

WHAT FACTORS INFLUENCE A  
CLIENT'S CHOICE OF COUNSELLOR  
OR PSYCHOTHERAPIST IN A PRIVATE  
PRACTICE SETTING?

JULIE MAY

DCouns & Psych

2018

## Abstract

This study considered how a client chooses a psychotherapist/counsellor working in private practice. It emerged from a desire to know whether clients made informed choices, which factors influenced their selection and the extent to which they were aware of the regulatory status of the profession. 22 participants including ten psychotherapist/counsellors, ten clients and two other professionals were interviewed using semi-structured interviews. This qualitative study was underpinned by pragmatism, and data was analysed using thematic analysis.

The findings suggested that the primary selection factor was third-party recommendation, and where this option was either absent or undesired, selection was made based on internet searching using location, experience of the presenting issues and the perceived ability to relate to the client. Clients assessed these factors using the photograph and rhetoric on the therapist's website or directory entry, as well as during the first face-to-face meeting, largely relying upon unconscious projection and 'gut instinct'. Factors of limited importance in the selection process included qualifications, professional standing and modality. There was an assumption that the profession was already statutorily regulated and that these factors would be obligatorily in situ, before a therapist could practise privately. The findings suggested little awareness that the responsibility to validate a therapist's professional standing or credibility rests, with the client. A lack of information for both clients and recommenders was highlighted, together with an increased risk for exploitation affecting private practice clients, because of unprotected titles and an absence of minimum education standards for the profession. Recommendations from the research included an increase in public education, urgent debate within the profession of the issues highlighted and support for statutory regulation.

# Contents

<b>Abstract.....</b>	<b>1</b>
<b>List of Tables .....</b>	<b>8</b>
<b>List of Figures .....</b>	<b>9</b>
<b>Acknowledgements.....</b>	<b>10</b>
<b>Author’s Declaration .....</b>	<b>11</b>
<b>Chapter 1 – Introduction .....</b>	<b>12</b>
1.1 Summary of Chapters .....	12
1.2 Contextualising the Researcher .....	13
1.3 Contextualising the Research Within Statutory Regulation .....	15
1.4 Timely Research .....	16
<b>Chapter 2 – Context and Background .....</b>	<b>17</b>
2.1 Historical Context to Regulation of Counselling and Psychotherapy.....	17
2.2 Quantifying the Risks .....	23
2.3 Role of Supervision .....	28
2.4 Regulation of Other Healthcare Professions .....	31
2.5 Mental Health Inequalities .....	33
2.6 Regulation of Counselling and Psychotherapy in other Countries.....	34
2.7 Sociology of the Professions .....	35
2.8 The Private Practice Paradigm.....	37

2.9	Service User Consultation.....	41
2.10	Why Do Therapists Choose Private Practice? .....	42
2.11	Issues Related to Training .....	44
2.12	Aims of the Study .....	47
<b>Chapter 3 – Literature Review .....</b>		<b>48</b>
3.1	Decision Theories .....	48
3.2	Prospect Theory.....	48
3.3	Rational-Emotional Theory.....	50
3.4	Theory of Irrationality .....	50
3.5	Social Functionalist Theory .....	51
3.6	Health Belief Model.....	51
3.7	Theory of Planned Behaviour.....	52
3.8	Existing Studies Exploring Client Choice of Therapist.....	52
3.9	Sociodemographic Variables.....	55
3.9.1	Gender.....	55
3.9.2	Sexual Orientation .....	55
3.9.3	Age .....	56
3.9.4	Ethnicity.....	56
3.9.5	Religion.....	56
3.10	Client and Therapist Attributes .....	57
3.11	Theoretical Orientation.....	60
3.12	Existing Models .....	61

<b>Chapter 4 – Methodology .....</b>	<b>64</b>
4.1 Role of the Researcher .....	64
4.2 Pragmatism .....	65
4.3 Ethical Requirements .....	70
4.4 Client Participant Recruitment.....	70
4.5 Therapist Participant Recruitment.....	71
4.6 Professional Body Spokesperson Recruitment .....	72
4.7 Inclusion/Exclusion Criteria .....	73
4.8 Data Collection Methods .....	74
4.9 Data Collection Process .....	77
4.10 Data Collection Location .....	78
4.11 Data Storage/Confidentiality.....	79
4.12 Consent.....	80
4.13 Analysis.....	82
4.14 Risks to Researcher and to Participants .....	84
4.15 Validity and Reliability .....	86
4.16 Benefits to Participants .....	88
4.17 Pre-Pilot Study .....	88
4.18 Pilot Study .....	90
<b>Chapter 5 – Findings.....</b>	<b>91</b>
<b>Main Theme - Third Party Recommendation .....</b>	<b>91</b>

<b>Main Theme - Location .....</b>	<b>92</b>
<b>Main theme - Therapist Previous Experience .....</b>	<b>92</b>
<b>Main Theme - Ability to Relate to Me .....</b>	<b>92</b>
5.1 Main Theme – Third Party Recommendation.....	92
5.1.1 Sub-Theme - GP .....	94
5.1.2 Sub-Theme - Other Professional.....	94
5.1.3 Sub-Theme – Friend .....	95
5.1.4 Sub-Theme – Another Therapist .....	96
5.1.5 Rationale for Third Party Recommendation Option.....	96
5.2 Main Theme - Location .....	104
5.2.1 Sub-Theme - Proximity to home.....	105
5.2.2 Sub-Theme – Convenience .....	107
5.2.3 Sub-Theme – Practice Setting .....	108
5.3 Main Theme - Therapist Previous Experience .....	111
5.3.1 Sub Theme - Matching my Issue to Therapist Experience .....	111
5.3.2 Sub-Theme - Age.....	113
5.4 Main Theme - Ability to Relate to Me .....	116
5.4.1 Sub Theme - Working Alliance Qualities.....	116
5.4.2 Sub-Theme - Speed of Availability .....	118
5.4.3 Sub-Theme - Therapist Personal Attributes (as relevant to the Client) .....	120
5.4.3.1 Gender.....	120

5.4.3.2 Religious Belief .....	121
5.4.3.3 Ethnicity .....	122
5.4.3.4 Sexual Orientation .....	123
5.4.3.5 Disability .....	124
5.4.4 Sub-Theme - Therapist professional attributes – as relevant to clients.....	126
5.4.4.1 Cost .....	126
5.4.4.2 Modality .....	127
5.4.4.3 Education and Training.....	129
<b>5.5 Assessment of Selection Factors .....</b>	<b>132</b>
5.5.1 Photographs.....	132
5.5.2 Rhetoric.....	136
5.5.3 First Meeting .....	138
<b>5.6 Implications for Voluntary Register.....</b>	<b>140</b>
5.6.1 Assessment of Professional Standing.....	140
5.6.2 Awareness of Professional Bodies.....	142
5.6.3 Making a Complaint .....	143
5.6.4 Awareness of Regulatory Status .....	145
5.6.5 Therapists responsibility to inform their clients.....	149
<b>Chapter 6 – Discussion.....</b>	<b>152</b>
6.1 Summary of Results – Factors Influencing Client Choice .....	152
6.2 Transference and the Unconscious Process.....	153
6.3 Implications for Voluntary Registration.....	155

6.4	Developments .....	156
6.5	Study Limitations.....	157
6.6	Impact on Researcher .....	157
6.7	Reflections for Practice and Recommendations.....	160
6.8	Dissemination.....	163
6.9	Conclusions.....	164
<b>References .....</b>		<b>165</b>
<b>Appendices .....</b>		<b>183</b>
	Appendix 1 – Semi-Structured Interview Questions (Clients).....	184
	Appendix 2 - Participant Consent Form .....	186
	Appendix 3 - Participant Information Sheet.....	187
	Appendix 4 – Semi-Structured Interview Questions (Professional Bodies).....	189
	Appendix 5 - Introduction Letter to Prospective Participants.....	191
	Appendix 6 – Semi-Structured Interview Questions (Practitioners).....	193
	Appendix 7 – Pre-Pilot Questionnaire .....	195
	Appendix 8 – Initial Themes.....	197



## List of Tables

Table 1. Types of Therapist Training.....	44
Table 2. Attachment Styles.....	59
Table 3. Client Participant Demographics.....	70
Table 4. Therapist Participant Demographics.....	71

## List of Figures

Figure 1. Health Belief Model, as adapted from Glanz, <i>et al.</i> (2002) .....	51
Figure 2. Stages of Change Model, as adapted from Prochaska and DiClemete (1983) .....	58
Figure 3. Lamberts Pie, as adapted from Asay and Lambert (1999).....	61
Figure 4. Thematic Analysis Results.....	91
Figure 5. Factors Influencing Client Choice.....	152

## **Acknowledgements**

I would like to thank my partner, my daughters, Charlotte and Sarah and my close friends for all their support during the last six years it has taken me to complete this course. I would also like to extend deep gratitude to my academic supervisors, Professor Diane Waller and Dr Nigel Sherriff for their advice to me and unwavering belief in my ability to complete this most arduous of tasks.

## Author's Declaration

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not previously been submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed

A handwritten signature in black ink, consisting of a series of connected loops and a long horizontal stroke.

Dated 3<sup>rd</sup> October 2017

# Chapter 1 – Introduction

## 1.1 Summary of Chapters

Chapter one presents a brief outline of the thesis, to provide the reader with an overview of the structure and summary of the thesis. Contextualisation of the researcher and the timely nature of the study are discussed.

Chapter two introduces a history of the regulation status of the counselling and psychotherapy profession and situates the study within this paradigm. There is a discussion as to the implications for the profession of the current voluntary register and the limitations affecting clients engaging with therapists who work in private practice, which emerged as a key theme informing the study. The chapter concludes by exploring the potential risks faced by clients who engage privately and stating the aims of the study.

Chapter three situates the study within the context of the current literature and theory. There is an exploration of existing studies which focus on client choice and an overview of decision theories. The chapter then goes on to discuss sociodemographic variables thought to be influencing choice factors.

Chapter four presents pragmatism as the methodology underpinning this study. The role and philosophical position of the researcher are discussed and an outline of research methods, including data collection, inclusion/exclusion criteria, ethical considerations and data analysis are presented. The chapter concludes with an overview of the pre-pilot and pilot studies and their impact on the final research design.

Chapter five outlines the results of the participant interviews, commencing with a summary of the four selection factor themes which emerged and the associated sub-themes. The findings are presented within the context of existing literature and the chapter concludes with an overview of participant awareness of the regularity status, including implications for voluntary registration.

Chapter six discusses the findings in relation to the study aims and the implications for voluntary registration. It includes the study limitations, dissemination, recommendations for future research and provides conclusions.

## 1.2 Contextualising the Researcher

I have worked as a counsellor and psychotherapist for seventeen years and for the last 10 years, I have been self-employed in private practice. I launched a very successful group practice in 2011 and now manage 22 therapists<sup>1</sup> in addition to my own caseload. Syme (1994) defines independent or private practice as:

*accepting private referrals, counselling clients in one's own time, using one's own premise and charging a fee. (Syme, 1994:6)*

I am a member of the British Association for Counselling and Psychotherapy (BACP) and my work is underpinned by adherence to the Ethical Framework for Good Practice in Counselling and Psychotherapy (BACP, 2016). I gained accreditation status as a counsellor/psychotherapist in 2006 and Senior Accreditation status in 2012. When I began my initial studies for certificate and then diploma, it was always my intention to find paid employment. It soon became obvious that paid employment in the profession would be unlikely, as positions simply did not exist and that the only option available to me was private practice. At that stage in my learning I did not feel adequately competent to enter private practice and so went on to study at degree level, continued in placement for a further two years and then achieved BACP accreditation. I reluctantly started my private practice, initially part-time alongside a paid administrative post. Then in 2007, once the business was well established, I became completely self-employed. I now work fulltime in private practice, seeing

---

<sup>1</sup> I am using the term 'therapist' throughout this thesis to denote generically the job title 'counsellor', 'psychotherapist' and 'therapist'. There is much debate within the profession as to whether counselling and psychotherapy are distinct, separate disciplines and whether titles are interchangeable (Dunnett *et al.*, 2007). This issue is outside the remit of this study and my use of the term 'therapist' will enable the reader to set this matter aside.

around 20 clients a week and manage a busy group practice, providing facilities for 22 other independent therapists.

