deficit. For the others, Heather, Kath and Pamela, there was a mismatch in how they understood what their problem was, what they wanted from counselling, and what the counsellor was offering. The joint construction of the therapeutic process has resonance for the therapeutic alliance, according to Howe (1993). The client needs to agree to the construct 'the problem is psychological and stems from your relationship with your parents' or 'your difficulties are a result of the way you habitually think about problems and you can practise other ways of thinking that will make you feel better'. But if the client is persisting with, for example, 'my problem is physical', or 'I need a deep psychotherapy that will address my childhood experiences', then there is no agreement and no contract to work. The therapy will either fail or will not even start, illustrating Clarkson's (1995) basic requirement for a therapeutic working alliance to be established, and J.D. Frank's (1973) 'culturally congruent narrative' whereby both agree a story to explain the problem and the treatment. Gergen and

Kaye (1992) first described the 'co-construction' of therapy, of how therapy proceeds according to the therapist's construct of therapy. The therapist and client have to agree, and without a mutually agreed understanding of the problem, the therapy and the healing, will not happen. For Pamela, Heather and Kath there was a lack of this basic agreement or working alliance. In Olive's case, this also illustrates Rogers' first 'necessary' condition, (1957), that the client and counsellor need to be in 'psychological contact'. Olive was unable to make psychological contact, possibly due to a cognitive injury.

Issues arising from expectations and changes

(1) Clients may bring expectations to the counselling that may be inaccurate, or they may have no clear expectations. This highlights the need for clear contracting, in that the counsellor needs to be transparent regarding what the client may realistically expect from the counselling in the given setting. This will need to take account of whether the counselling is short-term or open-ended, as well as the skills and preferences of the counsellor.

(2) The counsellor needs to ensure that a working alliance, that is, a basic agreement to work together, is in place. It may be that without an open discussion and clear contracting, it may be more difficult to establish a working alliance.

(3) Olive's case in particular lends support to the observations made earlier in this discussion, that at the time of referral to counselling, it may simply not be the 'right time' for the client to be able to engage in therapeutic work. Assessment needs to take account of the appropriateness of offering counselling *at this time*.

6.3 THE PRESENTATION OF SELF

In chapter five I looked at how clients present the origins of their problems, examining factors drawn upon by clients as causative of their emotional

distress. I also examined aspects of moral claims that emerged from client accounts, that of being a good person, and being a good patient.

6.3.1   Origin of problems

People spoke of life-events as causing their current distress. The range of life events drawn upon by participants fall into the categories put forward by Rose (1999) as strategic dimensions of the psychotherapeutic. The four dimensions relate to work, relationships, everyday problems, and existential concerns. The most frequently drawn upon origin factors were divorce and its aftermath, as well as family issues, childhood experiences and workplace relationships. This highlights the prevalence of relationships as the perceived cause of life problems, and supports Rose's (1999) 'neuroticism of social intercourse', discussed in chapter two, and can be seen in the references to on-going poor quality relationships cited within the accounts. When bereavement is also taken into account, the majority of the origin factors cited can be defined as loss, that is, loss of relationship through bereavement or divorce, loss of anticipated healthy relationship where there has been abuse or betrayal, and loss of the wished-for care-taking in the workplace, where managers 'ought' to have one's best interests at heart. Christine and Marjorie were both physically unable to have children, and Tracey had undergone a hysterectomy. The inability to have children, or for Tracey, to have more children, was not given as a reason for accessing counselling, but presented as part of their self-identity and was experienced as a major loss. Their accounts contained the distress this caused, and the incompleteness of themselves as women.

This focus on loss in the accounts of participants clearly illustrates Bowlby (1988)'s position on attachment and loss, with the importance it places on secure relationships. It also supports earlier findings regarding explanations of causal or vulnerability factors for depression, for example the early death of one's mother. (e.g. Brown & Harris 1978). Clearly many of the participants would have lost parents, yet only three offered the death of their mother as

an originating factor in their problems, two of these, Heather and Tracey, when they themselves were teenagers. The third, Zena, who was an adult when her mother died, explained in her account that she was an only child, and had no siblings to share her loss.

This concentration on early relationships can be mapped onto the theoretical psychotherapy positions discussed in chapter one. The psychodynamic approach to understanding and explaining human behaviour seeks to place early relationships as the precursor of later dysfunction. (see, for example, Burton & Davey 1996). The humanistic position speaks of a lack of facilitative conditions, with conditions of self-worth being absent or insufficient. (see, for example, McLeod 1996). Typically a mother fulfils these functions, and loss of the mother, or main care-giver, or alternatively, a mother or main care-giver who is otherwise 'absent', for example, with mental health problems herself, supports Bowlby's work (1988) on the importance of nurturing parenting.

A number of interviewees called upon childhood experiences and childhood family relationships. In terms of storied lives, many clients told narratives of having problems with living as an adult because they were mistreated as a child. This illustrates the way in which basic Freudian principles (e.g. Freud 1940) are used widely in society, and developmental theories that propose the causal effects of childhood experiences on adult life. The effect of such 'origin in childhood' narratives serves to absolve blame or self-responsibility. As such, they could be said to mirror moral claims, (Baruch 1982), as one's lack of ability to cope is presented as not being one's fault.

These accounts display elements of a vocabulary of causation that locates the sources of distress in the disruption of social relationships, rather than, for example, malevolence, fate or inherited constitutions. To that extent they throw an interesting light on a form of lay psychological epidemiology, that is, the terms that clients use to describe causal factors.

Pamela was an exception in this study, in that she described herself not as having a psychological difficulty, but as having fibro-myalgia. She accounted for her physical predicament as a consequence of 'having worn her body out' bringing up her daughter single-handedly, working all her adult life, and now, caring for her ageing father. Other than Pamela, no-one cited over-work or stress as the origin of their difficulties. Stress was presented as the consequence of a life-problem, with the client being unable to 'deal with' stress, or 'cope with' as much stress as previously, but this was not drawn upon the cause or origin of difficulties.

As discussed in chapter two, Rose (1999) spoke of the therapeutics of finitude, whereby the inevitability of loss is constructed as a key factor in psychological distress. Loss has also been recognised as a predictive factor for anxiety and depression. (e.g. Brown & Harris 1978). Bowlby (1988) wrote of attachment and loss, with secure and successful attachment as the cornerstone of psychological well-being and social adjustment. From the themes that emerged in this study, the origin of interviewees' difficulties was presented as loss, in various forms. Firstly in difficult or strained relationships with family members or at work. These troubled relationships can be seen as loss of the 'good' relationship to which one is morally entitled. For those who had left abusive relationships, they spoke of the loss of the relationship as it once was, or that was hoped for. Secondly, in loss of another, through bereavement, or of a relationship, through separation or divorce. Thirdly, in loss of health, in oneself or others in the client's close family. In this way, loss features throughout the client narratives of the origin of their problems.

6.3.2   Being a good person

In chapter five I looked at the kinds of qualities and statements my interviewees put into their accounts to render themselves as morally upright, and good persons. According to Bruner, (2003), the self is a perpetually rewritten story, and all are constantly engaged in 'self-making narrative'. There is a moral imperative to present ourselves, and thereby construct an

identity, as people of integrity. (A.W. Frank 1995). Accounts are treated as situational rather than factual, and are aimed at displaying the status of a morally adequate person. (Baruch 1982). In this way, accounts gathered for this study illustrate the shame felt by many at needing counselling. Interviewees used various linguistic devices to present themselves as morally upright individuals. They presented themselves as good mothers and strong people. Where they have fallen victim to emotional and psychological distress, they presented this in terms of illness. In this way they cannot be held accountable for being morally weak, or lacking the strength of character to maintain emotional health.

There were claims of being a good mother, caring for children, putting the needs of the children above everything else despite feeling desperate. This theme highlights the nature of 'gendered' talk. (see, for example, Tannen 1989, and Wodak 1997). Wodak noted that 'discourse is socially constituted as well as socially conditioned'. (Wodak 1997 p.6). Further to this, Lazar (2002) claimed that achievement of feminine self-identity comes about through 'other-centredness'. Through an analysis of various media she described the systematic cultivation of an acute consciousness and devotedness to men and to children. In this way, by speaking of being a good mother, women show themselves to be good persons. In my study it is difficult to make a direct comparison between the claims of males and females, since none of the men had young children. Gareth and Will were both childless, whilst the children of John and Leonard were now young adults. However, although both had children still living at home, neither drew upon 'being a good father' to support their claim of strength and integrity. It is interesting to note that the one client who had actually made attempts to end her life, Christine, was childless, and did not have the 'protective factor' of motherhood. Suicide was often presented as a measure of distress, 'I was so bad, I was suicidal'. In consequence, those who claim they could never take such a permanent action, may be judged by professionals as not in extreme distress, and may not be offered support.

When respondents talk of stigma, they often called on others to validate the sense of stigma or shame. In these accounts it appears that named people were used to present examples relating to counselling, whereas 'people in general' were used to present a stereotyped, prejudicial view, which can be proposed as either negative or positive. Interviewees used others to hide behind, or to avoid owning the comments they made, for example, 'people think if you go to counselling then you must be nuts'. By drawing on other people to express views, they were able to distance themselves from the views expressed.

Many interviewees also viewed engaging with any form of psychological therapy as stigmatising or shameful prior to their receiving counselling, but felt differently afterwards, having been a counselling client. It is possible this indicates that whilst going for counselling is not seen as shaming, perhaps 'needing' to go for counselling is. This also illustrates a change in evaluation, having experienced counselling for themselves.

It is said that people need to present themselves as persons of high moral integrity, and from this study, that includes being seen as a 'strong person'. It is possible that those suffering emotional distress may minimize their symptoms and their difficulties, and present themselves as being able to cope. By insisting they were not suicidal, for example, or that they were able to care for their children, clients expose themselves to the risk of the true level of their distress not being heard, and of not being offered such services that are available. There was a high level of stigma or shame present in the accounts that related to mental ill health in general, and often, prior to counselling, a lack of discrimination by the lay public between counselling and psychiatric service provision. All of my respondents had overcome any such sense of shame, as they had seen the GP counsellor. However, this sense of shame may have led to others failing to be recognised by GPs, or failing to accept counselling services offered.