I have evolved from my reluctant start in private practice, to my current position of enjoyment working within this environment and do not now believe that I could return to work for an organisation. I value the freedom to make my own choices but am acutely aware of my increased accountability that this freedom affords, to the BACP Ethical Framework for Good Practice in Counselling and Psychotherapy (BACP, 2016; Bond 2000).

I consider myself to be a passionate advocate of private practice, but also grounded in the knowledge of its inherent potential disadvantages, which I will discuss further throughout this thesis. I am in a privileged position of overseeing many new therapists launching their practices and the vulnerabilities of clients who take myself and my colleagues completely on trust. I have become increasingly intrigued by how clients go about making their selection of a therapist, especially in a market place that is so saturated with potential choice. In my experience, most clients entering my private practice are very distressed, desperate for help and situated in chaos in their professional or private lives. They may often not be in a state of mind appropriate to making a researched, informed choice, when selecting a therapist. Ariely (2009) concludes that an individual's ability to make a rational decision when in an emotionally charged situation, is significantly diminished.

Cognitive psychology offers several theories regarding decision making (Peterson, 2009). Kahneman (2011) discussed the concept of individuals using a set of heuristics, when making choices. In my own practice, clients have shared some of their heuristics involved in choosing to work with myself, many of which are quite questionable within the paradigm of rationality. These heuristics include; liking the sound of my name, my office being at a convenient distance from their home, I was the first therapist to answer the telephone and I have a friendly, well-presented website. It seems that because I use the titles 'counsellor' and 'psychotherapist', clients automatically take me on trust. Kahneman (2011) also offered the idea of a 'halo effect' which he described as a common bias which shapes our view of a person, arguing that if we find one quality within them we like, we will automatically

inflate our overall view of them, generalising the positive and overlooking any negative traits. The halo effect could explain then why a client may conclude that therapists with a friendly sounding name, would also be professionally competent. The professional bodies representing counselling and psychotherapy appear to present the impression to the public that all therapists are equal, but as I will discuss, the lack of statutory regulation means that standards of education, competency to practice, experience and ethical standing, vary considerably. This study aims to investigate upon which factors or heuristics clients might base their decision when selecting a therapist.

My own clients have informed me that looking for a reliable, safe psychotherapist or counsellor is a challenging process. I therefore focused my research on exploring how people go about selecting a therapist. This will include exploring which factors they consider, how aware they are of the existence of professional bodies; the extent of awareness of the complexities of regulation and how do they find out if their therapist is covered by a code of conduct and ethics; how do they make a complaint if they are not satisfied or, if they feel they have been damaged. This is an area that has been under researched in the past., leading to my initial research disturbance and the title of the study (*What factors influence a client's choice of counsellor or psychotherapist in a private practice setting*). As the research progressed, statutory regulation emerged as a major theme, which changed the focus of the study.

### **1.3 Contextualising the Research Within Statutory Regulation**

The last 15 years has seen many changes within the profession in terms of the expectations of therapists, clients and the public. There has been much discussion and debate on the contentious matter of statutory regulation which I will discuss in more detail in chapter two, to situate my study within this paradigm. It became increasing apparent throughout the study journey, that my interest in therapist selection was informed by awareness of client vulnerability, the risks associated with private practice and the potential impact on clients who engage with a non-regulated profession. The profession has no minimum education standards, no agreed ethical and practice competences and is unable to prevent those with impaired fitness to practice from working privately. As the research continued, I became increasing



concerned as to client awareness of the complexities surrounding regulation and whether this influenced the therapist selection process.

#### **1.4 Timely Research**

Shortly before completion of this study, Unsafe Spaces (Dore and Williamson, 2016) published a controversial report which described the voluntary register for the counselling and psychotherapy profession, introduced in 2011, as a “*complete failure*”. The findings were discussed in a meeting between the Government Healthcare Select Committee and the Professional Standards Authority (PSA) who are responsible for managing the voluntary register. During this meeting, the PSA advised that it is currently developing a risk assessment model, to ascertain which professions are suitable for voluntary registration and which are more appropriate to statutory regulate. The model, still currently in development, will include three elements: the risk of the intervention, the context in which it takes place, and the vulnerability of the patient or service user. The PSA stated that it is looking likely that counselling and psychotherapy will be a profession recommended to move from the voluntary register, to statutory regulation (Dore and Williamson, 2016). My study explores these three components and will make a significant contribution to this current area of debate within the profession. This has come at a time, when the Government announced a new regulator for the Social Services profession, Social Work England, which will be established in 2018. Moving away from the Health Care Professions Council (HCPC), Social Work England will be situated within the Department for Education and supported by the Department for Health. Statutory regulation, risks and public protection, would appear to be high on current Government agenda.

Following this introductory chapter, the next chapter situates the study within the context and background of the counselling and psychotherapy profession.

## Chapter 2 – Context and Background

In this chapter, I start with presentation of the background to the regulatory status of the counselling and psychotherapy profession and the implications for the profession, within the paradigm of private practice. In the first section, the historical statutory regulation proposals and the current voluntary register are outlined before then going on to explore the impact this has on private counselling and psychotherapy practice. The chapter concludes by exploring the potential risks faced by clients who engage privately and stating the aims of the study.

### 2.1 Historical Context to Regulation of Counselling and Psychotherapy

This research took place within the context of a recent major shift in Government policy towards the regulation of counselling and psychotherapy, namely a decision by the Conservative and Liberal Democrat Coalition Government (2010-2015) not to continue with the policy of the former Labour Government (1997-2010) to have these professions statutorily regulated by the Health and Care Professions Council (HCPC).

The profession rapidly grew during the latter part of the 20<sup>th</sup> century. BACP figures alone (Aldridge, 2010) state that in 1970 membership levels stood at under 2,000 and today at over 44,000. In 1971, the Foster Report (Foster, 1971) investigated the impact of Scientology, a religious framework rapidly establishing itself in the USA. The report recommended legislation to ensure that psychotherapy in the UK was conducted ethically. This report led to the formation of the United Kingdom Council for Psychotherapy (UKCP) and the Standing Conference for the Advancement of Counselling (SCAC) which later in 1977, became the British Association for Counselling (BAC) and in 2000, the British Association for Counselling and Psychotherapy (BACP).

The issue of legislative involvement and statutory regulation was debated within the profession and by the professional bodies over the next 30 years. There were strong opinions on either side of the debate with the majority favouring statutory regulation, to establish the profession's public status and the minority arguing that

self-regulation was sufficient, dismissing the need for external involvement (Aldridge, 2010).

The historical and sociological factors relating to the discussion to regulate the counselling and psychotherapy profession are succinctly summarised by Sally Aldridge, Director of BACP Regulatory Policy (2006-2014) in her doctoral thesis (Aldridge, 2010). Aldridge suggests that many of these factors had a direct impact on the decision to statutory regulate the profession, including a growing public fear due to the terrorist attacks in the United States of America in 2001 and subsequent attacks in Madrid, London and Bali. She concluded that the Labour Government (1997-2010) showed a greater interest in regulation and surveillance generally, in response to perceived threats from terrorism, national security and a need to reassure the public. The first ten years of the 21<sup>st</sup> century also saw a loss of public confidence in many professions, who were previously held in high regard and considered to be beyond reproach. The banking crisis (2008) led to global recession, exposure of widespread sexual abuse by church clergy emerged, the medical establishment was affected by cases of patient murder, including those of GP Harold Shipman and nurse Beverley Allet, and Social Workers were held responsible for the deaths of several children, including Victoria Climbié (in 2003) and Baby P (in 2009). The Government itself was also implicated, with the expenses scandal becoming exposed in 2009. Statutory regulation was the solution to impose standards and discipline on professions.

In 2001, Lord Alderdice (2001) put forward a House of Lords Private Members Bill, calling for the statutory regulation of the counselling and psychotherapy profession. This eventually led the 2007 White Paper *Trust Assurance and Safety – The Regulation of Health Professionals in the 21st Century* (DH, 2007) which outlined the intention of the Government to statutory regulate counsellors and psychotherapists, alongside applied psychologists, several groups of healthcare scientists and other psychological therapists. The White Paper (DH, 2007) proposed that the regulator for these professions was to be the Health Professions Council (HPC) – later, in 2012, to become the Health Care Professions Council (HCPC). There was disagreement about the appropriateness of the HCPC becoming the

regulator for counselling and psychotherapy, as members regarded the HPC Standards of Proficiency to be based upon the medical model into which the profession did not position itself. To overcome this challenge, three professional bodies: British Psychological Society (BPS), BACP, and UKCP joined forces to suggest an alternative independent, specialist regulator the Psychological Professions Council (PPC). The Department of Health issued a critical and damning dismissal of this proposal in July 2007. The Independent Practitioners Network (IPN) which publishes an online journal *Ipnosis* (Ipnosis, 2007) included extracts of the response on its website, stating:

*Given the history of failure to agree roles, competencies, standards, and interface between these professions, a single specialist regulator could be inappropriate because it could establish a system of roles and standards based on professional vested interests, not on service users' and providers' needs. This would not serve the public interest. (Ipnosis, 2007)*

The opposition to statutory regulation grew pace within the profession and on 9<sup>th</sup> January 2009, an organisation calling itself The Alliance for Counselling and Psychotherapy (ACP) put out a statement (ACP, 2009) expressing the objections to the statutory regulation of the counselling and psychotherapy profession. The organisation stated that its statement represented the views of its 1300 members (approximately 2% of professional body membership at that time). The BACP (Aldridge, 2009) issued a very critical response to this statement, supporting the need for statutory regulating, stating that:

*Professional associations are not able to act as both prosecutor and defence and members often feel unsupported if they are complained against. Members of the public may feel distrustful of a body that claims to investigate and, if necessary, discipline its own members. The UK model is therefore to separate the two. The regulatory council takes over the functions of registration and fitness to practise and is independent of the professions it regulates. This frees the professional associations, such as BACP, to support any of their members complained against, and to develop the profession instead of policing it. (Aldridge, 2009:28)*

In response to the 2007 White Paper (DH, 2007), the HPC set up a working party of interested stakeholders (including professional body representatives, national organisations and service users), known as The Professional Liaison Group (PLG), consisting of 11 professional members from the main counselling and psychotherapy professional bodies and service user organisations, selected using a published criteria, plus six registrant and lay members of HPC. The PLG was chaired by Professor Diane Waller, Council member, art therapist, psychotherapist and co-supervisor of this thesis. The PLG purpose was to make recommendations as to how the profession might be regulated.

The idea of statutory regulation by HPC proved to be highly emotive and Aldridge (2010) discusses the strong opposing opinions amongst the PGL members and the areas of contention describing the process as:

*Jurisdictional battles expressed in professional rivalry for status and superiority between counselling and psychotherapy. (Aldridge, 2010:325)*

The sociology of the professions provides an explanation for these power struggles which are discussed later in this chapter, in section 2.7 (p35).

In December 2009, The HPC (2009b) summarised the areas of disagreement between PLG members as:

- Differentiation between the titles counsellor and psychotherapist and whether the practices of counselling and psychotherapy were one of the same, or totally separate;
- Modality supremacy;
- Education standards and entry requirements and;
- Having a separate registration for therapists working with children and young people.

The HPC held a public consultation on the PLG recommendations, over three months in 2009. Following the consultation, the PLG was reconvened and had its last meeting on 2nd February 2011. Documents summarising the discussions

(HPC, 2009a; 2009b; HCPC, 2011a) show that significant progress had been made towards resolving longstanding conflicts among different modalities and professional groups and in setting both generic and profession specific standards. The remaining conflicts addressed through collaboration between these groups and the path seemed set for statutory regulation.

On 9<sup>th</sup> November 2009, the then Shadow minister for health, Anne Milton, met with the HPC, the professional bodies and other counselling organisations to discuss regulation for counsellors and psychotherapists. The HPC (2009) and BACP (2009) published a summary of the meeting content, both in agreement that self-regulation through professional bodies was failing to protect the public and was no longer a viable option. It was reported that there was significant agreement within the profession and more especially, service users, that statutory regulation was needed. HPC (2009) reported that:

*Anne Milton MP emphasised that the amount of correspondence and lobbying that she had received on the issue of the regulation of psychotherapists and counsellors was different from any previous subject she had dealt with as an MP, both in terms of strength and quantity.*

(HPC, 2009)

This statement suggests that the issue of regulating the counsellors and psychotherapists was taking up a considerable and unprecedented amount of the MP's time, which might have been a factor in the subsequent change of direction.

The Conservative and Liberal Democrat Coalition Government (2010-2015) came to power in May 2010 at a time of worldwide financial crisis and Milton became parliamentary under-secretary of State for Health. In the context of preventing bankruptcy of the nation, the issue of regulating counsellors and psychotherapists became relatively insignificant, as the Government focused on addressing the financial crisis. On 16<sup>th</sup> February 2011, just two weeks after the final PGL meeting, the Secretary of State for Health, Andrew Lansley, after consultation with his colleagues, issued the Command Paper '*Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers*'

(DH 2011a). This document emphasises repeatedly the cost implications for statutory regulation of various professions which was very clearly a major factor in the move away from statutory regulation, to the support of the voluntary registration as the way forward. For the counselling and psychotherapy profession, which had come so close to statutory regulation under the previous Labour Government, this was a complete 'U-turn', following on from the consensus of the meeting in November 2009. The Command Paper (DH; 2011a:3) opens with the statement:

*The coalition government shares the country's trust in those who work in health and social care.*

An interesting statement, in view of Aldridge (2010) analysis of public opinion and confidence in professions at the time, to the complete contrary.

On 17<sup>th</sup> February 2011, the HPC wrote to the Government in response to this Command Paper, to clarify the position relating to counsellors and psychotherapists. In her response, the undersecretary confirmed that statutory regulation:

*Should only be considered where there is a compelling case on the basis of public safety risk and where Assured Voluntary Registers are not considered sufficient to manage this risk. (HPC, 2011)*

The rationale from the Government for this major shift in a policy that had existed for over 20 years was that full statutory regulation was disproportionate to the risks presented for the counselling and psychotherapy profession. It was felt that insufficient proof of risk to the public existed and that such risk could be managed through voluntary registers held by the professional bodies and assured by the Professional Standards Agency (PSA) formally known as the Council for Health Regulatory Excellence (CHRE).

Historically, Lord Benson's criteria (Benson, 1992) had been used to establish a professions' standing and was the basis upon which the HPC provided approval and recommendation for statutory regulation to the Department of Health. The HPC consultation document (HPC, 2009) outlines how each criterion was used to assess counselling and psychotherapy validity for statutory regulation. The Health

and Social Care Act (DH, 2012). Part 7 addressed the issue of regulation and established the power for the PSA to set up voluntary registers for professions not covered by statutory regulation. This effectively took a sharp deviation from the former method of assessment and a new focus on risk. The PSA (CHRE:2010) introduced its eight-element model for identifying, quantifying and managing risk, evolving into the '*Right Touch Regulation*' which now underpins the voluntary register for counsellors and psychotherapists. The risks associated with private practice are now discussed in the next section.

## 2.2 Quantifying the Risks

Setting aside the financial considerations, the rationale for regulation is dependent upon the potential risk of harm to clients. The risks associated with private practice involve both unintentional harm (e.g. caused by therapist incompetence) and deliberate harm. In a profession that has no minimum standards for education, no obligation for professional body membership, insurance or supervision, and where there are limited paid opportunities, driving the newly trained straight into self-employed private practice, the scope for therapists working beyond their capability and causing psychological damage to their client is significant. Confidentiality which underpins the profession means that the identity of clients in private practice remains known only to the therapist. A therapist who wanted to cause deliberate harm, could do so without detection or awareness of any third party. There is also the potential for deliberate harm caused by financial exploitation and other forms of misuse of power and malpractice.

The literature suggests many differing opinions regarding the vulnerability of clients and potential risks. There is evidence from well-established texts such as Masson (1988) and more recently, Lambert and Ogles (2004) in their meta-analysis and Bates (2006) in her collection of client narratives, supporting the view that therapy can and does harm a minority of clients. This harm to clients takes the form of emotional abuse, financial exploitation, traumatisation and sexual misconduct. The foremost opponent to this stance is the Alliance for Counselling and Psychotherapy (ACP), the peer group set up to challenge statutory regulation of the profession in



2009 who argued (ACP, 2009) against the evidence of therapist abuse. In her article published in the BACP journal, Aldridge (2009) succinctly challenged the ACP viewpoint on the issue of risk, suggesting that if as a profession, we would wish for the power of counselling and psychotherapy to be recognised and valued, we must also then accept the potential to abuse this power.

In its July 2007 response dismissing the formation of the Psychological Professions Council, suggested by the consortium of professional bodies, the Department of Health is reported as acknowledging the risks associated with the counselling and psychotherapy profession, stating:

*There is no doubt that applied & practising psychologists, counsellors and psychotherapists meet criteria based on risk and potential harm which indicate their need for statutory regulation. (Ipnosis, 2007)*

The professional bodies all have codes of ethics for their membership to adhere to and a complaints procedure for clients and therapists to raise concerns of malpractice. They publish cases investigated before their internal conduct hearings and post the results on their websites. This information is therefore publicly accessible to those who look for it. The cases with more serious implications for the public, are also regularly reported in the national and local press, ensuring that to some small extent the information is disseminated to those who are most at risk of harm. To provide some idea of the damage therapists have caused their clients, I have reviewed several reported cases:

In May 2014, the BACP investigated and upheld a complaint against Phoenix Counselling Services and its director, John Clapham. The complainant alleged being sexually exploited by her counsellor, after having been coerced into undertaking a form of body therapy, which involved both herself and her counsellor being naked. In its conclusion, the BACP (2014) stated that the client had:

*experienced emotional advantage being taken of her in a sexual nature, which amounted to an abuse of her trust....the Panel was unanimous in its*

*decision that these amounted to serious professional misconduct.*

(BACP, 2014)

The BACP applied its harshest sanction, that being the withdrawal of membership for Phoenix Counselling Service. In response to this investigation, The Daily Mail (2014) reported that Phoenix Counselling Service:

*Denies the findings of the BACP and is no longer connected to that organisation. According to his website, Clapham is still practising and accepting referrals.* (Daily Mail, 2014)

My own research has shown that Phoenix Counselling Services is now trading under a new name but it is unclear as to whether Mr Clapham is continuing to practice, although this remains his choice to do so.

In May 2012, the BACP investigated the case of Lesley Pilkington, a Christian counsellor, who was offering 'Reparative Therapy' (also known as Gay Conversion Therapy<sup>2</sup>). The complainant was a journalist who engaged with Pilkington as a homosexual client, looking to become heterosexual. The case led to much debate within the profession and because of media coverage and the involvement of Geraint Davies MP, a bill was submitted to Parliament in February 2014, calling for the statutory regulation of counsellors and psychotherapists. Although the bill was unsuccessful, this case did lead to the unprecedented publication of the '*Memorandum of Understanding on Conversion Therapy in the UK*' (UKCP, 2014). This document was produced in partnership with the NHS, the counselling and psychotherapy professional bodies and major counselling/psychotherapy organisations, as guidelines for the public and therapist, condemning the practice of reparative or gay conversion therapy. The complaint against Pilkington was upheld

---

<sup>2</sup> Gay Conversion Therapy is a discredited practice usually underpinned by religious views, that falsely claims to change a person's sexual orientation or gender identity or expression. It is a fundamental abuse of human rights and has long been rejected by BPS, APA and all mainstream medical organisations.

by the BACP panel, and her membership withdrawn in September 2012. The Guardian (2014) reported that Pilkington was subsequently accepted for membership with the Association for Christian Counsellors and continues to practice.

In 2013, Kent Online (a regional media company) published an article about the suicide of a nineteen-year-old man, Anthony Dunne, who suffered with severe mental health issues. The report stated that the suicide had taken place in 2004, but that that case was only now, nine years later, being investigated at the inquest. Shortly before his death, Dunne began a sexual relationship with his counsellor, Anita Setz, who was working for a charity which visited offenders in prison. Dunne hung himself, as their relationship was ending, after having violently attacked Setz. At the inquest, Setz was implicated in Dunne's death and showed remorse. In the article, Kent Online (2013) stated:

*Ms Setz tried giving counselling again after the incident but soon gave it up, she told the jury. She is now working as a self-employed horse box driver and a valeting of mobile homes, with no intention ever to return to counselling. (Kent Online, 2013)*

I have been unable to find any evidence to suggest that Setz held professional body membership at the time she was working as a counsellor, or her standard of education, so am unable to suggest whether these were factors contributing to her lack of professional insight into the potential harm commencing a sexual relationship with a client could have. Setz informed the inquest jury that she attempted to return to counselling after her client's death, but chose to stop practising (Kent Online, 2013). It would be quite inconceivable that a medical practitioner implicated in the suicide of a patient in this way would be the position of being able to choose whether to continue practising. There is an apparent disparity between the way professional malpractice of a counsellor implicated in the suicide of a young man with mental health issues is assessed and the death of a patient because of a medical professional's malpractice.

The Adept study (Understanding and Preventing Adverse Effects of Psychological Therapies), funded by The National Institute for Health Research (NIHR) is exploring

when and how therapy can go wrong and whether preventative measures are possible. The preliminary findings suggest a complacency within the profession, an acceptance that sometimes a client will feel worse after therapy and that this attitude is unchallenged. The lead investigator acknowledged that there is evidence to suggest that a small minority of therapists do abuse client trust and some work outside competency (Guardian, 2014a). One preliminary conclusion from this study (BACP, 2015a) is that a client's deterioration is not evidence that they have been harmed by the therapy and concurring with the findings of Lambert and Barley (2001) the quality of the relationship between therapist and client is a key factor for a successful therapeutic outcome. Several recommendations from the initial findings have been published on a website <sup>3</sup> and suggest monitoring the therapeutic relationship, setting expectations and using outcome measures. Interestingly, statutory regulation of the profession has not been recommended, with the investigators suggesting that this could lead to 'defensive practice' as found within the NHS. Instead, it is recommended that therapists learn from the study findings and change to a more open, collaborative practice (BACP, 2015a).

The Clinic for Boundary Studies is an organisation which supports victims affected by professional boundary violations and offers therapist training. The clinic does not focus exclusively on the counselling and psychotherapy profession, but more broadly upon boundary transgressions within all professions. The organisation argues that all therapists have the capacity to transgress and that complaints are under reported, due to the power dynamics within the relationship (Coe, 2014:92). Additional risks identified include the therapeutic process, commitment to supervision and the arena of private practice offering minimal external scrutiny, presenting a greater threat of professional boundary violation and the ability for a therapist to be able to harm clients.

---

<sup>3</sup> <http://www.supportingsafetherapy.org/>

Studies have been carried out exploring the impact of the practice setting (Elliott, 1972; Carlin, 1962) and potential correlation with ethical violations. Carlin (1962) investigated lawyers in different settings and concluded that ethical violations, particularly client exploitation, were greater in independent, solo practices, which he suggested was because of the client being:

*Less intelligent than the lawyer, less expert, lacking in social backing and power and as most low-status legal problems are non-repetitive, unlikely to be a source of further business for the lawyer. (Carlin, 1962:120)*

Whilst it would be inappropriate to directly compare the American legal profession with the UK counselling and psychotherapy profession, practice setting would seem to be a relevant factor when assessing risk to the public.