6.3.3. Being a good patient

In analysing the narratives of people with illness, A.W. Frank (1995) identified three stories, or 'illness narratives'. The first, the restitution plot, has the theme of 'yesterday I was healthy, today I am sick, but tomorrow I will be well again, with the storyteller as the active player. In contemporary culture, health is portrayed as the normal state. Compliance with a doctor's treatment, in whatever form that takes, is at the centre of the plot. Second is the chaos narrative, within which life never gets better, as, for example, when caring for a relative with Alzheimer's disease. The narratives of those with chronic fatigue syndrome illustrate the chaos narrative. There is an incessant present, with no memorable plot and no future worth anticipating. There is no active player, but a story of loss, with no-one in control. Chaos is at the centre of the narrative. 'Life will always be like this. Isn't it awful?' Thirdly is the quest narrative, presented from the ill person's perspective. These people have accepted their illness and seek to use it for a greater good, for example, for patient advocacy causes, perhaps by publishing their own story in the hope that it may benefit others. (A.W. Frank 1995).

I considered the shape of the narratives of my respondents and how they fit with A.W. Frank's observations. The restitution narrative can be seen in many of my interviewees' stories, for example, in their compliance with medication, despite expressing reservations, because the doctor recommended this course of treatment. It follows that those clients whose narrative positions reflected a restitution position, would find benefit in the counselling. Examples in this study are Angie, Debbie, Sian and Will. The chaos narrative is evident, for example, both Bridie and Christine expressed a sentiment that they will never get better. The third narrative, the quest narrative, is seen where individuals make use of their own misfortune, to help others. They may campaign for better access to services, and for an increase in services to be made available, promoting the value of counselling to others, and to the extent of training to become a counsellor in order to pass the benefits to others. Both Debbie and Victoria had decided to train to become counsellors.

It can be argued that those who hold the restitution and quest positions will report subjective improvement, whilst those who hold the chaos narrative position will continue to remain stuck in their woes. Where a chaos narrative position is entrenched, counselling is unlikely to be evaluated as an effective form of treatment. Whether this is a solution-focussed, behavioural intervention, or a cathartic, insightful approach, it is unlikely to make much impact on the client's symptoms. Whilst the client may express appreciation at having 'someone to talk to', the counselling does not lead to change, since the client lacks an appreciation of self-agency. Resolution is seen as 'out there' and not 'within'. Those with chaos narratives, with no positive outcome anticipated, are unlikely to feel they have benefited from counselling in the short term, since nothing can improve their situation. Examples in this study are Bridie, Christine and Kath, each of whom found the counselling disappointing in some way.

There is, however, the potential for a narrative therapy, to facilitate a client who is entrenched in a chaos narrative position that holds no hope of improvement to adopt a more empowering narrative. As discussed in chapter one, narrative therapy seeks to change the nature of the patient's negative, unhopeful or 'stuck' narrative, to one with a positive or hopeful outcome, where the client has a sense of agency and autonomy over their life-choices. (White & Epston 1989).

A.W. Frank's restitution narrative includes the following of doctors' advice. 'Being a good patient' involves compliance with the regime recommended by the GP, which in this case included both counselling and medication. The section in chapter five also included clients' constructions of psychotropic medication. There are quotations from everyone except Angie. For most interviewees, the topic of medication arose naturally. As the interviews proceeded, the subject became almost universal. At least twenty of the 23 interviewees had been (or continued to be) on anti-depressants. As the study

progressed, if the topic of medication did not arise within the narrative, I would ask directly. Angie, being the first interviewee, did not raise the issue, and I did not ask.

As seen in the audit data in chapter one, GPs in the pilot counselling services prescribed medication at a higher level than the national average. Since I collected my data, recently published NICE guidelines (2004) have recommended that GPs are more circumspect in their prescribing habits. My interviewees' comments indicated mixed judgements of medication, with many calling upon their GP to justify their (the client's) use of drugs. This supports findings from a study using focus group data, where it was seen that anti-depressant medication was frequently viewed with suspicion by the lay public. (Pill et al. 2001). In examining presentations of being a good patient, there was a pattern of respecting the GP, and of following the GP's treatment plan. Clients in this study identified themselves as people who have reservations about taking prescribed medication, but who are willing to do so upon the recommendation of their doctor. There is a history within the medical profession of 'wonder drugs' promoted as having little or no adverse side effects, which time has shown not to be the case, Valium being a notable example, and Seroxat is currently facing public scrutiny. Patients expose themselves to the current 'magic bullet' when GPs do not have access to the full facts of a psychotropic drug's potential harm. (see, for example, Healy 2002).

Issues arising from the presentation of self

(1) The majority of issues that clients bring to counselling involve loss, although this may not be expressed as such. It would be wise for the practitioner to be aware of loss either directly as a presenting issue, or in the background, and for this to inform the therapeutic plan appropriately.

(2) In fulfilling moral obligations to appear strong or able to cope, the client may minimise difficulties or attempt to disguise symptoms, with the

consequence of problems not being identified, and/or of services not being offered.

(3) Where a client is stuck in an entrenched narrative, such as A.W.Frank's (1995) chaos narrative position, and where the client does not seem to improve as the counselling progresses, it may be useful for the counsellor to work with the narrative itself, using ideas from narrative therapy (White & Epston 1989).

(4) The counsellor needs to note the potential impact of the setting. This client group has accessed counselling through their GP, and for many in my study, counselling would not have been considered were it not for the doctor's suggestion or recommendation. The counsellor needs to be aware of the dynamic of the three-way relationship, and the impact that this may have on the client's view of the counselling.

(5) GPs in these counselling services were prescribing at higher rates than national averages, and there were many references to the side effects of their medication, for example, feeling 'like a zombie', or 'being out of it'. Counsellors need to be aware of impact of the various pharmacological preparations on the client, both the client attitudes toward being on medication, and the possibility of interference with the psychological availability to do the therapeutic work.

(6) Attitudes towards, and evaluation of, the use of medication changes over time, and counsellors need to be alert to prevailing attitudes both within the medical profession and the media, and the influence that this may have on the client's beliefs and preferences.

6.4 THE LIFE-WORLD OF THE CLIENT

In chapter five I presented a view of the life-world of the client as apparent from the interview accounts. Life-world includes the symptoms of mild-to-moderate emotional difficulties, and how lives are peopled with friends, family and others. Here I will explore how the client's life-world, both historical and current, may impact on the counselling.

6.4.1   Symptoms

All clients in this study had been referred to primary care counselling by their GP. Referral guidelines were for those with mild to moderate mental health problems. The symptoms described by participants reflected symptoms associated with depression and anxiety, the most common neurotic disorders, as would be expected in this client group. They described a lack of hope for the future and being paralysed by fears, which are symptoms that are used as diagnostic factors for named psychological problems. (APA 2000). For example, those with symptoms of depression described lethargy and depressed mood. Clients described their life-world, their lived experience of low self-esteem, of struggling to appear to be coping, and of doubting their sanity. They described being low in mood and low in energy. A literal meaning of depression is to feel 'pressed down' by life's demands, and when 'pressed down' in this way, it can seem difficult, if not impossible, to find a means of escape. Anxiety was presented as a hyper-activity, almost an opposite pole from the depression, with being 'so full' people could not cope with any more to think or worry about.

Some claimed to have had little or no symptoms prior to a breakdown event. Eileen described her breakdown as uncontrollable sobbing, whereas other breakdown episodes were described according to their physical attributes, such as feeling sick, (Bridie), and seeing spots in front of her eyes (Tracey). Breakdown events were described as non-predicted, the culmination of being over-stretched by stressful circumstances, with a toll on both their mental and

physical well-being. Breakdowns were unanticipated, but on reflection, were presented as 'reaching breaking point'. Describing stress in this way illustrates the metaphor of 'mind as a machine' (Lakoff & Johnson 1980), with a finite capacity, which can only operate under a given amount of pressure. A further metaphor consisted of a 'real' or 'inner' self in distress that was not known by others, or in some cases was portrayed as weak or fragile and needing to be protected from others, often by the 'wearing of a mask'. This real self was located 'within' the person, or was 'under the surface'.

Clients reported symptoms that are recognised in the medical model, most commonly, depression and anxiety. This was, however, the means to accessing counselling, rather than a basis for determining a treatment plan. The majority of clients in this study spoke of their counselling as talking about their troubles and resolving difficulties, rather than treating and reducing symptoms. It has been noted that many people do not disclose emotional or psychological problems to their family GPs, with the suggestion that this is due to stigma associated with mental health (e.g. Byrne 2000, Hutchinson & Bhugra 2000). More recently Prior et al. (2003) have suggested that people do not disclose, believing the GP is not the most appropriate person to help, or are reluctant to pursue a medicalised treatment for what is construed as a life-problem. In a recent survey a majority of respondents (60 per cent) said they would turn to family or friends for support, compared with only 30 per cent who said they would look to their GP for help. More than four in five respondents thought people in general were too embarrassed to admit to having a problem. (Norwich Union Healthcare 2004a).

6.4.2 Living with symptoms

Individuals reported a sense of lack of connection with others, of others not knowing how they truly felt or of what life was like for them, and of maintaining a 'pretence' of coping whilst questioning their sanity. This highlights the inadequacy of formal diagnosis to capture the experience, and the potential gulf between doctor and patient. Diagnostic categorisation

systems, such as DSM, upon which NICE guidelines (2004) then recommend the use of psychological therapies, CBT or medication, are formed on the basis of uncertain criteria such as numbers of symptoms observed or reported as present. (Middleton et al 2005). Referring back to the discussion in chapter two, (Bohart et al. 1998, Marzillier 2004), from these client accounts of their experience of counselling, there was nothing to indicate that categories such as those offered by DSM are helpful for classifying clients or determining therapeutic treatment plans in this setting.

6.4.3   Family, friends and other sources of support

As Shaw & Middleton (2001) describe, traditional communities have broken up and personal relationships are becoming shorter and more transitory as people move away, for example, for work. A degree of personal capital is required to make new relationships. Without this, the supportive role of family and friends is gone and the GP may become the first port of call when an unhappy life event strikes. Writers such as Furedi (2004) lament this reliance on professional helpers. Furedi considered that increasingly, we are becoming a nation of 'therapy junkies', and that people turn to professional support in preference to self-reliance, or seeking the support of family and friends in times of need.

However, in this study, for many of my interviewees, husbands, wives or partners were presented as supportive, although not necessarily able to help to resolve the client's problems and distress. Some clients were concerned that disclosing their problems would be damaging in some way for the family member or other listener to hear. For others the family was the site of the problem, and therefore unavailable as a source of emotional support. Nor were friends able to support and facilitate change, in the way in which the counsellor was able. For various reasons, friends were too much 'on the side' of the interviewee, and therefore, not sufficiently impartial to be helpful, or they would minimise the problem, making it difficult for the client to broach

the topic again. For some interviewees, their problems were felt to be so shameful that disclosing to friends was unthinkable.