### **2.3 Role of Supervision**

Supervision is, for members of the BACP and UKCP at least, an ethical requirement. Loganbill *et al.* (1982) define supervision as:

*An intensive, interpersonally focused, one to one relationship in which one person is designated to facilitate the development of therapeutic competence in the other person. (Loganbill et al., 1982:4)*

Proctor (1988) explains the three tasks of supervision as formative, restorative and normative, adapted to the developmental needs of the therapist. The formative task is about education and skills development, restorative is focused on processing emotion and debriefing and the normative task focuses on looking at blind spots and transference acting out with the therapist and identifying growing edges. I have always historically felt that supervision is a safety net for the client, with the supervisor holding responsibility for monitoring competency, a view supported by Hawkins and Shohet (2006) who state that supervisors:

*Have some responsibility to ensure that the work of their supervisee is appropriate and falls within defined ethical standards.*  
(Hawkins and Shohet, 2006:58)

I am now aware that this viewpoint is somewhat naïve and have come to question the power of supervisors in carrying out the task of monitoring competence and upholding ethical standards. During this study, I encountered a therapist (an accredited BACP member) whose practices raised ethical concerns. I became aware of abuses of power, consistent blurring of professional boundaries and behavior which was to the detriment of both clients and colleagues. In line with the BACP Ethical Framework (BACP, 2016) I brought my concerns to the therapist's attention and was met with an abusive denial and an inability to reflect upon her conduct, which further reinforced my fears for her mental health. Thus, I dismissed the therapist from my group practice, citing my duty of care to her, to her clients, my colleagues and the reputation of the group practice (BACP, 2016). Whilst my actions served to protect the clients using my group practice, they did not prevent the therapist from continuing to practice elsewhere nor her current or future clients at other practices. I became aware that the therapist had a history over many years of being dismissed by training institutions, numerous supervisors, training placements and employers, who all had questioned her competency to practice, following behavior like that of which I had experienced. Despite the frequent dismissals, the therapist had never addressed her behaviour and continued in private practice, working with adults, young people and children and supervising other therapists work. I referred my concerns to the BACP and to my own clinical supervisor who validated my decision to remove the therapist from my practice. I was informed that unless the BACP received a formal complaint from myself, a colleague or one or more of her clients, dismissal from the group practice was the only action which could be taken.

I deliberated upon making a complaint and eventually concluded that I was not prepared to put myself through the emotionally traumatic experience. At best a formal complaint would lead to the termination of the therapist's BACP membership, which would not prevent her continuing to practice, or protect further clients from harm, as would be the case, if the profession were statutory regulated. I reflected upon the rationale of the other professionals before me (trainers, placement managers, supervisors, employers and colleagues) and her former clients for not making a formal complaint and concluded that like myself, they were likely to feel

vulnerable and foolish for enabling the behaviour and powerless to remove her from practice.

Shortly after this experience, I commenced supervision training myself and discussed the competency to practice issue at length with my peers and trainers. I concluded that as a supervisor, the only options to manage a supervisee whose competency to practice is in question, would be to make a formal complaint to their professional body or terminate their supervision contract with myself. As discussed, neither action would prevent the therapist continuing to practice. As such the profession, arguably both colludes and facilitates their members in incompetent practice which has the potential to harm clients. The literature does not offer much guidance in managing incompetence within the supervisee. Wheeler and King (2001) only refer to the incompetent trainee supervisee, being held back from seeing clients until competency can be established, but completely overlook the trained therapist acting unethically. Carroll (1996) acknowledges that the supervisor holds a 'gatekeeper' role over the supervisee's work with clients, and from his own study in the area, concluded:

*They (supervisors) will confront bad practice, take steps when they have worries about the professional conduct or abilities of their supervisees and in extreme cases, suggest someone gives up counselling, at least for some time. There was an element of anxiety expressed throughout the interviews about negative evaluation of ethical issues. (Carroll, 1996:68)*

As Carroll (1996) reiterates, the supervisor can only make a recommendation and not insist on a course of action. The latest version of the BACP Ethical Framework (BACP, 2016) states:

*When supervising qualified and/or experienced practitioners, the weight of responsibility for ensuring that the supervisee's work meets professional standards will primarily rest with the supervisee. (BACP, 2016:11)*

The profession acknowledges that when supervising a trainee therapist, there is a role for monitoring competence, but once training is complete, it would appear to

consider that a therapist can self-monitor competency. When we consider that the profession has no agreed minimum education standards and that 'qualified' could constitute a five-minute online course, it could be argued that this is potentially very dangerous practice. In addition, supervision is only an ethical requirement to those therapists who choose to hold relevant professional body membership. One professional body, the National Counselling Society (NCS), holds voluntary registration with the PSA, but does not make supervision a compulsory contingent to practice for its members.

## 2.4 Regulation of Other Healthcare Professions

The debate as to whether clients are vulnerable and at risk of harm continues. In its 2010 paper, the PSA (formally CHRE) (CHRE, 2010) explained its rationale for supporting '*Right Touch Regulation*' stating that it was common sense and proportionate to risk, accepting however that:

*There is an inherent risk in all interventions in healthcare and nothing can be said to be completely safe. (CHRE, 2010:9)*

In this section, I will discuss how other healthcare professions have managed the issue of regulation and the rationale for and against the statutory position.

Several professions in recent history have made the switch from voluntary regulation to statutory regulation. A closely aligned profession, art therapy became statutory regulated in 1997, achieving protection of title in 2005. In their article comparing experiences of the regulation of art therapy with counselling and psychotherapy, Waller and Guthrie (2013) suggested that the rationale for art therapy statutory regulation was to provide the public with clarity about their activities and to protect them from untrained therapists. This rationale for the statutory regulation of art therapy resonates very closely for me with the very similar needs of the counselling and psychotherapy profession. However, art therapy became regulated under the Benson criteria, so it is questionable whether they would be seen to present significant risk under the current criteria used by the government. It is notable, that unlike counsellors and psychotherapists, most art therapists work within the NHS



(Waller and Guthrie, 2013), and it is questionable as to whether this was a factor driving statutory regulation.

Dance movement psychotherapy, arguably the approach in the arts therapies involving most risk in that it requires physical intervention in movement patterns, has not succeeded in becoming statutorily regulated. The profession missed the opportunity earlier on, even though their petition was approved by the then HPC in 2004 under the Benson arrangements. It is too small a group now to establish a voluntary register under PSA arrangements. The only safeguarding put in place by the profession itself is a voluntary register, that due to resource reasons, cannot meet the PSA criteria for accreditation thus causing confusion not only to members of the public but also to employers.

The psychology profession eventually became statutorily regulated in 2009. The British Psychological Society (BPS) first applied to the Health Professions Council for the statutory regulation of psychology in 2002. Within the profession, there was discord like the counselling and psychotherapy profession, of not feeling aligned to the medical model and questioning the HPC as an appropriate regulator. This application was withdrawn and the BPS partnered with the counselling and psychotherapy profession, which collaborated in producing the unsuccessful proposal to the Government in 2006 to create the Psychological Professions Council. Following this failure, the BPS renegotiated with the HP and eventually in July 2009, the 'register for applied psychologists' opened, protecting nine different working titles and setting qualification entry standards. It is notable that most psychologists work in the public sector, although private practice is becoming more popular (Careers in Psychology, 2015) and I again question whether this was a factor affecting the rationale for statutory regulation of the profession. Similarly, the counselling and psychotherapy profession is situated outside the dominant medical paradigm and the inequalities between physical and mental ill health are explored in the next section.

## 2.5 Mental Health Inequalities

Mental health in the UK is well recognised as having a lower status of importance, compared to physical health (NHS England, 2013) reflected in terms of NHS funding, despite it affecting the population in far greater volume compared to physical health. NHS England (2013) states that mental ill health affects half the population under 65 years, but that only 25% receive NHS treatment. They compare this figure to physical health conditions and the percentage of those affected receiving treatment, which are diabetes 94%, hypertension 78% and heart disease 78%. The figures for the population seeking private treatment for mental health are unknown, but the statistics produced by the NHS England remain shocking and instigated a new programme, *The Parity of Esteem* launched in 2013, focusing on redressing the inequalities.

In April 2012, the Royal College of Psychiatrists (RCP) was asked by the Government to produce a paper advising how to achieve parity of esteem between mental and physical health in practice. In March 2013, the RCP (2013) published its open paper '*Whole-person care: from rhetoric to reality. Achieving parity between mental and physical health*'. The forward written by Professor Sue Bailey, President of the RCP (2013) gives an emphatic acknowledgement of the inequality in mental health stating:

*In our society, mental health does not receive the same attention as physical health. People with mental health problems frequently experience stigma and discrimination, not only in the wider community but also from services. This is exemplified in part by lower treatment rates for mental health conditions and an underfunding of mental healthcare relative to the scale and impact of mental health problems. (RCP, 2013:4)*

The report (RCP, 2013) goes on to make a further acknowledgement and recommendation about the way mental health professionals are experienced by other health professionals:

*No part of the NHS should tolerate professional attitudes, behaviour or policies that stigmatise mental illness and thus contribute to the discrimination experienced by people with mental health problems. Unless such attitudes are challenged and changed, mental health will not gain parity with physical health. An element of this is showing the same respect to mental health professionals as to professionals working in other areas of health, as the stigma associated with mental health can also affect the esteem in which they are held. (RCP, 2013:10)*

Although these comments are directed to the attitudes towards mental health professionals within the NHS, they could also apply equally to all mental health professionals, including counsellors and psychotherapists. It is one explanation as to why counsellor John Clapham, found by the BACP (2014) to have committed serious malpractice, can continue practising, and a dentist, GP or nurse behaving similarly, would be struck off their respective registers and forbidden to have future access to patients. The disparity between mental and physical health, extends to the judgement and accountability of malpractice by its professionals. It would be inconceivable that a physical health professional implicated in the death of a patient would be able to continue practising, but cases within the counselling and psychotherapy profession, such as Setz (Kent Online, 2013) highlight the different accountability placed upon mental health professionals.

I will now discuss how other countries have managed the issue of regulation for counsellors and psychotherapists.

## **2.6 Regulation of Counselling and Psychotherapy in other Countries**

Reviewing the regulatory status of the counselling and psychotherapy profession in other countries, revealed a very confusing picture. The issue of whether to statutory regulate the profession or not, seems to have divided opinions worldwide. In the USA, the profession is regulated at state level and it is illegal to practice without a licence (Counselling Resource, 2015) and in Canada, 3 of its 10 provinces have statutory regulation for the profession (Martin, 2013). In Australia, the Psychotherapy and Counselling Federation (PCFA) carried out a review and the final report published in

February 2008, emphatically supported a system of self-regulation involving a national voluntary register. Unlike the voluntary registration opted for in the UK, the Australian version included minimum education standards for entry to the register (PCFA, 2008).