Whilst friends were often found to be unavailable or unhelpful, the exception in this study was John, who had suffered a life threatening event, and found hearing the stories of other 'survivors' of such events to be reassuring. This he found helped put things into perspective, in a way that the counsellor, whilst he considered her to be excellent in other respects, was unable to do. It is interesting to note that John's 'problem', a serious health incident, did not hold the same embarrassment, and he was able to make use of his support network. However, when he later developed depression, and difficulties in his marriage, this was not suitable for sharing with friends, but was material for the counsellor.

Of other sources of support, most were compared unfavourably with the GP counselling. A church group (Olive), spiritual resources (Ffion), and animal companions (Sian), suggest a means of finding support and connection lacking from other sources. Therapeutic groups received a mixed evaluation, Debbie found hers very helpful, whereas this was not so for Sian or Pam. Debbie found a valuable support that reduced her sense of isolation and normalised her situation, whereas Sian felt that she did not fit into the group. Similarly, Pam did not get what she was hoping for from her group experience.

In conclusion, there is a literature that emphasises the necessity of social and family support, and which highlights the negative impact on psychological well-being when such emotional capital is missing or insufficient. It is argued that social mobility increasingly distances people from their family of origin and also the sense of connectedness and support from social networks, which in turn leads to an increase in psychological problems. However, this study shows it is not geographic distance of family, relatives simply did not provide

sufficient to satisfy needs for emotional support. Similarly, even where friends were available, in most cases they were not considered helpful.

Issues arising from the life-world of the client

(1) The inability of diagnostic criteria to capture the essence of the client's lived experience suggests that a diagnosis may better be thought of as a description, rather than objective fact.

(2) Family and friends were not seen as an alternative to counselling. For many, family and friends were not available as an option, or where they were available, they were not able to provide a comparable source of support.

6.5 CHAPTER SUMMARY

To summarise the key issues arising in this chapter, what mattered most to clients in this study was the importance of a relationship with the 'right' person, who was outside their usual circle of family and friends, and who had 'time' for them. A wide variety of interventions were appreciated. Sometimes these interventions were apparently opposing, for example, for some the importance of 'just talking', whereas for others merely being listened to was insufficient and unsatisfactory, and they appreciated a more directed course of action. This points to the differences between individuals, such that no one approach or intervention will be right for everyone. Of contextual issues for these clients in short-term primary care counselling, it was beneficial to involve clients in a negotiation over the spacing of sessions and the ending of the counselling, and also to keep clients informed regarding time to be spent on a waiting list. Counsellors would also be well advised to manage their case-load, and their diary, such that there is space to offer appointments to current clients. The importance was noted of clear contracting, to include a discussion of expectations, which was essential to lay the foundations for an effective working alliance and shared understanding of the work. The location of the counselling in the medical setting arose, and for counsellors to be aware of the potential impact on the work of the effect of medication, the

medicalisation of distress through the use of diagnostic categories, and of the doctor–patient–counsellor triad. From the interview accounts it was apparent that friends and family were not considered as an alternative to professional counselling.

CHAPTER SEVEN

CONCLUDING CHAPTER

It really was just fantastic. Looking back on it now, it was just like somebody had taken away all the dark clouds and the light shone through. Really made me feel good about myself. [Will]

In this concluding chapter I will offer a review of this study, I shall offer some personal reflections and some suggestions for further research.

7.1 SUMMARY OF THE THESIS

In chapter one I set the scene for this thesis. I set out my experience as a counselling psychologist involved in an evaluated pilot project, where I noted that there was plenty of quantitative evidence for client satisfaction with counselling, but little by way of the client's voice. I noted my own interest in researching counselling, with my background in behavioural sciences, and noted calls to research in the primary care setting using a qualitative methodology. I sought to hear from clients in the primary care setting, with a view to investigating their views, and from there to put forward findings that may inform debates in this field.

I explored the history and development of counselling as a specialism in this setting, Department of Health policy regarding the management of mental health needs, and how counselling has adapted to exist in the environment of the NHS. I then looked at theoretical approaches to counselling and psychotherapy, and the movement toward a more generic therapeutic approach, one that draws upon a range of traditions and techniques, that is emerging in practice. Also in chapter one I presented detail of the two primary care counselling services from which I drew my interviewees.

In chapter two, I presented a review of published material, beginning with quantitative studies with a focus on establishing the effectiveness of therapy,

and Keithley (1995)'s work set in counselling in primary care. I also considered literature that critiques effectiveness studies, claiming the basis on which such work is carried out is flawed. I also looked at work claiming the central import of common features of therapy. I then presented a section on client voices, both from the perspective of the researcher, and from that of the clients themselves. I also introduced some sociological concepts which I have used to inform aspects of my analysis.

In chapter three I offered a detailed account of my method for conducting this study, of how I made contact with the 23 former clients who took part, and how I conducted the interviews. The following two chapters contained findings based upon a content analysis of my data. In chapter four I presented the voice of the client on counselling, where I considered the client's thoughts on what it is that makes counselling successful. I also looked at contrasting stories from those clients who had experienced therapeutic episodes in other settings. I then looked at expectations that clients held prior to attending for counselling, how they described change, and those who presented the counselling as having been disappointing in some way. In chapter five I presented the voice of the client on self, which was an exploration of how the client's perception of self, and their life-world, can impact on their presentation in counselling and the way in which they may be able to use counselling. This included a focus on symptoms experienced, and also how lives are peopled with friends and family.

In chapter six I discussed issues that arose from the findings of the study. In reflecting on previous published material, I used the clients' voices to raise issues that were of importance to them from their experience of having attended for counselling in a primary care setting. I also raised issues that emerged from my analysis of the clients' life-world, which was their lived experience according to the clients in their accounts.

Life problems were related to loss in some form, which was positioned both in the client's personal life and close relationships, but also in the work place. Even in short-term work, clients valued working on 'deeper issues', namely childhood relationships and trauma. There was a widely held understanding of childhood experience as affecting present day psychological well-being. Where there was criticism of the efficacy of counselling, it was where the counselling failed to deliver the hoped-for benefits, by being too shallow in its focus. Regarding previously published client voices, I did not find any abuses of power of the kind written of by Dinnage, (1988), Alexander (1995) and Sands (2000), such as poorly maintained boundaries or insufficiently contained transferences. However it is not surprising that this is absent from client accounts in this study, as the three authors quoted have written of their experience in longer-term, psychoanalytic work, which is unlikely to be offered in a primary care setting.

In chapter six I also presented issues that can inform debates for practitioners and managers of counselling in primary care settings. In refining the issues that emerged from the analysis of interview data, it can be seen that the client group in this setting forms a heterogeneous population, living with mild to moderate emotional problems arising from a wide range of originating factors. The overwhelming majority were either currently, or previously, prescribed anti-depressant medication. The nature of counselling in the primary care setting was of short-term provision with some flexibility afforded to counsellors.

From the client accounts it emerged, firstly the importance of the relationship with the counsellor, secondly a wide variation in therapeutic interventions appreciated as helpful, and thirdly, contextual factors arising from the counselling being located in the doctor's surgery. This suggests that counsellors need to be adept in a wide range of techniques from therapeutic approaches, and to be sufficiently responsive to adopt interventions to best suit the individual client, in a relatively short number of sessions.

Contextually, they need to manage their diary mindfully, recognising the effects of medication on the client and on the therapeutic work, and contextual relationships with client and doctors. This calls for the counsellor to be mature in self and practice, with the confidence and flexibility to include the client in negotiating the pattern of sessions and endings.

From the above it may be proposed that counsellors would benefit from a specialised training for working in primary care, or possibly a post-qualifying training, to address the specific issues that arise in this context, in order to best meet the needs of clients.

From a funding perspective, whilst it was not the intention of this study to evaluate the counselling received by clients, the overwhelming majority of my interviewees expressed their satisfaction and appreciation of the service. Family and friends were not considered a substitute or alternative. Interviewees in this study had all received short-term counselling in a primary care setting, where the referral criteria were for those with 'mild to moderate' mental health problems. (Cocksedge 1997). Bearing in mind the cost to society of mental ill-health, as discussed in chapter one, counselling was presented in the client accounts as 'inoculating' against worsening mental illness and was presented as worthwhile and highly-valued. Views were expressed such that without the counselling, instead of coming off their medication, the client may have required a higher dose in order to function. From the accounts gathered for this study, counselling was experienced as beneficial in helping people to cope with life problems. For many, counselling offered a new perspective on their problems. For others, counselling was considered a means of limiting the symptoms of psychological distress, or of preventing them from escalating to the point of a 'break-down' or serious mental illness.

7.2 REFLECTIONS

Aware of my own interest in researching counselling, rooted in both my professional speciality as a practitioner and my academic background in behavioural sciences, I noted the lack of the client's voice in the research/audit I was involved in. I noted calls to involve 'service users', for example in the National Service Framework, and from within the professional field encouraging practitioners to undertake research. In reviewing the literature, I noted a shift in focus within counselling research from the counselling itself to the experience of the client. As I observed in chapter two, much research is carried out to determine whether counselling 'works'. It can be seen that it does, but there is a resistance to carrying out qualitative work. Audit and evaluation are required to satisfy the purchasers of services. Qualitative work does not meet this need, but serves a different aim.

The poem-like structures (Richardson 1992) included as Appendix 6 were created as part of my process. Having transcribed my interviews in great detail, and produced many pages of data, I wanted something to represent each of the former clients, something that contained the essence of their interview presentation more wholly, and more manageably, than the transcripts were able to do. In doing this, I also found that I was fulfilling my initial intention, which was to provide an opportunity, or a vehicle, to hear the client's voice with regards to their counselling. I have not used the poem-like structures here as the basis of my analysis, but I have included them in order to offer presence to those who participated in this study. To further this line of research I would like to engage with ethno-biographical methods and to examine client voices using such poem-like structures.

The process of carrying out this study afforded me the opportunity and the discomfort of examining my own profession and my professional practice. As J.D Frank noted:

'There is no denying that research poses threats to the therapist. He may discover that what he actually does differs considerably from what he thinks he does.' (J.D. Frank 1973 p. 331)

In carrying out this research I gained insight into clients' views of their experience of counselling. As a therapist myself, I have been obliged to re-examine my understanding of the work that I do and the impact that it has on clients' lives. I usually have little by way of feedback from my own clients after the closure of the counselling. Participants in this study were not my clients, but a mixed group of self-selecting former clients in the primary care counselling service, who agreed to talk to me about their experience of counselling. This direct communication with people who have previously had counselling has highlighted the importance of being flexible in addressing the client's needs and for counsellors not to meet their own agenda by adhering to a rigid imposition of therapy.