Throughout Europe, counselling and psychotherapy are more widely seen as separate professions. 10 of 27 countries currently have some form of regulation for psychotherapy, together with the protection and minimum education standards (Warnecke, 2010). The statistics for counselling are unclear, with some countries such as Italy, seeing it as a newly emerging profession (Remley *et al.*, 2010)

## 2.7 Sociology of the Professions

The sociology of the professions offers a framework within which to situate the structure, dynamics and conflicts of the counselling and psychotherapy profession. Theorists have been influenced by the concept of capitalism (Marx, 1990) and the theory of stratification or social advancement (Weber; 1992). Sociology of the professions emerged in the 1950s with functionalist authors such as Durkheim (1957; 1958) suggesting that the ethical standing of professions was in some way underpinning the stature of civilised society. By the 1970s however, theory was more influenced by Foucault (1980) and focused on the impact of power dynamics. (Johnson, 1972; Freidson, 1988). Larson (1977) argued:

*Professionalization is thus an attempt to translate one order of scarce resources – special knowledge and skills – into another – social and economic rewards. To maintain scarcity implies a tendency to monopoly: monopoly of expertise in the market, monopoly of status in a system of stratification.*

Burrage and Torstendahl (1990) elaborating on Larson's work, offered an actor based framework for the sociology of the professions, exploring the interactions between the different parties involved in maintaining the profession. This framework has been helpful for me, in terms of identifying the contributing pillars within my study: therapists, Government, clients/public and the role played by the educational establishments. More recently, Morrell, (2013) suggested that professions gain value

in society and take control over their knowledge base, which he terms “*epistemological autonomy*”. He stated that all professions are hierarchical and that this encourages internal power struggles and a conformist culture. Referring to the relationship a profession has with the public, Morrell (2013) argued:

*There is thus an intrinsically ambivalent and conflict-ridden relationship between members of a profession and the public they serve, often described as paternalistic. This sense of dislocation from the rest of society breeds paternalism and professional arrogance as well as a cold indifference, professional distance, with which they are liable to treat their clientele. Being paternalistic is an aspect of the sense of elevation, demarcation and underpinning arrogance of members of all professions as a self-acknowledged elite social group, and it runs in the feeling they have of higher status and of being demarcated from the host society as special and elite, privileged persons with a specialised technical knowledge and expertise that places them above most of the rest of society.*

The rhetoric used by Morrell is very strong, but his view can be supported in relation to the counselling and psychotherapy profession. The public and therapists have been arguable marginalised by the government and the professional bodies, having been excluded from the process of deciding the best approach for safeguarding our profession. The rhetoric used by the PSA (CHRE 2012) can be interpreted as patronising and degrading towards the public, with an assumption that the public is ignorant and incapable of understanding complex procedures. Morrell argues that professions need a code of practice to maintain society’s high regard and to be seen as credible. He suggests that external regulation is necessary for upholding these principles and as justification to the public, that the profession deserves its position in society. Johnson (1972:820) offered a rationale for the professional bodies preference for voluntary registration, rather than statutory regulation:

*Where the functions of maintaining standards are taken over by state agencies, or are provided for in legislation, the association is transformed into an occupational pressure group, effectively losing its powers to prescribe the manner of practice.*

Macdonald (1995) explored the relationship between professions and the state and establishing the 'regulative-bargain'. Referring directly to the experience of the accountancy profession, he suggests that internal conflict within professions is the cause of delay in state registration or regulation. Macdonald (1995:119) concludes:

*Dissent within an occupation seems to be more significant than anything else in determining the direction in which the state/profession relationship develops. The roots of discord lie in forms of professional organization and in the nature of professional knowledge and practice and as these are bound to change, internal or internecine conflict may at any time re-emerge as the dominant influence on a profession's development and thus on its relation with the state.*

## **2.8 The Private Practice Paradigm**

In this section, I will discuss the issues my study focuses upon which are especially pertinent to the private practice paradigm. The fact that 'right touch regulation' is still voluntary raises many concerns and has not resolved the current and continuing situation, that legally, anyone can practice as a psychotherapist and counsellor with no training and no adherence to a code of conduct and ethics.

Attempting to estimate the extent of private practice within the profession is complex. The BACP provided figures of professional body membership, showing a total membership of over 75,000 broken down as follows:

- BACP 41, 500 individual members and 1,031 organisational members;
- BPS 18, 629 chartered members (not all are practitioners);
- United Kingdom Council for Psychotherapy (UKCP) 7,000 individual members;
- British Psychotherapy Foundation (BPF) 700 qualified members;
- British Association for Behavioural and Cognitive Psychotherapies (BABCP) 6,400 and;
- British Psychoanalytical Council (BPC) 1,450 registrants.

In the interim report on the mapping of counselling and psychotherapy, prepared for the Department of Health, Aldridge and Pollard (2005:28) stated that 73% of psychotherapists and 50% of counsellors work in private practice. The accuracy of these figures is questionable as they are based upon professional body membership. It is unknown how many counsellors and psychotherapists are practising without professional body membership. Those without professional body membership are unlikely to be in employment and more likely to be in self-employed private practice. The numbers practising privately are then, quite probably, much higher than the figures prepared by Aldridge and Pollard (2005). These figures contrast with the information provided by the Department of Health for the regulated professions (DH, 2011:7) where the overwhelming majority (72%) are employed by the state. This suggests a difference for counselling and psychotherapy, compared to other professions.

The DH Enabling Excellence White paper (DH, 2011a) does acknowledge the existence of self-employed therapists, but repeatedly throughout the document refers to organisational and employment settings and the role they play in safeguarding the public from malpractice, stating:

*The vast majority of healthcare workers, social workers and social care workers do not strive to provide excellent care because they fear regulatory action if they do wrong or because they are told to do things properly. They do so because they are caring people, who are well trained and well-motivated. They do so because they work in teams with people who share those characteristics. They do so because the organisations they work in are well led, in touch with professional values, and driven by a commitment to the individuals, families and communities that they serve. (DH, 2011a:4)*

As I have already shown, the assumption that most professionals work in teams and for employers, does not apply to the counselling and psychotherapy profession. The DH (2011a) does acknowledge the possibility that for the self-employed, the public are at a greater risk and that statutory regulation might be more appropriate:

*We recognise that there are limitations to the model of assurance described above for some groups of workers and, particularly for self-employed practitioners, there may be no team or employer present. Indeed, people using personal budgets or direct payments to meet their support needs may actually be the employers of those providing them with services. In a limited number of cases therefore, statutory regulation may be the only way of effectively mitigating against risks to people using services, although it would need first to be clear that assured voluntary registration would be insufficient to help guide choices by commissioners and patients. (DH, 2011a:8)*

I conclude from this statement that the DH accepts the greater risk to the public from self-employed therapists, particularly when we bear in mind that the voluntary register has not been publicly advertised. No studies have yet been carried out to assess public awareness of the voluntary register and the counselling and psychotherapy profession has a proportionally high number of private, self-employed therapists. Interestingly, DH (2011a) accepts that the voluntary registration system will only safeguard the public if therapists choose to join it and if the public are aware of its existence.

*Individual members of the public seeking care from self-employed practitioners will be able to choose to go to practitioners on an assured voluntary register. Independent practitioners themselves will take a judgement on whether to join the register in order to attract more patients or clients. To underpin this, we will need to ensure that members of the public, including those managing their own care, have adequate and appropriate information to enable them to make informed decisions about arranging their own care with independent practitioners. (DH, 2011a:18)*

Six years on from this statement, there has been no advertising campaign to the public and as a private therapist, I have seen no increase in clients engaging with me based on my registration. I intend to explore this with my study participants and ascertain on that very small scale, their knowledge of the regulatory status of the profession.



In the later document, '*Standards for Accredited Registers*', the PSA (2013) supports the voluntary register, for which it now has responsibility concluding that it offers '*right touch regulation*', a balance between assessing risk and promoting good practice. Responsibility for assessing risk has been passed by the PSA to the professional bodies whose registers it has approved, who are obliged to remain:

*vigilant in identifying, monitoring and reviewing risks associated with the practice of its registrant.* (PSA, 2013:3b)

If a therapist is not then a professional body member, the client becomes solely responsible for identifying, monitoring and reviewing risks. My study questions whether the client participants are aware of this responsibility to risk assess and how to do so. I also intend to clarify with the professional bodies how they have disseminated awareness of the voluntary register to the public and the measures they are taking to ensure this knowledge is reaching the clients.

Within the statutory services (NHS, Social Services etc.) it is highly unlikely that any psychotherapist or counsellor could be employed unless they held at least a recognisable qualification or were a member of one of the larger professional bodies (BACP or UKCP for example). They would have been subject to stringent employment conditions and be managed within a team, referred to by Syme (1994) as the "*institutional buffer*", but in private practice, this is a different matter. Anyone can set up a private practice, advertise for clients and call themselves a psychotherapist or counsellor. It is therefore in this area, that the public are at greatest risk.

Syme (1994) discussed the effect of clients being unable to screen the self-employed and therefore having to take the private therapist at face value. She suggests that employed therapists pass a recruitment selection process and as such would have been chosen from a range of applicants, presumably by an experienced manager and Human Resources representative. This filtering of applicants would ensure that the candidate offered a position, would be the most suitably trained and experienced individual. Therapists in private practice are not subject to any selection process and have no employer to take on the responsibility of short listing and

filtration. There was an acknowledgement of this issue by the DH in its Health and Social Care Bill (DH, 2011), and it stated that the burden of responsibility rests with the client when there is no employer and the therapist is working independently. Syme (1994) concurs that responsibility to establish a private therapist's credentials is passed to the client and questions whether they are aware of this. The Health and Social Care Act (DH, 2012) opens opportunities for counselling/psychotherapy services previously offered by the NHS, to be outsourced to the private sector, extending the void of employer responsibility even further for the future. The PSA (2013) argues that management of this risk is the shared responsibility of all parties involved, including the therapist, the profession, the law, the public and the employer. It is very questionable how this model can work if the public are unaware of their responsibilities and there is no employer involved in the equation.

## **2.9 Service User Consultation**

Consultation with service users has a well-documented history and is a crucial aim of my study. Lyotard (1988) suggested that in health and social care research the layperson holds untapped professional knowledge. User involvement has been the cornerstone of Government policy since it was enshrined in the Health and Social Care Act (DH, 2001)<sup>4</sup> and The National Institute for Mental Health in England (NIMHE, 2003) suggested that users are experts of their own experiences of mental health disorder and the mental health services offered, a view supported by Mind (2009). The PSA (CHRE, 2010) suggest that they did undertake some service user consultation prior to the launch of the voluntary register, which informed them that the public was generally confused. From this, the PSA concluded that a simple, straight forward-solution was required. I am questioning whether voluntary regulation can be considered as the simple approach in direct comparison to a statutory option. Unless clients are aware of the existence of a voluntary register, and therapists choose to join it, voluntary regulation is pretty much the system we have always had

---

<sup>4</sup> The Health Act of 2001 created the Health Professions Council (now known as The Health and Care Professions Council) which regulates 16 professions, including art therapy, psychology and social work. Protection of title is a key element of statutory regulation.

in place, which, the PSA (CHRE, 2010) themselves concluded as being confusing and difficult to navigate. The PSA (CHRE, 2010) does state that Right Touch regulation is underpinned by the “*active participation of citizens*”. (CHRE, 2010:8)

As there are few existing studies which have explored client selection of a private therapist, I have therefore concluded that many assumptions have been made about levels of client knowledge, without grounding the assumptions in empirical research evidence. I have also been unable to locate any evidence of dissemination to the public, following the launch of the voluntary register by the PSA, although all the professional bodies have information accessible to the public, on their websites.

From the perspective of service user consultation, my aim through interviewing clients, was to give them a voice to express their views. I wanted to explore which factors had affected their choice when selecting a private therapist and their levels of knowledge about the complex issues I have discussed. Interviewing therapists gave me an insight from their alternative ‘insider’ perspectives.

## **2.10 Why Do Therapists Choose Private Practice?**

Many therapists are attracted to private practice because of a lack of employed work opportunities within the profession. King (2007) concluded that the motivation for trainees coming into the profession is often a means to increase income and that they are then disillusioned with the reality of the scarcity of available positions. The absence of paid work is in part due to the limited empirical evidence validating therapeutic efficacy and well-documented challenges (McLeod, 2001; Lambert and Ogles, 2004; Cooper, 2009) in collecting such quantitative data. In 2006, the Government launched IAPT (Improvement of Access to Psychological Therapies), based on the recommendations of Lord Layard (2005) for the NHS to offer patients a centralised service. The National Institute for Health and Care Excellence (NICE) approved psychological support for the treatment of depression and anxiety disorders. NICE recommends only evidence based therapies, leading to the side lining of some modalities of counselling and psychotherapy and the promotion of Cognitive Behavioural Therapy (CBT). This has resulted in some counsellors and psychotherapists, practising in non-CBT modalities, losing their paid employment

with the NHS and an effective block on newly trained counsellors and psychotherapists from gaining employment with the NHS (Marguerite, 2004; Hadfield, 2015). Therapists had a choice to either retrain to qualify as an IAPT therapist or to set up a private practice. Counsellors and psychotherapists invest heavily in their training, both financially and with their time, with an obligation from their training institution to work on a voluntary basis over several years, before they can achieve their counselling/psychotherapy qualification. Quite understandably, once trained, therapists expect a return on this investment and often the only option to achieve this is self-employed private practice. Schools, further education colleges and universities have, in the past, been the other common employer for counsellors (Feltham, 2000) however, since the Government austerity cuts, these positions are being increasingly eroded (Owen-Pugh and Jewson, 2015).