As a researcher I had responsibility for conducting this work respectfully and ethically, but without the familiar remit to facilitate therapeutic change. This entailed being mindful of my role, and maintaining a different ethical stance. However, the effect on myself, particularly with regard to those participants who were discharging emotion within the interviews, was as of conducting a counselling assessment session, but without the opportunity to offer hope of improvement or resolution to the client by engaging in a therapeutic contract. Some clients were clearly troubled during the interview, most notably Heather, who had dropped out of her GP counselling. Heather could not afford to pay privately for counselling, and 'did not know where to go'. This was in contrast to, for example, Irene, who was undoubtedly distressed but decided before I left her that she would contact her GP with a view to requesting a re-referral to the GP counsellor. Bridie, also, was very tearful during the interview, but already had an appointment with her psychiatrist within the following week. In setting up this study I had paid heed to ethical concerns, and I was aware that my interviews had the potential to reactivate distressing memories or emotions for clients. However, I had not anticipated

the continued distress that I would encounter in some of the interviewees. It seemed that I was not reactivating their distress, but stepping, for a brief moment, into the interviewees' ongoing troubled life-world. I was aware that I carried counter-transferential material, that is to say, thoughts and feelings relating to the interviewee, in particular, toward Heather, as being 'in need of help' during the interview. I considered offering her therapeutic sessions, but quickly recognised that this would not be appropriate. Instead I offered her the contact details of local, low-cost counselling agencies. As a further example of such counter-transference, I had feelings of irritation and frustration toward both Bridie and Christine. They were 'stuck' in their misery and were resigned to their situation as being out of their control.

As findings emerged from my analysis, it was inevitable that I began to incorporate learning from this study into my professional practice. During the period of this study, I have progressed from being a counsellor in primary care, to offering supervision to counsellors working in primary care, and have since taken up a post as a counselling services co-ordinator. I began this research having accreditation with BACP as a counsellor, and at its conclusion I have accreditation as a supervisor, and have qualified as a chartered counselling psychologist.

7.3 SUGGESTIONS FOR FURTHER RESEARCH

In addition to raising my interest in the potential for ethno-biographical methods (Richardson 1992), in carrying out this study a number of ideas for possible future research emerged, both to improve or enhance the current study, and from the findings, suggestions as to further avenues of inquiry. For example, the process of recruiting participants for this study was time-consuming, complicated, and resulted in only 23 former clients available for interview. A more effective means to facilitate this process would be, say, for a researcher to have some level of responsibility within the counselling service, or indeed, by setting up a counselling service, with the explicit

intention to both provide and research counselling. In this way, a post-counselling interview could be incorporated into the counselling contract. Clients would be aware that an invitation to a post-counselling follow-up interview was part of normal practice. By having access to a central database of clients a researcher would be able to contact a wider and potentially more representative sample. This would eliminate doubts concerning clients being selected by their counsellors for inclusion. It would also address concerns regarding the intrusion into the lives of former clients by being contacted 'out of the blue'.

All counsellors employed in the counselling services in this study were accredited by BACP or of an accreditable standard, but no allowance was made within this inquiry for difference in approach between counsellors. Whilst previous research points to most variation occurring between experienced and inexperienced counsellors, not between theoretical approach (Fiedler 1950), nonetheless, it may be of interest to interview the clients of counsellors whose theoretical orientation is known, which would permit an analysis of similarities and differences within client narrative accounts.

Furthermore, some clients in this study were dis-satisfied with their experience of counselling. I set the inclusion criteria as those who attended more than one session, and in so doing, I excluded a number of possibly disappointed individuals who did not attend for a second session. Further research could be undertaken with those who drop out of counselling, and with those who decline to accept a referral for counselling from their GP, to explore some of the factors that prevent people from engaging in counselling.

For this study I gathered client accounts of themselves and their counselling. Such an approach required me to treat the interview data at face value. An account is considered no more than, and no less than, an account. (Baruch 1982). I made detailed transcriptions from the audio-tapes of the interviews, which remain available for further analysis. Attention could be paid to how

clients address difficult issues that arise in the interview, for example, using devices such as minimising or distracting. Further detailed analysis could be used to uncover the devices participants use in their communication about their counselling, for example, the way in which arguments are made, and who and what are called upon in support of their argument. Such an analysis would also take account of the effect that the interviewer has on how the interview conversation is co-constructed. Analysis of discourse uncovers the ways in which norms and values are both constructed and transmitted. It is argued that language as the conveyor of meaning is not neutral. (Messer & Wachtel 1997). In this setting, the language is of the therapy room, filtered through the clients into the current interview situation, and the norms and values are those privileged in the therapeutic world of the psy-sciences. Employing the methodology of conversation analysis, a detailed analysis of the interview situation could be made.

Employing a variety of data gathering procedures would yield further insight and different perspectives of counselling in primary care. In addition to data gathered from clients, to inquire into the views of counsellors would offer a fresh perspective of the therapeutic endeavour. One option would be to present counsellors with initial findings from the client interview transcripts, in order to generate discussion and progress the exploration. As Coffey and Atkinson (1996) emphasised, of utmost importance is to choose methods that are best suited to the purpose in hand. So, for example, focus groups can elicit group norms and values that might be difficult to uncover in one-to-one interviews. They can be used to identify shared understandings and the norms and values of a particular setting. In addition, when there is a security and spontaneity present within the group, participants can feel freer to speak out. The group format makes use of the concept of synergy - or the gestalt principle that what emerges is greater than the sum of its parts. Group synergy can enrich the material elicited, and also provide support for the participants (see, for example, Bloor et al. 2000).

As regards equity of access to counselling, my interviewees came from a broad spectrum of employment backgrounds, including a senior local authority official, a business manager, a part-time cleaner and a long-term sickness benefit claimant. Anecdotally, those of the middle class and those better educated are more likely to be referred for psychological treatment, whereas those of lower socio-economic groups are more likely to be offered a drug regime. All of my interviewees were white, and the gender balance in the sample reflected that seen in counselling services. Ethnic minorities are under-represented in counselling generally, and there were none in the sample. Yet as service-users in mental health, women and African/ Afro-Caribbean people are over-represented. Further research could usefully be undertaken with 'minority' groups, those excluded or under-represented at present. Are ethnic minorities referred for counselling in primary care but do not attend? Do they drop out? Or are they not being referred?

Final word

The culture of the psy-sciences (Rose 1999) is clearly with us. During the latter days of the writing up of this thesis, newspaper articles acknowledged the ever-increasing demand for counselling:

> 'Weary dons seeking counselling: Lecturers at Cambridge University are turning to counselling in droves to help them cope with the stresses of academic life. Demand for counselling among lecturers and staff has jumped by 60% in the past four years, university officials said.' (The Times 18/08/04 p.12)

> 'Results anxiety too much: Counsellors are gearing themselves up for one of the busiest times of the year as children and parents turn for support in the lead-up to A-levels results day.' (Western Mail 16/08/04 p.6)

Yet attempts to study counselling inevitably fall short of capturing the essence of such a unique experience. In my study of client accounts, the overwhelming majority appreciated what they had gained from their experience of counselling. Some reported their lives had turned around, for others, nothing changed, and yet there was still the appreciation of the time

spent with the counsellor. I will close with contrasting quotations from the first two clients I interviewed for this study. The appreciation is there in both accounts, yet the marked difference in outcomes for the two highlight the uniqueness of the counselling process and the complexities of the counselling interaction.

There wasn't enough time for me in the counselling that I had, to express how I felt. I haven't got the answers. I feel I am still in a state of needing help because there hasn't been a resolve of - {continues tearfully} I think I'm angry now. Angry that I've been let down. That, er, my personality's been changed. It feels almost like, my mind's been affected, and my body's been affected, without choice. {pause} I think to have had so much taken away from me, I think it's just a total injustice {tearful}...The counselling was helpful at the time. Yeah, I think it was helpful at the time. She can't change what's happened, nor can she alter the future, except to support how I'm feeling, or what I've felt because of what I've gone through. [Bridie]

By the time I finished counselling, I felt a lot better about myself, and changed my way of thinking about things, and dealt with things differently. I felt a lot happier in myself. People were different towards me and said how much calmer I was, and nicer. People enjoyed being in my company. And then I finished counselling in September and in October I met somebody! And I'm really happy. [Angie]

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APPENDIX 1

Referral Guidelines to the
Primary Care Counselling Service

NHS
CYMRU
WALES

COUNSELLING SERVICES IN PRIMARY CARE

Counselling Services	Mental Health Services
A counsellor can enable the process of change by helping people to express their feelings, clarify thoughts, reframe their problems and consider potential solutions so that they can understand themselves better and be able to manage their lives more effectively.	Referrers should use mental health services when they are seeking a mental health assessment or diagnostic advice.
Problems appropriate for counselling services	Problems appropriate for mental health services
Mild to moderate problems	*Moderate to severe problems*
Depression Relationship difficulties Anxiety Bereavement Emotional and psychological difficulties Response to physical illness Life cycle development issues Problems to adjustment Response to trauma Sexual difficulties	Schizophrenia and related disorders Mania/hypomania Depressive disorders Cognitive impairment or dementia Risk of Suicide, violence or self-neglect Hypochondriasis Obsessive-compulsive disorder Post traumatic Stress disorder Eating disorders Substance abuse Personality and behaviour disorders Severe anxiety

From Clinical Psychology Forum No 101 – March 1997

APPENDIX 2

Letter of Approval from the

Local Research Ethics Committee

AWDURDOD IECHYD
BRO TAF
HEALTH AUTHORITY

13 December 2001   CP/JJL

Ms J Johnson,
Cardiff University School of Social Sciences,
Room M/1.29,
21 Senghenydd Road,
Cardiff,
CF24 4AG.

Dear Ms Johnson,

01/4263 - Talking Therapy in Primary Care

Thank you for your letter of the 10th December 2001, regarding the above application for ethical approval.

The Chairman of the Bro Taf Local Research Ethics Committee (Panel B), Mrs A Dowden, has confirmed that your response is satisfactory. Mrs Dowden has therefore taken 'Chairman's Action' to grant full ethical approval to this application.