Private practice within the counselling and psychotherapy profession has, historically, always been considered appropriate only for very experienced therapists who are adequately prepared for the ethical challenges (Bond, 2004; Syme, 1994; McMahon *et al.*, 2005; Hemmings and Field, 2007). Certainly, within the BACP, accreditation has been the benchmark level at which a therapist can practice privately. The online information accompanying the therapist accreditation application pack, (BACP, 2015) suggests that the standard for accreditation is “to *demonstrate the capacity for independent, competent, ethical practice*”. (BACP, 2015)

Increasingly, I am finding therapists coming straight from completing their diploma course and approaching my group practice, asking to be recruited. Historically, this would have been quite exceptional and is perhaps a reflection of the austere times we are currently living in, with the lack of paid employed positions for counsellors and psychotherapists. It makes me question the numbers of unsupervised self-employed lone therapists who perhaps, unknown to themselves, are working way beyond their competency or experience and present a potential risk to their clients. Owen-Pugh and Jewson (2015) made the very same conclusion, citing the potential income, as the factor blinding the newly trained into private practice, directly from training, rather than considering a diploma as the conclusion of initial study with

a need to develop expertise with ongoing training and learning. The long-held belief that maturation and career development for counsellors and psychotherapists is a life-long process (Ronnestad and Skovholt, 2003) would seem to be under challenge from new entrants to the profession.

In the next section, I will discuss what exactly constitutes a trained therapist and the simple misnomer of the term 'qualified therapist'.

## 2.11 Issues Related to Training

The table below shows the plethora of training from which a potential therapist can choose. Typically, students start at introduction level and previous learning is considered as a pre-requisite before acceptance to the next level. For instance, most diploma courses would expect an applicant to have first completed a certificate, and Bachelor's degree courses would not normally accept an applicant who had not completed a diploma first.

Title	Duration	Content
Introduction	6-12 weeks	Basic skills
Certificate	1 year part time	Overview of theory and skills
Diploma (also, Post-Graduate Diploma and Advanced Diploma)	1 year full time or 2 years' part time	In depth understanding of theory and practice
Bachelor's degree	1 to 2 years' part time	Additional training in specialist areas and research module
Master's degree	1 to 4 years' part time	In depth training in specialist areas and research project
PhD and Professional doctorate	Up to 6 years	Professional Researcher training and opportunity to make a unique contribution to knowledge.

**Table 1. Types of Therapist Training**

In the absence of any minimum education standards, establishing the credibility of a private therapist is extremely difficult. As the manager of a group practice, I am regularly approached by therapists looking to rent a room and establish their own

practices, using the legitimacy and reputation of my business name that has built up over many years, as a spring board. I have adopted the BACP (2016) minimum education standards for colleagues wishing to join the practice which the BACP has set for membership criteria. This standard is for the therapist to hold a diploma in counselling/psychotherapy studied over one year full-time, or two years' part-time, comprising 450 hours of taught tuition, and 100 hours of supervised face-to-face placement. I am regularly approached by therapists who state that they hold a counselling/psychotherapy diploma and are a 'fully qualified counsellor or psychotherapist' only to discover they have studied online with no direct personal interaction with a lecturer or have completed their studies over a handful of weekend workshops. Increasingly, I am also meeting therapists who have never worked in a placement or had any experience of face-to-face client work. It concerns me that trainees' sign up to courses on the promise that they will be competently trained for work in private practice. Arguably, they have not studied to an adequate depth and thus are likely to be unprepared for private practice.

Within the profession, it is readily accepted that private practice should only be undertaken by the experienced (Syme, 1994; McMahon *et al.*, 2005) and yet these newly trained therapists frequently approach me. As an experienced therapist, I am fully aware that a diploma in counselling or psychotherapy cannot be taken at face value and that criteria for the award varies. I would question whether a client in crisis, looking for a private therapist, would be aware of their responsibility to validate the therapist, let alone make enquiries into the credibility of their 'qualifications'.

The confusion over comparing therapists is further complicated by the different membership standards adopted by professional bodies. The UKCP offers either individual or organisational membership and does not have an accreditation membership category. The UKCP does, however, dictate expected membership training standards of a course lasting three years, consisting of a minimum of 450 taught skills hours and a minimum of 105 hours of personal therapy. To achieve accreditation status with the BACP, a member must go through an application process, complete study equivalent to 450 tutor contact hours and have completed 450 face-to-face supervised client hours over a period of three to six years (BACP,

2015). The National Counselling Society (NCS) offers a member accreditation status, which requires the therapist to have simply completed one of its approved courses. In recognition of a shortage of placement opportunities, NCS (2015) do not expect an accredited member to have undertaken any face-to-face client hours or have any obligation to regular supervision. Both the BACP, UKCP and the NCS operate a voluntary register accredited by the PSA and members of any can, therefore, advertise their creditability using the PSA logo. How is a client able to differentiate between the levels of experience and credentials of a private therapist who advertises themselves as MBACP (Accred) or MNCS (Acc) or UKCP and the very same PSA Voluntary register logo? The standards of education and clinical experience needed to achieve accreditation with each organisation could not be any more at opposing ends of a spectrum, but are clients aware of this fact when they make the choice of therapist?

To summarise, being a 'qualified therapist' is a very difficult term to quantify. As the title counsellor, psychotherapist or therapist are not protected, anyone can legitimately use the title without any training or education at all. Professional body membership (if any) dictates at what level a therapist is classed as 'qualified'. The BACP (2015) considers, a diploma in counselling and/or psychotherapy the minimum standard, whilst UKCP (2015) considers three years of training acceptable for a psychotherapeutic counsellor, but raises the standard for psychotherapists to having undertaken post-graduate study.

The issue of inconsistency in the levels of therapist education and training, is a significant theme throughout this study. I was interested to understand the participant's awareness of this and any impact on the therapist selection process. I will now summarise the study aims.

## 2.12 Aims of the Study

- Explore which factors clients consider when selecting a private therapist;
- Explore client awareness of the complexities around the regulation of the profession and whether this is an influencing factor in the selection of a therapist.

Chapter three will now discuss the existing literature and how this relates to this study.



## Chapter 3 – Literature Review

This study is exploring the heuristics client's use to select a therapist working in private practice and the extent to which this choice is informed by awareness of the complexities surrounding the profession's regulatory status. This literature review chapter commences with an overview of decision theories and the cognitive psychology of decision making. It will then explore existing studies looking at client choice and discusses sociodemographic variables thought to be influencing factors. The chapter then concludes with exploring the relevance of clients' ability to choose a therapist and the potential impact on therapy outcome.

### 3.1 Decision Theories

This study draws upon cognitive psychology and various decision theories. Decision theories can be categorised into either normative theories, which explore how decisions should be made to be rational, or, descriptive theories, which explore how decisions are made. I will present a brief overview of several theories which have influenced my thinking throughout this study.

### 3.2 Prospect Theory

Prospect theory (Kahneman and Tversky, 1979) suggests that people make decisions based upon the value of losses and gains, rather than upon the therapeutic outcome itself. They evaluate the losses and gains using heuristics, a set of cognitive judgements. Several theorists, including Dewey (1910) and Brim (1962) have developed sequential models to show how people follow a set of stages to make decisions. Prospect theory is informed by the heuristic sequential model (Simon, 1960), and the three stages; 'intelligence', 'design' and 'choice'. Prospect Theory (Kahneman and Tversky, 1979) suggests how people choose between different options and that this choice can be predicted. The key factors are:

- Certainty – People are willing to pay more for a guaranteed result;
- Loss Aversion – More weight is given to what we can lose, rather than what we can gain when assessing the heuristics;

- Relative Positioning – Comparison to others makes a person feel in an elevated place;
- Small Probabilities – If the probability of disaster is low, people will take higher risks;
- Weighting Characteristics – Some characteristics carry greater weight than others and influence the decision more than others.

Kahneman (2011) discusses how people process and make decisions in two completely different ways, which, he has labelled System 1 or Fast Thinking, and System 2 or Slow Thinking. System 1 thinking is based upon our past experiences and intuitive preferences. It is automatic and informed by our beliefs, social norms and conditioning which underpin our heuristics. System 2 is referred to as analytic thinking and it is conscious and deliberate, Kahneman (2011) suggests that system 1 is our preference for decision-making and that system 2 will only take over if the:

*Spontaneous search for an intuitive solution fails – neither an expert solution or a heuristic answer can be found. (Kahneman, 2011:13)*

There is increasing evidence to support this and several studies (Bargh and Chartrand, 1999; Hogarth, 2001) have concluded that system 1 has far greater impact in decision making than was previously thought. Gilbert and Gill (2000) argue against this, suggesting that system 1 is only used in the decision process when time is constrained.

Kahneman (2011:12) states that our desire to use system 1 is very strong and that if we are faced with a difficult question and have no intuitive answer, the question is often changed, or substituted to an easier question, without our conscious awareness. A question relevant to my study could be 'Which therapist would be the most appropriate for me to work with'. If a client has no prior experience or relative expertise to draw upon and answer with, the question could then be changed to 'Which therapist do I like'. The client is more likely to be able to answer the substituted question with ease, drawing upon his history of preferences about personality and character traits. Earlier in this thesis, I referred to Kahneman's concept of the 'halo effect', and so if a client has substituted the decision to choose a

therapist into whether they like a therapist, the client would only then need to find a couple of likeable traits in the therapist, before convincing themselves that the therapist is professionally competent and ethically sound.

Kahneman (2011:201) discusses another concept which is relevant to this study. He argues that when a person has limited information, they fill in the knowledge gaps to make themselves believe the decision made, is the best one. For instance, if a client is looking at a therapist's website, they could convince themselves of the therapist's professionalism, or expertise in their area of distress, just by reading the limited text available. Kahneman (2011) concludes:

*Our comforting conviction that the world makes sense rests on a secure foundation, our almost unlimited ability to ignore our ignorance.*

(Kahneman, 2011:201)

### **3.3 Rational-Emotional Theory**

One critique of prospect theory is that it does not consider the influence of emotion on decision-making. Anderson (2003) found that fear and regret have an impact, most often leading to decision avoidance, or acceptance of the status quo. I am often told by new clients that their need for therapy is long held and that they have procrastinated, until the issues have become unbearable. This would suggest that by the time a client makes the decision to choose a therapist, they are quite possibly in a heightened state of emotion.

### **3.4 Theory of Irrationality**

The influence of emotion on decision-making, has resulted in the theory of irrationality (Ariely, 2009) to explain the difficulty of predicting how people might behave in an emotionally charged situation. He has concluded that how people make a decision, differs greatly to how they think they will, influenced by how they are feeling at the time. He introduces the concept of hot and cold states of mind, cold being a sense of calm normality and a hot state being emotionally charged. Ariely (2009:194) suggests that when we are in a hot state of mind, our attitudes change and our rationality is compromised, often resulting in the wrong decision being made.

Lemersie and Arsenio (2000) concluded that where knowledge is incomplete and the outcome uncertain, the emotional state influences the ability to process heuristics and make a rational choice. As clients, usually approach counselling and psychotherapy in a state of emotional distress or crisis, the findings of these studies might be very relevant.

### 3.5 Social Functionalist Theory

Another critique of prospect theory is the absence of the social context within which decisions are made, including the culture, education, values, norms, social settings which all interact with complexity, affecting the decision process. Tetlock (2002) concluded that people have a need to justify their decisions to others, as well as to themselves, which, can affect the decision outcome. Likewise, Schwarz *et al.* (2004) found that accountability for the decision outcome made a significant impact on the decision-making process. Some clients choose to keep therapy a secret and in these circumstances, accountability or justification to others would not be a factor affecting therapist choice.