Yours sincerely,

Mrs Jagjit Sidhu
Deputy Executive Officer
Local Research Ethics Committee

☎:   **029 20226470/20402451**
🖳   JSidhu@bro-taf-ha.wales.nhs.uk

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17 Churchill Way, Cardiff, CF10 2TW

☐ Temple of Peace and Health
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CYMRU
WALES

PRIF SWYDDFA:
Tŷ Churchill
Ffordd Churchill, Caerdydd, CF10 2TW

Teml Heddwch ac Iechyd:
Parc Cathays, Caerdydd, CF10 3NW

Tel: 029 20 402402   Fax/Ffacs: 029 20 402403   WHTN: 1809

APPENDIX 3

Documentation for Recruiting Participants:

Introductory Letter (from counsellor)

Introductory Letter (from researcher)

Information Sheet

Response Form

Letter to Practice Manager

Letter to GP

Consent Form

[ON COUNSELLING SERVICE HEADED PAPER]

[DATE]

Dear

I am writing to introduce Janet Johnson, who is a qualified counsellor and researcher based at Cardiff University. Janet is doing research into counselling in GP surgeries.

The names of people who have attended for counselling at their GP surgery during the past twelve months have been selected at random to be included in the study. Janet is keen to speak to a good cross-section of people who have had counselling at the surgery, and I hope that you will agree to assist in the research.

I am enclosing a letter inviting you to meet with Janet for a single interview. The letter contains information about the study, and will explain that you do not have to take part if you do not wish to.

Yours sincerely

[NAME OF PRACTICE COUNSELLOR]
(practice counsellor)

CARDIFF UNIVERSITY

PRIFYSGOL CAERDYⅮ

[DATE]

I am conducting research into people's experience of counselling. I am asking people to take part in a single interview, which should last about an hour.

I am writing to a selection of people who have received counselling at their doctor's surgery during the last twelve months, and I would like to invite you to participate in the study. I can assure you that I have received no personal information about you from your counsellor, nor do I have access to your medical records. Your involvement in this study would amount to one interview, to take place at a time and place convenient to you.

Please take some time to read the enclosed patient information sheet and think about whether you wish to be involved. I am keen to speak to a good cross-section of people who have had counselling at their doctor's surgery, and I hope that you will agree to assist in the research. I can assure you that whatever you say to me will be treated in confidence, the names of participants will not be revealed to others and will not affect any future counselling you may have.

Of course you do not have to participate in the research if you don't wish to. If you would like to help, please complete the enclosed form and return it in the pre-addressed envelope to me. I will then contact you to confirm the date, time and location of the interview.

If you have any questions whatsoever, my contact details are on the enclosed patient information sheet.

Thank you for your help

Sincerely

Janet Johnson
[researcher]
version: 04
date: 05/02

STUDY TITLE: TALKING THERAPY IN PRIMARY CARE

INFORMATION FOR PARTICIPANTS

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Please ask if there is anything that is not clear or about which you would like more information. Take time to decide whether or not you wish to take part.
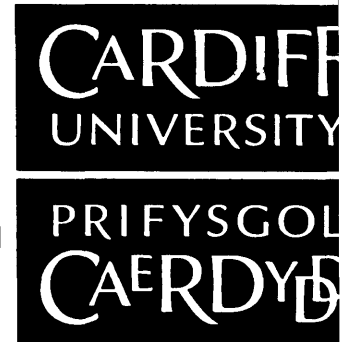
What is the purpose of the study?

Studies have shown that people who receive counselling at their doctor's surgery show significant improvement in their sense of well-being, and that people value the counselling service. We know that counselling can work for many people. However this study seeks to explore the patient's viewpoint and experience of counselling. We would like to get your views on the process of counselling.

Why have I been chosen?

You have recently received counselling at your doctor's surgery. We are asking a small number of people who have had counselling at their doctor's surgery if they wish to participate in the research.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide we would ask you to sign the enclosed consent forms and you should keep this information sheet. If you decide to take part you are still free to withdraw at any time without giving a reason.

What will happen to me if I take part?

The researcher will make an appointment for an informal interview with you to listen to your views, observations and understandings about the counselling process. The interview will take place at a time to suit you, (daytime or evening), and at a location to suit you (e.g. your doctor's surgery or at your own home). The researcher will request your permission for the interview to be audio-taped so that she can carefully analyse the discussion after the interview has taken place.

What are the possible disadvantages and risks of taking part?

It is unlikely that this study will benefit you directly. However we hope that you will enjoy talking to the researcher about your views. It is also hoped that the study will eventually be of help to the work of counsellors and other health professionals in understanding how counselling is understood by patients.

What if something goes wrong?

We cannot envisage any circumstances under which you would be harmed. However, if you were to be harmed, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. The researcher works to the British Psychological Society's Code of Conduct, Ethical Principles and Guidelines. If you wish to complain about any aspect of the way you have been approached or treated during the course of this study, the normal British Psychological Society complaints mechanisms may be available to you.

Will my taking part be kept strictly confidential?

Your G.P will be informed that you have agreed to take part in this study but he/she will not be told anything recorded during the interview. All information collected during the study will be kept strictly confidential. After the research is completed the audio tapes will be destroyed and data from the interview will be anonymised so that your name and other details cannot be identified.

What will happen to the results of the research study?

A summary of the results published from this study will be available to all patients who have taken part.

Who is organising and funding the research?

The study is being organised at the School of Social Sciences at Cardiff University, using a grant from the Economic and Social Research Council. No doctor has been paid for you to be included in the study.

Who has approved the study?

The study has been approved by Bro Taf Health Authority Local Research Ethics Committee.

What do I have to do if I would like to participate?

If you would like to participate in this research, please complete the details on the enclosed form, and return it using the pre-addressed envelope supplied.

Contact for further information

If you have any questions regarding this study, please contact the researcher, Janet Johnson, at Cardiff University on telephone 029 2087 XXXX or mobile 07968 37XXXX. Alternatively you may call Dr Lindsay Prior, research supervisor, on 029 2087 XXXX.

We thank you for your interest in this study.

version: 03
date: 02/02

CARDIFF
UNIVERSITY

PRIFYSGOL
CAERDYdd

Title of Project: **TALKING THERAPY IN PRIMARY CARE**

Name of Researcher: Janet Johnson [Cardiff University]

Name of Supervisor   Dr Lindsay Prior
overseeing the research: [Cardiff University &
University of Wales College of Medicine]

I agree to take part in the above study.

name [please print]_____

signature_____date_____

address _____

_____

_____

phone [day]_____[eve]_____

name of GP [or GP Practice]_____

can I contact you:

by letter?   yes / no [please delete]

by phone? yes / no [please delete]

if yes, when is the best time to phone?

        morning / afternoon / evening [please delete]

Please return this form in the stamped envelope provided. Thank you.

CARDIFF
UNIVERSITY

PRIFYSGOL
CAERDYDD

[DATE]

[NAME OF PRACTICE MANAGER]
[NAME OF GP SURGERY]
[ADDRESS OF GPSURGERY]

Dear [NAME OF PRACTICE MANAGER],

re: "Talking Therapy in Primary Care"

I am writing to bring to your attention a piece of research that is being funded by the Economic & Social Research Council. The research involves a single interview with former counselling clients, to take place a minimum of three months after the counselling has ended. The interview will be conducted by a qualified counsellor and researcher, who has experience of working in primary care, and who works to the codes of practice for research of the British Association for Counselling and Psychotherapy and the British Psychological Society. As with all research of this nature, participation is voluntary.

The research has the full ethical approval of Bro Taf Health Authority Local Research Ethics Committee (ref: 01/4263), and the support of Ms {name of manager}, consultant clinical psychologist & project manager {"North Oaktown"} Counselling Service and Dr {name of GP}, GP at {"Acorns Health Centre, North Oaktown"}.

A maximum of ten patients from each practice, who have previously received counselling, will be chosen at random and invited to participate. Prior to any interview being carried out, the patient's GP will be informed, and invited to comment on the suitability of the patient being interviewed.

I have had informal discussion with [NAME OF PRACTICE COUNSELLOR], practice counsellor, regarding the procedure for inviting patients to participate.

For further information, of if you have any queries or concerns, please contact me on 029 2087 XXXX or mobile 07968 37XXXX. Alternatively you may call Dr Lindsay Prior, research supervisor, on 029 2087 XXXX.

Yours sincerely

Janet Johnson
(researcher)
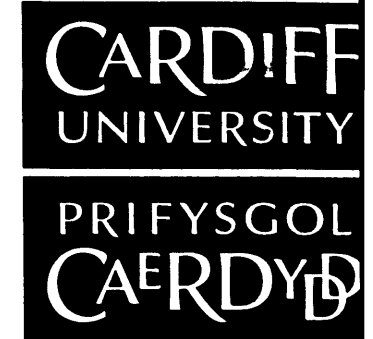
**CARDIFF
UNIVERSITY**

**PRIFYSGOL
CAERDYᴅᴅ**

[DATE]

Dear Dr [DOCTOR'S NAME]

Re: [PATIENT'S NAME; ADDRESS]

The above named patient has given their consent to participate in a study that aims to examine lay and professional accounts of counselling. A copy of the patient information sheet is enclosed with this letter. If you know of any reason why the patient should not participate in the research, please let me know.

Yours sincerely

Janet Johnson
[researcher]

version: 02
date: 11/01

CONSENT FORM

Title of Project: **TALKING THERAPY IN PRIMARY CARE**

Name of Researcher: Janet Johnson [Cardiff University]

Name of Supervisor   Dr Lindsay Prior
overseeing the research: [Cardiff University &
University of Wales College of Medicine]

yes no

I confirm that I have read and understood the information sheet for the   ☐ ☐
above study

I understand that my participation is voluntary and that I am free to   ☐ ☐
withdraw at any time, without giving any reason.

I understand that my GP has been informed of my agreement to   ☐ ☐
participate in this study.

I understand that by signing this consent form I give permission to   ☐ ☐
be interviewed by the researcher and for her to audio-tape the interview.

I understand that the audio-tapes will be destroyed after the completion   ☐ ☐
of the research, and that written transcripts will be anonymised.

I agree to take part in the study   ☐ ☐

name [please print]_____

signature_____date_____

signature of witness_____

Contact details:
Janet Johnson tel: 029 2087 XXXX, 01446 73XXXX or mobile 07968 37XXXX.
Dr Lindsay Prior tel: 029 2087 XXXX.