### 3.6 Health Belief Model

The Health Belief Model (HBM) (Glanz, *et al.*, 2002) is used to predict how individuals engage with health-related behaviours, such as smoking cessation, or choosing to get immunised. The diagram below demonstrates the HBM:

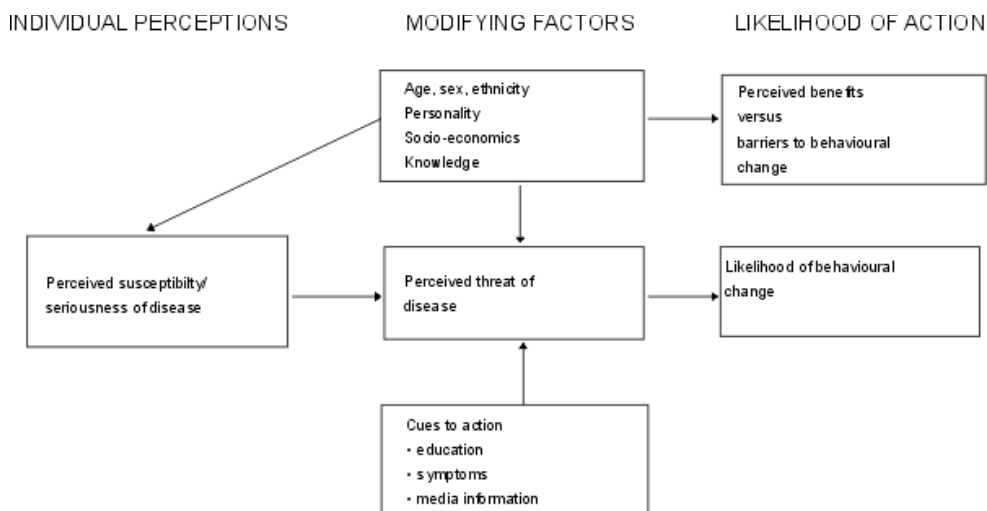


Figure 1. Health Belief Model (HBM) as adapted from Glanz, *et al.*, 2002

The HBM is useful for understanding the process of health-related decision making. It is relevant to this study in respect of the modifying factors, which include the complexities of sociodemographic variables, which I will discuss later in this chapter (p55).

### **3.7 Theory of Planned Behaviour**

The Theory of Planned Behavior (TPB) (Ajzen, 1991) is a behavioral change model, used to predict an individual's intention to engage in a behavior at a specific time and place. The theory was intended to explain all behaviors over which people can exert self-control and, the influence of attitude about the likelihood that the behavior will have the expected outcome, with the subjective evaluation of the risks and benefits of that outcome. The TPB is used to predict health-related behaviour with focus on the influences of attitude, intentions, social and subjective norms, power and behavioral control. The TPB suggests the complexities of factors influencing health-related decision making.

### **3.8 Existing Studies Exploring Client Choice of Therapist**

A recent study (Spalter, 2013) asked 10 private practice clients how they made the decision to work with a particular psychotherapist and why they chose to continue. Spalter found that participants did not generally make informed, well-researched choices. He suggested that clients gather details about the psychotherapist to assess whether the person would be suitable to make a relationship with them, based upon their needs and that this assessment led to an ongoing judgement about the developing relationship. He identified that recommendation was a common factor, but this did not always lead to a successful, congenial choice. Spalter (2013) found that cost and location were choice factors and that the first meeting between therapist and client was crucial in terms of the observable features such as appearance and tone of voice, from which clients would assess age, intelligence, educational standard and socio-economic class. The conclusions of this study would infer that the client choice process is logical, although not always well informed, with client's having an awareness of what they need from a psychotherapist. Spalter (2013) concurred with the findings of Van Audenhove and Vertommen (2000) who

suggested that clients are under-informed about therapy and the process. My study was informed by the recommendation of Spalter (2013) that future studies include therapist participation in addition to clients.

All participants in Spalter's study were educated to degree or post-graduate level which might be representative of psychotherapy clients, who tend to commit for the longer-term and therefore have a greater financial outlay. Counselling tends to be a shorter-term practice and attracts clients from a wider range of educational attainment (PCFA, 2017; Pearson and Bulsara, 2016). The debate regarding whether counselling and psychotherapy are separate disciplines or practices remains one of the unresolved issues from the HCPC's work on statutory regulation, mentioned earlier (p20). The meta-analysis carried out by Dunnett and colleagues (2007) concluded that there was no reliable evidence to support a difference. However, it is generally accepted that counselling relates to shorter term, work, and focuses on difficulties in day-to-day functioning and psychotherapy to unconscious, deep-seated, chronic difficulties, which require a longer-term intervention. In my own private practice, working as both a counsellor and as a psychotherapist, clients come from a wide range of backgrounds, in terms of ethnicity, socio-economic status and educational attainment. Spalter acknowledged the inherent recruitment method bias, whereby participants tend to be educated to a higher standard and that his sample was not diverse in terms of socio-economic status and educational attainment, which might have influenced his results. Qualitative samples are never intended to be generalisable and by their very nature may generate data that is not generalisable beyond the sample itself. Reviewing Spalter's study however, led me to question whether the client's educational attainment level and perception of socio-economic status were factors affecting the selection process and thus, I added an interview question to explore this with my client participants (appendix 1, p184).

Balmforth (2009) acknowledged the limited volume of research in counselling and the impact of socio-economic status on the therapeutic relationship. She concluded that differences between the client and counsellor's socio-economic status can lead to the client feeling disempowered and misunderstood. Most counsellors and psychotherapists are from a middle-class background (Balmforth, 2009; Ballinger

and Wright, 2007). Kearney (2003) concluded that the profession is guilty of an arrogance which promotes middle class knowledge as a 'universal truth'. She suggests that this can affect the client's frame of reference and the counsellor's ability to empathise, leading to an unequal societal power (Kearney, 2003; Proctor, 2002) which needs to be acknowledged.

Norcross *et al.* (1988) explored the factors affecting a therapist's choice of therapist and concluded that personal attributes (empathy, kindness, caring nature etc.) and professional reputation were the most frequently cited criteria for selection. This study was repeated 20 years later, (Norcross *et al.*, 2009) and the findings concurred with the earlier study, concluding that 'cultivation of the therapeutic relationship' was the most important factor influencing a client's decision to work with a particular therapist. All participants in these studies were professionals and it is unclear as to whether insider, expert knowledge impacted the findings and whether a study carried out with client participants would draw a similar conclusion. Manthei (2006) concluded that little research within the profession is carried out from the client perspective.

Swift and colleagues (2011) reviewed the findings of 35 studies which investigated clients' preferences and matching these preferences to the therapist. They found that matching client preferences does influence an improved therapeutic outcome, however, not all clients are asserting these preferences at the commencement of therapy. Swift *et al.* (2011) attributed several reasons for this, including a lack of knowledge as to the potential options available, having insufficient knowledge as to the relevance of preference and the relational power dynamics preventing clients challenging the therapist. Manthei has carried out several studies (2006; 1988; 1983; 1982), with different colleagues, investigating the impact of client choice. Manthei (1982) explored the correlation between the client choosing a therapist within a clinic setting and, the outcome of the therapy was included in the Swift *et al.* (2011) meta-analysis. Contrary to the conclusions made by Swift *et al.* (2011), Manthei (1982) found that there was no significant impact on the therapeutic outcome, comparing the group of clients who had chosen their therapist and the groups that had had their therapist allocated without choice. In his most recent study, Manthei

(2006) suggested that clients do appreciate the opportunity to make a choice and recommended that clients are encouraged to share their preferences.

### 3.9 Sociodemographic Variables

Much research within the profession focuses on factors thought to affect the efficacy of therapeutic outcome, a reflection perhaps of the current evidence based practice paradigm. There is a plethora of material (Cooper, 2009; Lambert and Ogles, 2004) looking at factors thought to affect efficacy, which could impact a client's choice of therapist. Vera *et al.* (1999) concluded that matching client's preferences, or demonstrating similarities with the therapist, together with meeting preconceived expectations are important factors affecting a positive therapeutic outcome. Braaten (1993) found that clients are keen to receive advanced information about their therapist, in terms of experience, credentials and personal characteristics and value this knowledge to inform choice. Sociodemographic variables are thought to be a modifying factor within the HBM (Glanz, *et al.*, 2002) referred to earlier and I will now discuss, in turn, the studies which have considered various sociodemographic variables:

#### 3.9.1 Gender

Whilst matching the gender of the client with the therapist is not thought to affect the therapeutic outcome (Beutler and Castonguay, 2006; Roth and Fonagy 2005) clients do commonly express a preference for the same gender in their therapist (Zlotnick *et al.*, 1998; Sue and Lam, 2002). This is leading me to question whether matching gender is a selection factor, or whether matching the client's gender preference in their therapist, is more relevant.

#### 3.9.2 Sexual Orientation

There are inherent inequalities with the service provisions for the lesbian, gay and bisexual (LGB) communities (Chakraborty *et al.*, 2011; Semlyen *et al.*, 2016). Existing literature suggests some preference for LGB clients choosing therapists with a matching sexual orientation (King *et al.*, 2007; Sue and Lam, 2002) and LGB clients found male heterosexual therapists especially unhelpful (King *et al.*, 2007;



Burckell and Goldfried, 2006). King *et al.* (2007) concluded that matching sexual orientation was not the priority, but the therapist's attitude to sexuality and ability to empathise with the client's orientation, were essential.

### 3.9.3 Age

Beck (1988) found that therapists who were 10 years younger than their clients achieved the poorest therapeutic outcomes and similarly, Dembo *et al.* (1983) suggested that young adults (aged 18-30) achieved better therapeutic outcomes, where the therapist was no more than 10 years older. Beutler and colleagues (2004) concluded that the therapist's age in relation to the client is not considered to be relevant, if the two can relate and the therapist can empathise with the client's life stage.

### 3.9.4 Ethnicity

Murphy *et al.* (2004) concluded that matching ethnicity between client and therapist made no difference to the therapeutic outcome and Dauphinais *et al.* (1980) suggested that trustworthiness is a factor of greater importance to clients. Norcross (2002) reviewed studies affecting different ethnic minorities within the USA, including African Americans, Latino Americans, Indian Americans and Asian Americans and found only limited evidence to support the practice of matching ethnicity, recommending that this is an area requiring further investigation. In an earlier study, Coleman *et al.* (1995) found that clients with strong cultural beliefs are more likely to have an improved therapeutic outcome if ethnicity is matched with the therapist, but that matching ethnicity was not the priority factor, ahead of other characteristics, such as personality, approach and educational standard.

### 3.9.5 Religion

Worthington and Sandage (2002) meta-analysis concluded that there is currently insufficient evidence to support or oppose the matching of religion between client and therapist, to achieve a better therapeutic outcome. Martinez (1991) concluded that highly religious clients might be less likely to benefit from therapy within a secular setting and Worthington and Sandage (2002) suggesting that such clients

are more likely to seek out religion accommodative therapies, or therapeutic support within their own religious community. Wikler (1989) carried out a study involving Orthodox Jews to investigate whether matching these clients with a therapist of the same religious belief, influenced the therapeutic outcome. He found that the factor most cited as important was the therapist's ability to relate to the client's religious beliefs and values, rather than the therapist being from the Jewish faith. In private practice, I am occasionally asked by clients who themselves hold a strong religious belief to disclose my own. I recall once being approached by a client who was looking to find a therapist with adoption experience (which I have), who also shared her religious faith (which I did not). The client made an extensive search of local therapists and could not find one, who matched both of her needs. The client eventually decided that matching the need for the therapist to have experience of working with adoption was her priority and was satisfied that although I did not share her religious beliefs, I would be able to sufficiently step into her frame of reference. On one other occasion, I did refer a highly religious client who was having a crisis of faith, to her minister of religion as I felt this issue was outside my own competency and the minister could provide a more appropriate intervention.

### **3.10 Client and Therapist Attributes**

Several personal characteristics attributed to the client and the therapist are also thought to impact the success of the therapeutic outcome (see Cooper, 2009; Chambless & Ollendick, 2001; Asay and Lambert, 1999; Orlinsky *et al.*, 1994) and might be factors considered by the client during the process of choice. I will explore the existing evidence looking at both client factors and then therapist factors.