APPENDIX 4

Example of Analysis Matrix

Example of analysis matrix: Effective factors in the GP counselling

	different perspective	qualities of counsellor	impartial	books	expression of emotion	deeper issues	expertise	options	session choice	teaching	talk	location	relationship			totals
Angie	X	X	X	X			X	X		X	X	X				9
Bridie			X								X					2
Christine	X	X		X			X			X	X		X			7
Debbie	X								X	X						3
Evelyn	X	X	X				X				X					5
Ffion	X		X		X	X	X			X	X					7
Gareth								X	X							2
Heather							X									1
Irene		X			X	X	X	X	X	X	X					8
John							X			X						2
Kath										X						1
Leonard	X															1
Marjorie											X					1
Nikki		X	X					X	X	X	X					6
Olive																0
Pamela			X								X					2
Ruth	X	X				X	X	X	X	X	X	X	X			10
Sian	X	X	X		X		X			X	X	X	X			9
Tracey	X		X		X				X	X						5
Victoria	X	X	X			X	X			X		X	X			8
Will	X	X	X	X						X	X	X				7
Yvonne		X	X				X		X	X						5
Zena			X							X	X		X			4
totals:	11	9	13	3	4	4	11	5	7	15	13	5	5			

n.b. This analysis represents 'work in progress' and was later finalised as described in Chapter 4: The Client's Voice on Counselling

APPENDIX 5

Table of Participants

participants

name	gender	age	marital status	children	employment	presenting symptoms	presenting difficulties
Angie	female	39	divorced	3 children	mature student: nursery nurse	anxiety & depression	ex-husband physically abusive
Bridie	female	49	divorced; co-habiting	2 adult children	long term sick (formerly FE college tutor)	anxiety & depression	bullying at work
Christine	female	48	married	none	part-time cleaner	depression, suicide attempts	relationship problems
Debbie	female	46	divorced	2 children	full-time childcare (formerly office worker)	depression	ex-husband with schizophrenia
Eileen	female	54	widowed	1 adult child, 1 dependent child	community nurse	'lost the plot' at work	bereaved of husband
Ffion	female	37	divorced	1 child	nursery nurse	panic attacks	divorce
Gareth	male	18	single	none	shop assistant	post traumatic stress	victim of violent attack
Heather	female	33	married	2 children	full-time childcare (formerly care assistant)	depression	multiple bereavements in adolescence
Irene	female	35	married	2 children	full-time childcare	depression	childhood sexual abuse
John	male	46	married	3 children	proprietor of building company	depression	brain haemorrhage
Kath	female	57	married	adult children	long-term sick	depression	physical disability / childhood family relations

name	gender	age	marital status	children	employment	presenting symptoms	presenting difficulties
Leonard	male	65	divorced	1 adult child	semi-retired consultant engineer	depression	divorce
Marjorie	female	79	widowed	none	pensioner (never in employment)	anxiety	victim of mugging
Nikki	female	29	married	3 children	care-worker	anxiety & depression	workplace relationships
Olive	female	70	widowed	7 adult children	pensioner (never in employment)	brain tumour: reduced cognitive functioning	bereaved of husband
Pamela	female	51	divorced	1 adult child	full-time carer for father (formerly factory worker)	depression, chronic fatigue	redundancy / divorce
Ruth	female	43	divorced	none	domestic services manager	depression & stress	divorce
Sian	female	59	married	1 adult child	civil servant	depression	abuse by & suicide of previous husband
Tracey	female	38	married	2 children	p/t office worker	depression	family relationships
Victoria	female	40	divorced; co-habiting	2 children	local government administrator	stress	divorce
Will	male	35	married	none	supervisor in chain-store	anxiety & depression	workplace bullying
Yvonne	female	55	married	2 adult children	doctor's receptionist	anxiety	family relationships
Zena	female	63	married	4 adult children	part-time shop assistant	mild recurrent depression	bereaved of mother, divorce

APPENDIX 6

Poem-Like Structures

Angie

I find it hard to talk to my parents.
I grew up in a family where 'children should be seen and not heard'.
My ambition in life was to get married and have children.
I've had poor relationships with men.
Physically abusive.
Men are not thoughtful.
Men are selfish.
I used to put far more effort into relationships than my partners did.
I desperately needed a man but they didn't want me.
I used to be 'put upon' by others taking advantage of my good nature.
I struggled as a single parent to do the best for my kids.
In the past I have been suicidal.
More recently, I have been highly stressed.
Losing my temper all the time.
I had nightmares involving my son having an accident.
I imagined rats climbing all over me.
Other people didn't understand how stressed I was.
But I knew I needed help.

The counsellor was very good.
I could relax with her.
Being able to 'get on' with someone
The relationship is very important to me.

The counsellor suggested other ways of looking at things.
She lent me self-help books.
I identified myself completely in the books.
I used the techniques in the books.
I learnt assertiveness techniques to use with the children and other people.
Now I set and keep boundaries.
I have changed my expectations from relationships.
I am much happier than I was.
I am much less stressed.
The counselling has made such a huge improvement in my life.
I appreciated having the counselling at a familiar and convenient location.

Bridie

I'm a conscientious person.
I try to do the right thing
and try to treat others as I wish to be treated myself.
I've led a hard but good life and I should be reaping the rewards.
I was unfairly treated at work, some five years ago.
When I brought this in the open
I did not receive the support I anticipated from my Head of Department.
I have fought against the system.
This 'wrong' has never been acknowledged.
But as well as that
I cannot comprehend how someone I thought was my friend
could be so vindictive towards me.
I had a break-down.
I was on diazepam.
I'm still on anti-depressants.
This matter has taken its toll on me both physically and emotionally.
I am no longer able to work.
I have support from close family and my GP
however I am unable to take their advice to 'put it behind me and move on'.
I believe that improvement to my well-being can only come about through
recognition and acknowledgement of this unfairness at work.
I had counselling at the time and learnt some useful ideas to protect myself,
in particular, to document meetings
and ensure I had witnesses present at all times.
It's 'good to talk'
but the counselling at the GP surgery wasn't really enough
to make any difference.
I would need to see someone on an on-going basis.
My GP has referred me to a psychiatrist.

I have been robbed of my personality.

Christine

I had problems in my marriage about twenty years ago,
and that was the cause of my depression.
Things are better in the marriage now,
but I haven't said much about the problems in this interview.
I didn't let the researcher come to my house because he would be there.

I couldn't have children.
My mother-in-law doesn't understand my problems.
I have suffered bouts of depression for many years.
I've seen different counsellors and take anti-depressants.
It's good to have someone who'll listen to you.
The counselling is good, but it's never for long enough.
And I need my tablets as well.
I'm terrified of having to come off them.
My doctor is great.
I have a good relationship with him.

Three times I've taken an overdose.
The first time I meant to do it.
After that it was 'a cry for help'.
People don't understand about depression, and mental health problems.
They think you can 'snap out of it'.
They put the blame on you.
I have to fight not let myself get so low again.
I've learnt some things about self esteem from a book the counsellor
recommended to me.
I've learnt not to let things get to me.
And I've learnt not to let other people see if I'm hurt.
I feel like I've done some growing up.
I'm not like a little girl any more, ready to cry at anything.
It's a hard struggle. But I've got to do it.
I wanted to do this interview
to say firstly, that there shouldn't be waiting lists to see a counsellor.
When you need to see someone, you need to see them 'now'.
And secondly,
that there should be more awareness of depression
amongst the general population,
so that people would be more sympathetic towards those who suffer with it.

Debbie

The counselling was excellent.
I had cognitive therapy.
She showed me how my faulty thinking was causing my problems.
I'd had cognitive therapy before, but that was different to this.
That one was more like visualising your problems shrinking away.
This kind of cognitive therapy was brilliant.
I wish I'd had this years ago.

I was on anti-depressants,
but I told my doctor that I needed something more.
I asked her could I have some counselling.
The counselling service was just starting so I got in straightaway.
No waiting. Excellent.
And the counsellor knew about an assertiveness group that was starting.
So I did that too. Together they were excellent.
I got some of my confidence back.
I always used to think I was a bad person.
Worthless.
Now I think 'I'm okay'

My ex-husband was my big problem. He was mentally ill.
He made my life hell. It was because of him I was on the tablets.
I stayed with him while the children were young.
The counselling and the group
made me look at taking responsibility for my choices.
Years ago I left him.
I hate living like this. On benefits. Counting the pennies.
After I'd moved out he used to hassle me.
And for the first time I was able to say 'no' to him.
Before I would have given in.
He killed himself last year. It's horrible to say, but I'm relieved.

I've got to help the kids now. He messed up their lives too.
We're waiting to go for some family therapy.

I keep expecting him to come back and spoil my life again.
It's going to take time.

Maybe next year I'll do a training course.
When the kids are old enough, maybe I'll get a job.

After the tape was switched off,
I told the researcher that I'm doing a counselling skills course,
and I've been seeing a bereavement counsellor,
but it's not going very well because she keeps cancelling the appointments.

Eileen

My husband died nearly two years ago.
I seemed to be okay to begin with.
I was so busy looking after everybody else.
Then about a year ago I had this breakdown in work.
I couldn't understand it.
I'm not one for taking tablets.
My doctor suggested counselling.
It was wonderful.
Everyone should have it.
It was so good to talk to someone who didn't try to have a worse problem.
Whenever I talk to my friends I end up listening to their problems.
The counsellor made me feel good.
She was calm, like the researcher.
The counsellor made me think about things.
She dug things out of me.
Even now I still things think about things, like when I was a girl,
and how I felt when my brother died.
My family are great but they have their own lives to lead.
They can't really understand what it's like to lose your husband.
To come to an empty house.
I'm 54 now.
I'm lonely and I miss my husband.
But I'm not as bad as I was.
I sleep with teddies in the bed.
It's frustrating trying to get people to do the things around the house
that he used to do.
I'm adjusting to life within him.
I still talk to him, of course.
Next month it'll be two years since he died
and I've decided it's time I sorted out his clothes.

Ffion

I was having panic attacks.
Not as bad as I had before, nine years ago, when my husband walked out.
But I recognised the symptoms.
And I knew I had to get some help.
The doctors gave me some anti-depressants to help with the panic attacks,
and suggested the counselling.
I'd had counselling before, with someone from a local voluntary agency.
It was okay, but, I don't know, there was something about her –
Like when I said about going out with someone, she used the word 'courting'.

It was unfortunate that the counsellor I started seeing this time was taken ill,
and I had to start again with another one.
The counselling was good.
Someone to offload onto.
And help me see a different perspective.
It's different to friends.
With friends you have to give and take.
With the counselling I could just use it for me.

Before this I've been exploring my spiritual side.
Crystals and things.
All three of the counsellors,
I don't think they were on the same wavelength as me.

And I've read some good books, like 'Feel the Fear and Do it Anyway'.

It's hard to say what's changed as a result of the counselling.
It's like you take on board everything from everywhere.
It becomes part of you.

Since that breakdown nine years ago I'm not as strong as I used to be.
I have to keep alert.
Remember my affirmations.
Watch out it doesn't creep up on me again.
That's what happened.
I forget to keep doing them.
I didn't notice how stressed I was.
Cos my husband is still around.
Hassling me.
Putting me down.
He's my little girl's father.
Maybe one day she'll choose not to see him, and then I can be free of him.

Gareth

I've had about six jobs, and I've had trouble in them all.
I've worked in local shops, and supermarkets and in a pub.
And I'm doing a course at the college.
An NVQ Level One in Retail.
I want to do Level Two next.
But I don't really have anyone to go out with. No friends.
I work really long hours.
Early mornings.

Three years ago I was mugged in the shop.
I got compensation.
I knew them from school.
Took me ages to get over it.
I didn't want to go out.
They live near here.

Then I had problems
because my one employer wrote a bad reference about me.
I got a solicitor on that.
I was getting so stressed out I knew I needed someone to talk to.
You know, like you see on Kilroy and that.
I was having trouble at home too, with my family.
We'd had a bereavement and everyone was upset.
So that's why I needed counselling.
It helped, yeah. It helped me get over things.
And helped me make decisions about getting a new job.

But I wish things were different. I wish I had some friends.

Heather

I had a terrible time last summer.
Just wanted to stay in bed where it was safe.
Didn't want to go outside the house.
I thought that everyone else was looking at me and judging me.

I don't think counselling was what I really needed.
She tried to give me ways to help me
with talking to the other mothers outside the school.
But that's not my problem. On good days I can do that anyway.
I need something deeper.
Where I can talk about my childhood
and where they can tell me why I am like I am now.

Cos my mother died when I was 12.
And my brother committed suicide when I was 19. I lost a baby.
Years later my father-in-law died. My brother-in-law died.
Everyone leaves me.

I need loads of reassurance and love. My husband doesn't understand.
My dog is always here with me. He knows how I feel.
He's always kissing me and loving me.

I know I'm lacking in self-confidence.
Friends do courses but I wouldn't have the courage.
I never believe compliments but I always believe the negative things.
If I make a mistake then I won't try again. It's proof that I can't do it.
And I'm so scared of upsetting other drivers
that I hardly ever drive outside the town.

I wouldn't say I've got depression with a capital D.
Y'know, where life is so black there's no point carrying on.
I read some good self-help books talking about depression.
My sort of depression.

But it's really hard to change your way of thinking
when you've always been like this.
I dropped out of the counselling because I didn't really think it was helping.

I'm still on the anti-depressants. They take the edge off things.
I wouldn't ask my doctor for a referral to the hospital.
I wouldn't want him to think I'm mad.
If I could afford it I'd go for something like psychotherapy.
But we haven't got the money.

I haven't got the confidence to go back to work.
I've been thinking about being a volunteer in a dogs' home.

Irene

I first knew I had a problem when I had my daughter.
I told my partner I didn't want my grand-father anywhere near her.
But I didn't tell anyone else.
I didn't tell my mother.
I thought it would upset too many people in the family.
My grand-father abused me when I was twelve.
After my second daughter was born I had post-natal depression.
The health visitor thought counselling would be a good idea.

Whilst I was on the waiting list I got an appointment through BUPA.
I went for the assessment. It was awful.
A high-up doctor. She excused my grand-father for what he'd done.
And she rubbished counselling.
'Oh you don't want to waste your time doing that!'
So when I got to see the counsellor at the surgery I had to undo that as well.

My doctor, my health visitor and the counsellor were good.
We made a list of things, like making time for myself.

I'm still on the anti-depressants.
My doctor wants me to come off them.
I'm really worried.
I'm afraid of going back down again.
But maybe it's normal to have good days and bad days?

The counselling was good.
I wrote a letter to my grand-father.
It really got the feelings out.
I've talked to people, my partner's family, to tell them about what happened.
My partner and his mother have been great about this. Very supportive.

If there's one thing I haven't done it's talk to my mother about it.
I want to know 'did she know?'
She can't have, or she wouldn't have let it happen.
It's still very emotional.
I thought it was finished but maybe it's not.
I might go back to the counselling.

John

I had a brain haemorrhage about two years ago.
I had no idea how long it would take to feel better. I got depressed.
I'm sure that if I could have talked to someone at the time,
someone who'd been through it,
someone who knew what it was like,
I wouldn't have been so bad.
But there was nothing.

I didn't know I was slipping into depression.
I thought it was all my wife's fault.

I found it helpful reading the stories of other people who've had this.
And I knew I had to get help.

My doctor was great.
I used to get panic attacks and he came here and spent all afternoon.
He said he'd get me better, no matter what it took.
He put me anti-depressants, and they helped.
And then with the counselling as well – the two together – it was just great.

She made me face up to my fears.
She took me right back and made me re-live that day.
She was excellent.

When you've stared death in the face it changes your whole outlook on life.
You never really expect it to be you.
I was only in my forties.
Now I know that you've got to live life for today.
Enjoy it.

I try to tell people but they don't understand.
They can't.

Kath

I have suffered bouts of depression for the last twenty-five years.
I can usually cope with it.
I feel I'm going down-hill again this week.
Twenty-five years ago, after my marriage split up, I had a breakdown.
I was referred to a psychiatrist.
I felt so much worse after I saw him – like it was all my fault.
I stopped going to see him.

Over the years my doctors have never really listened to me.
They just prescribe tablets. I was on prozac for a while.
It was a locum doctor I saw who listened to me
and suggested the counselling.

I was disappointed by the counselling I had at the doctor's.
I don't think she was very experienced.
She said I expected too much of myself.
That's true, but I can't change the way I am.
She wanted to work on current issues
and we only really skimmed the surface.
There was so much more we could have done.

My father always expected a lot of me.
Now I feel I have nowhere to go for help.
There is help for people on drugs and alcohol.
But I try to lead a good life and there is no help for people like me.
I have physical problems that stop me working.
I was in a car accident.
I know there are people who've suffered worse things than me.

I have a grandson I never see.
I feel very sad about my whole life.

Leonard

Five years ago my wife and I separated.
Two years ago we got divorced.
I was alright before,
but since the divorce I just wasn't coping.
People thought I was managing,
but I knew I wasn't.

I'm willing to try anything if it'll help.
I took anti-depressants for a while,
but I felt drowsy so I stopped taking them.
Friends are okay to talk to, but they're on your side.
They don't tell it to you like it really is.

I'd read about counselling and asked my doctor to recommend someone.
Initially I was disappointed.
I expected to be given advice.
She didn't do that.
And she was young.
And a woman.
She didn't have a clue what it was like to be me.
I think I gave her a hard time.

But what she did do was give me the situation from where <u>she</u> could see it.
Most of it wasn't especially productive.
But there were a couple of things that were pertinent.
I don't think she even knew how important those comments were.
One was the way my wife – my <u>ex</u>-wife – had so many things in her life.
Our son, her job, her friends.
But to me, she was everything.

The counsellor made me look at myself.
Made me see things I'd rather not have seen.
So it wasn't what I expected,
and it wasn't easy,
but it was useful.

And time's a great healer.
Life goes on, and you have to cope with it.
I've completely redecorated the house.
It used to be <u>our</u> house.
Now it's <u>mine</u>.

After the tape was switched off
I asked 'were there any male counsellors?'
Because I would have preferred to have seen a man.

Marjorie

I've been a widow for twelve years.
Couldn't have children.
One miscarriage after another.
I remember going to see a counsellor at the doctor's.
Nice girl.
My doctor suggested it.
Can't quite remember when it was.

I was having sort-of anxiety.
Funny feelings. Didn't know why. It wasn't like me.
It was about the time this man tried to take my bag outside the post office.
I must have been seeing the counsellor then,
because I remember showing her the bump on my head.

I talked to her about what happened when I was about ten.
I was out blackberry picking with some friends.
This man fiddled with me.
Messed about with me.
They caught him.
I had to go to court to give evidence.
I often wonder whether that's why I could never have children.

I've not been well this last week.
I've been getting funny phone calls. With no-one there.
And I'm worried about my nephew.
He's the only family I've got.
And all this stuff on the telly about those little girls that were murdered.
They were about ten as well.

It was nice having the researcher come to visit.
She liked my chocolate biscuits.
Everybody does.
I felt better for talking to someone today.
But I probably wouldn't go back to the counsellor.
Other people probably need her more than me.
And anyway, we'd only go over the same stuff.

Nikki

There's a lot of stress in my life.
My job is stressful. I work in an old peoples' care home.
There's my two girls. And the baby.
Don't get me wrong. I love 'em to bits.
And my fifteen year old step-son. He's a bit of a handful.
My husband's not well. He's got asthma.
The one girl they tested for leukaemia last year. I was beside myself.
And the other one they thought had that Asperger's.
My Mum lives next door. I don't know how I'd manage without her.

I had this terrible time in work. I was shaking and sick.
They had to bring me home and I didn't get out of bed for two days.
That was before I caught for the baby.

I had post natal depression on my first one,
and I just knew I'd have it again this time.
I was keeping the kids immaculate.
I was keeping the house spotless.
I was up at three in the morning bleaching the walls.
That was never right.
My score on the questionnaire was so high
the health visitor recommended I see the counsellor.

I'd been up to the CMHT before. It was awful. Two hours I was in there.
But they didn't want to know how I was feeling.
And there's a stigma to it.
You don't want people to know you've been to the nutty farm.
I said I'd never go there again.

But the counsellor was different.
She was very calming.
She was interested in me and my family.

I learnt quite a bit about her, too.
I had to wait to see her and I think I got worse while I was on the list.
She didn't tell me what to do,
but she encouraged me to see that I had options.
If I couldn't think of the options, then she would prompt me with suggestions.
Like I could make time for me. Have a long soak in the bath. Go for a walk.
Now I just tidy round and it doesn't matter if there's toys everywhere.

It was really good that the counsellor didn't rush me to finish.
She asked me 'did I feel ready to finish?'
I'm not quite ready to come off the anti-depressants yet.
I know there'll be ups and downs.
That's life, isn't it? I'll cope.

Olive

I lost my husband eighteen months ago.
All of last year was a complete blur.

Nineteen years ago I had brain surgery to remove a cyst.
I hate it, but I've got to be on medication for the rest of my life.

So that blur last year,
I don't know if it was the medication,
or because my husband died.
I don't remember anything. I didn't talk to anyone. I wasn't myself.
This year I'm starting to come back to myself.
My friends and my family have noticed the difference.

I never thought this would happen to me.
I never thought I'd lose my husband.
I always said we'd go together.
In my generation, people didn't really talk much about things.

I may have seen a counsellor last year.
I honestly don't remember.
If I did, it wasn't much good.
But then maybe that was because of me.

I've just started seeing a Cruse counsellor.
He's very good.
He gets me talking.

The people at the church are good.
Not that I go to church much.
I like the clubs.
Lots of the people there have lost their husband.
They know what it's like.

I go to the meetings at the Spiritualist Church too.
Not that I believe in all that, but the healers there are good.

I'm a bit confused about what the researcher is doing here.
Has she come to assess how I'm doing?

Pamela

I had to give up work about four years ago.
I had Chronic Fatigue.
I had all these aches and pains but no-one knew what it was.
In the end they said I was unfit to work,
but they put it down to depression.
I've got asthma as well.

I've had a hard time.
Since my mam died, I've looked after my dad.
He's got heart failure.
And he's getting forgetful.
Set the kitchen on fire when I was out.
And it's bad living round here.
We had a break-in the other week.

My husband walked out when the baby was five months.
I had to go to work to bring her up.

But I miss work.
I lost my independence when I had to give up my job.

I saw the counsellor at the surgery.
It was okay,
and it's nice to have someone to talk to,
but we didn't really get anywhere.
I missed it when it finished.
She always seemed busy.

I went on a pain management course.
It was a group thing.
I didn't like it.
It's not easy saying things in front of a whole group of people.

Now I'm seeing a psychologist up at the hospital for cognitive therapy.
I go once a month.
He's great. I wish I'd seen him years ago.
He says with everything I've done over the years, my body's just burnt out.
He says he's going to give me a kick up the bum.
He's given me homework exercises, about my thoughts.
I've bought the book he told me to get.
And he said I should go to Tai Chi, so I've joined a class.
I'm on anti-depressants
but that's so I get the right kind of sleep.
He explained that to me.
I'm on prozac as well.
That's to do with the seratonin in the brain.

Ruth

I'd had all the classic symptoms of depression for a few years
– tho' I hadn't put a name to it until my doctor said.
I didn't want to get out of bed in the morning.
I was so tired all the time.
I used to love my job.
I was a deputy manager at a large hotel.
I'd been on anti-depressants for a while.
Christmas was particularly stressful
so we always upped the dose before the Christmas rush.
It seemed to be working okay.
I'm fine about taking medication.
If it works – do it!

But this one day,
it was a big function,
and I just didn't want to be left on my own.

I knew I couldn't go on working there.
I made the decision to look for something else.
I have lovely new job.
It's with a charity and it's part-time.
Less stressful and more supportive.

It was at this time the doctor suggested counselling.
The counselling was good, but I can't give it all the credit.
By the time I got to the top of the waiting list
I had already been offered this new job.
But the counselling helped me
to think about different ways of handling stressful situations at work.
And even now, I think 'now what would my counsellor say?'

We both agreed I was a very good client.
I had high expectations that it would work.

We talked about my divorce.
There were no children, so the divorce was straightforward.
But I never really dealt with all the feelings. The loss.

I could see there were other things
that would have been useful to talk about.
Like my parents.
I'm still very close to my parents.

So yes, the counselling was good.
Maybe one day I'll do some more.

Sian

I'm ashamed at how silly I was.
I couldn't talk to anyone about it for years.
I thought it was my fault for being so foolish.
And I used to be such a strong person.
I was active in politics and the Trades Union.
I left my husband behind.
We got divorced and I moved to the city.
I met this man. He was nearly thirty years younger than me.
I was so naïve. I didn't know he was a drug addict.
He used to beat me. Stubbed cigarettes out on my back.
He was sick. He was evil. He committed suicide.
In my house.

I couldn't tell anyone.
I just went back to work as if nothing had happened.

I went to a group for people bereaved through suicide,
but it wasn't for me.
I talked to the Samaritans.
Then a few years later I went to a counselling centre*
The first woman I saw was okay,
but she referred me to this man.
I couldn't work with him.
For starters, he reminded me of the man I'd been with.
And he wanted me to go to a group for battered wives!
I didn't want to be labelled an abused woman.
I just wanted someone to listen to me.
Not put me in a category.

My doctor suggested seeing the new counsellor
who was coming to the surgery.
I was apprehensive, but I trust my doctor absolutely.
The counsellor was marvellous. She listened to me.
It was emotionally draining, but I knew I needed to stick at it.
I couldn't go on as I had been.
She helped me see things another way.

I'm still not as strong as I was before.
But at least now I can talk to people about it.

I wanted to talk to the researcher
because I want people to know how vital the service is.
I wish I'd had someone I could talk to when it happened,
instead of having to wait ten years.

*CMHT

Tracey

I had a breakdown at work.
And then I went into a really bad depression.
I wasn't doing anything.
I couldn't get out of the house.
I couldn't have got any lower without 'doing something'.
I didn't know it was depression.
I thought I should just shake it off like I usually do.
It was the doctor who said it was an illness.

There had been a lot going on.
My husband had been made redundant several times over.
And we'd had to move house.
But I'd done all that before.
I see myself as a 'coper'.

I'd fallen out with my sisters and that was terrible.
Family is so important.
My mother died when I was at school.
My mother-in-law died two weeks after she retired.
So I have no family other than my sisters.

I love being a mother.

I had to leave school and not finish my A levels or go to university.
I still feel sad about that.

I'm on the highest dose of Cipramil
– my depression was <u>that</u> bad.

Oh, and three years ago I had a radical hysterectomy.
They found something they didn't like the look of.
It didn't occur to me until later how serious it was.
I thought I'd dealt with it, but I hadn't.

The counselling was good and made me see things from another perspective.
I speak my mind more now.

But I wish I could have had more sessions.
She seemed busy.
It finished too soon.

Victoria

I think counselling's a good thing.
I had counselling before at Relate.
That was good.
It helped us to sort things out while we were breaking up.
Maybe I should have carried on and done some individual counselling.
Instead I just got on with things.

I went to my doctor for something else,
and it was he who thought I was depressed and suggested counselling.
A lot of stuff started to come out.
About the marriage,
but before that, too.
From when I was living at home.

I got worse before I got better.
I went on to the sick with stress.
But it had to come out.

I was on anti-depressants for a while.
I didn't like the way they made me feel like a zombie.
And anyway, they're not the answer.

I have a stressful job.
But now I can handle the stress better.
The counselling helped me to see things differently.
I used to think everything was my fault.
Now I know it's not.

I think it is a huge benefit
to have the counsellor based in the doctor's surgery.
It's a matter of communication.
So much better than the counsellor sending in written reports.
The counsellor kept the doctor updated on my progress.
They had that personal contact.

I think that counselling is such a good thing,
and there's more and more demand for it.
I've enrolled on an Introduction to Counselling course.

Will

I had a break-down on the way to work one morning.
I didn't know what hit me.
I couldn't do anything for months.
I just sat at home, watching the telly.
I couldn't answer the phone to anyone.
And I wouldn't answer the door.

My family were great.
They encouraged me to do things.
At my own pace.

I'd been having trouble with my line manager.
I thought everything was fine,
but looking back,
things had been building for eighteen months or so.

I don't mind being on medication
but I don't see it as a long-term answer.
I'm not ashamed of being on anti-depressants.
I tell everyone.
I make a joke out of it.

I knew a bit about counselling.
In my job as a supervisor
I had to talk to people coming back to work after sick leave.

The counsellor was great.
After just the first session I felt so much better.
She helped me see the bigger picture.
Get things in perspective.
She helped me see it wasn't my fault.

I was so much better I only needed two sessions.
There was a long gap between the sessions.
I was back at work by the time we had the second one.

I still use the book she said I should get.
I find it a good reminder.

I think counselling is great
and there should be more counsellors.

Yvonne

I saw the counsellor
because I was having trouble coping with my daughter's situation.
She was having problems in her marriage
and phoning me up all the time.
It was telling on my health.
I was having anxiety attacks.
I decided I needed to talk to an expert,
someone who could advise me what to do.

Because I don't like to tell all my troubles to my friends.
And they don't really have any answers.

The doctor gave me some anti-depressants as well.
They made me feel dull,
but the anxiety was better.
I still take them now.

The counsellor helped me see things differently.
The counselling was like stripping something off,
then putting something back on again,
only differently.

The counsellor taught me some really useful things.
Like, people have to take responsibility for themselves
– you can't do it for them.
And to tell her not to phone me up in the middle of the night.
I still remember the things she said, and I still use them.

Although my daughter's not properly settled,
I feel better about things now.

And at work.
I was so stressed out before.
Now I think differently about situations.

When I think about it, maybe I've always been this way.
Maybe I could have done with the tablets years ago.
But you can't help the way you are, can you?

I'm back on the waiting list to see the counsellor again.
Things have changed with my daughter.
She's got divorced.
I just want to update the counsellor with what's been going on.

Zena

I've had bouts of depression for the last 20 years.
Since I was forty.
Not the worst kind of depression,
where life doesn't seem worth living.
But times where I just don't want to do anything.
Depression is familiar.
It becomes your friend.

I've always been a friendly person.
But I've always preferred my own company.

I've tried lots of anti-depressants over the years.
They usually have side effects.
Right now I'm on a maintenance dose of Prozac.
Helps keep my head above water.
And seems to help with the aches and pains of arthritis.

Years ago my doctor gave me Valium.
That was in the days when the doctor was God.
He thought I was struggling to cope,
with the four girls being small.
But I loved those days.
I loved it when the girls were young.
It was while I was on them that my marriage broke up.
And my mother died.
I'm quite sure the Valium stopped me grieving properly.
Years later, when I weaned myself off them,
that's when I really grieved.
For my marriage and my mother.

The best thing about the counselling was having time that was <u>mine</u>.
The doctor is always so busy.
No time to talk.

The counsellor talked about useful techniques to help with the depression.
Like making lists.
Go for a walk.
I knew all that before.
But it was useful to hear it again.

For someone who didn't know the techniques,
the counselling would be even more helpful.