#### **Client Factors**

A client's positive attitude to therapy has been found to be a key predictor of a successful therapeutic outcome (Orlinsky *et al.*, 1994) and in a later meta-analysis which reviewed fifty years of psychotherapy process-outcome research, Orlinsky *et al.* (2004) concluded that clients who engage with a co-operative attitude have the best therapeutic outcomes. Tryon (1985) attributed this positive attitude to "*higher engaging therapists*" who can use their life experiences to draw the client in and

build the collaborative alliance. Having a positive belief in the efficacy of therapy was found to be an indicator of a positive therapeutic outcome (Bohart and Tallman, 1999), while Teasdale (1985) attributed a client attitude of hope was important. The client's expectation of therapy is also a key component to a successful therapeutic outcome (Snyder *et al.*, 1999) with Asay and Lambert (1999) estimating a 15% variance. Elkin *et al.* (1999) concluded that all clients come to therapy with preferences which the therapist should assess and recommend the therapist asks the client to share these preferences.

Similarly, the client's desire to change has been found to be a factor greatly impacting the success of therapy. Prochaska and DiClemete (1983) developed a 'Stages of Change Model' to explain the psychological process of change. The authors suggest that unless a client is situated at the preparation stage, or later, therapy is likely to be unsuccessful and this model is depicted below, as adapted from Prochaska and DiClemete (1983):

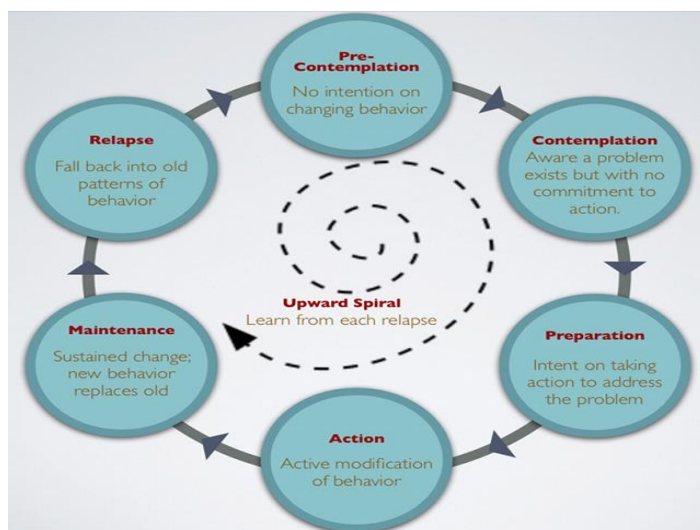


Figure 2. Stages of Change Model, as adapted from Prochaska and DiClemete (1983)

Brogen *et al.* (1999) found that clients at the pre-contemplation stage were most likely to terminate therapy prematurely and this study could predict with 90% accuracy, the pre-contemplative clients, who did indeed go on to terminate prematurely. I can relate these findings to my own practice and experience of clients who are sent to see me, usually by a parent or partner, rather than making the decision by themselves to self-refer. Most of these clients are at the

pre-contemplative stage and do not recognise they have any issues to address, but are presenting to therapy to appease the sender. My experiences agree with the Brogen *et al.* (1999) findings, in that these clients do not engage in the therapeutic process and terminate. It would seem then that the choice of whether to want to change, is one that is made before the client makes the decision as to whom they would like to work with. Cooper (2009) summarises this with humour:

*How many therapists does it take to change a lightbulb?*

*One, but the lightbulb has really got to want to change.* (Cooper, 2009:156)

The client's ability to relate with the therapist might also be explained in terms of attachment theory (Bowlby, 1979; Ainsworth, *et al.*, 1978) developed following observation of babies relating with their mother. It was discovered that the patterns of relating established in the early years, remained with the individual and affected intimate relationships throughout life. Three attachment styles were identified in the table below:

<b>Attachment Style</b>	<b>Characteristics</b>
Secure Attachment	Confident in relating
Anxious Attachment	Fearful in relating
Avoidant Attachment	Defensive and uncomfortable in relating

**Table 2. Attachment Styles**

Limited existing studies have found that clients with a secure attachment style have a better psychological functioning and are more likely to achieve a good therapy outcome (Meyer and Pilkonis, 2002; Orlinsky *et al.*, 1994), which has been linked to having little concern for being rejected by the therapist (Eames and Roth, 2000). In terms of my study, I am unclear whether a client's attachment style would affect their therapist selection process, although it would appear evident that it could impact whether they chose to continue working with a particular therapist, or indeed continue with therapy at all.

## Therapist Factors

High standards of therapist training seem to be a predictive factor towards a positive therapeutic outcome (Lambert and Ogles, 2004; Stein and Lambert, 1995). Orlinsky and colleagues (2004) concluded that it is specifically the therapist's skill in applying the training to the therapeutic process and not just the level of training achieved. As discussed earlier in chapter 2, standards of training for counsellors and psychotherapists varies greatly and there is currently no legislation in place to prevent the untrained from practising. Roth and Fonagy (2005) concluded that the evidence supporting a correlation between therapist experience and therapeutic outcome is modest, but to remember novice therapists are likely to be heavily supervised by more experienced colleagues. The therapist's interpersonal skills are also relevant to a successful therapeutic outcome, qualities such as empathy (Bohart, 1999; Mohr, 1995) being rated highly by clients and positive regard, or feeling liked/affirmed by the therapist (Orlinsky *et al.*, 2004). It is unclear to me how a client at the stage of selecting a therapist would make an assessment in these areas.

As already discussed, attachment style is thought to be a factor in forming a therapeutic relationship and the therapist's attachment style in addition to the client's attachment style could influence the outcome of therapy. Rubino *et al.* (2000) found that therapists with anxious attachment styles had a diminished ability to empathise with clients and Tyrrell *et al.* (1999) carried out a study of 21 clinicians, which revealed a confusing picture. Tyrrell and colleagues (1999) recommended further longitudinal studies be carried out and the impact of therapist attachment style remains inconclusive.

### 3.11 Theoretical Orientation

There is much controversy and rivalry within the profession around the superiority of one modality over another, supported by a confusing array of research findings and the sociology of professions recognition regarding power struggles within professions. Several studies conclude that CBT is the most effective approach (Chambless, 2002; Hunsley and Di Guilio, 2002), whereas others suggest other therapies are equally effective (Lambert and Ogles, 2004; Wampold 2001; Hubble *et*

a/. 1999) In his review of existing studies, Cooper (2009) questioned validity and the authors professional biases, recommending that an independent review in this area would be useful. Whilst the issue of theoretical orientation is of pertinence to the profession, there is limited research as to whether it is a factor influencing choice for clients. Experience of my own private practice suggests that most clients rarely enquire into modality or ask me to explain how I work. This could be due to the information being clearly detailed on my website, or due to a lack of awareness or interest into the theory behind practice. It has been argued that clients do need to be educated about the different modalities, in order that they make informed choices to meet their needs (Addis and Jacobson,1996; Devine and Fernald,1973). Spalter (2013) concluded that information is available, but clients choose not to access it.

### 3.12 Existing Models

Asay and Lambert (1999) developed a model, 'Lamberts Pie', to depict their estimates for the impact of factors which affect the therapeutic outcome. As can be seen on the model below (Figure 3), 55% of the variance is directly attributed to the client and a further 30% to the relationship. Only 15% is attributed to therapist technique. This model suggests that 85% of the variance in therapeutic outcome is attributed to the therapist skill.

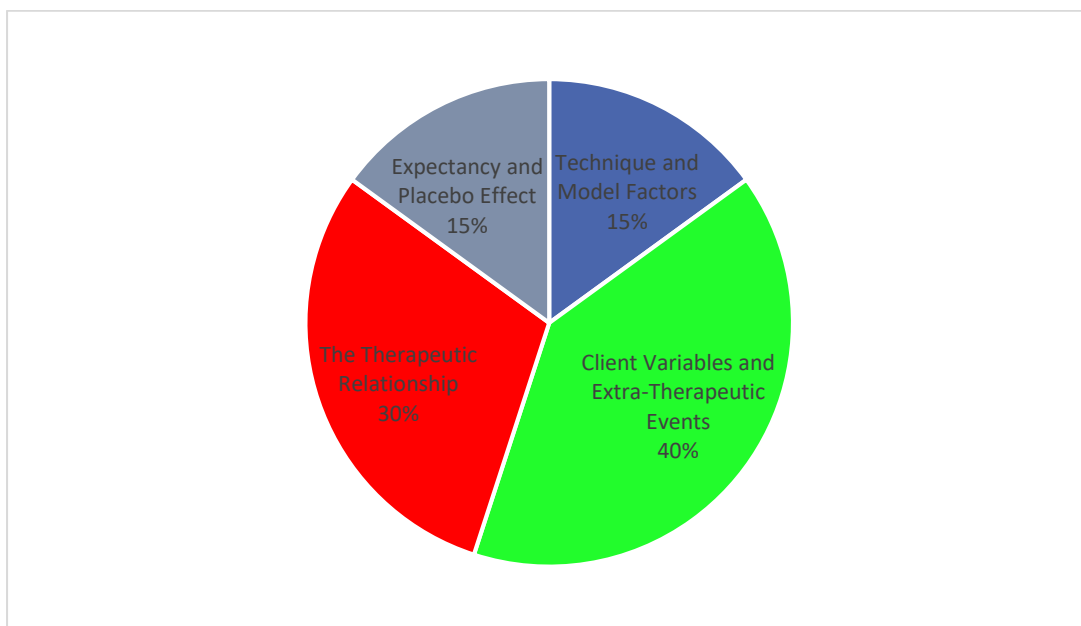


Figure 3. Lamberts Pie, as adapted from Asay and Lambert (1999)

Chambless & Ollendick (2001) argued that whilst this model represents factors to consider, it is too simplistic to apply the same weight to each factor, across all potential client issues and levels of distress, which might be presented in therapy. Cooper (2009) in his meta-analysis of existing literature, concluded that it is the client's level of involvement in therapy and their capacity to make use of the therapeutic relationship are the strongest predictors of a positive therapeutic outcome. He suggested that it is how therapists relate to clients that makes the difference, over and above their personal or professional attributes. Orlinsky *et al.* (1994) found that client-active participation is the strongest predictive factor of a positive outcome of therapy. In their later study, Orlinsky and colleagues, (2004) concluded that client 'resistance to therapy' was a strong determinant of a poorer therapeutic outcome. Similarly, Bohart and Tallman (1999) found that the therapist is the facilitator of the client's own self-healer process and it is this which makes the therapy work. In terms of my study, exploring the factors the client assesses in making their choice of therapist, is the first stage in the client's involvement in the process.

Castonguay & Beutler (2006) identified three clusters of factors as relevant for therapeutic change, which summarise the client and therapist variables I have discussed in this chapter. The clusters identified are as follows:

1. **Participant Factors** which apply to both client and therapist and include; attachment style, gender, ethnicity, religion/spirituality, preferences and personality disorders. They also identified 'moderating variables' which included; resistance, stage of change, expectations and attitudes;
2. **Relationship Factors** which include interpersonal skills, working alliance qualities, management of transference<sup>5</sup> etc. and;

---

<sup>5</sup> Transference is a phenomenon where clients project historical relationship patterns onto the therapist and is widely recognised and acknowledged as affecting the therapeutic relationship both positively and negatively (Cooper, 2009; Castonguay and Beutler, 2006; Rosenberger & Hayes, 2002).

**3. Technique Factors** which include the skill of the therapist and application of therapeutic interventions.

Lambert and Ogles (2004:197) suggested that only a minority of people requiring psychological support seek it out and those that do are “*almost automatically placed in therapy*”. It could be argued that this conclusion was made in relation to the organisational paradigm within the public services where most counselling and psychotherapy research is carried out, and where clients are allocated a therapist, rather than given the option of selection. My interest in client experience of private therapist selection is, therefore, both from a different perspective to most research proposals within my professional paradigm and timely in terms of the recent introduction of voluntary registration. This study will make a unique contribution to knowledge, in the area of private practice overlooked by researchers.

My conclusions concur with this review of the existing literature (e.g. Spalter, 2013; Manthei, 2006; Morrison, 1979) in that clients need to be informed and educated about the choices available. What is currently unclear however, is to what level clients are currently aware and which factors are considered when selecting a therapist in private practice. One of the biggest factors pre-disposing a positive therapeutic outcome is both party’s ability to forge a relationship with each other.

The next chapter explores the methodology behind the study, the philosophical position of the researcher and discusses the research methods used.



## Chapter 4 – Methodology

In this chapter, I commence with presenting the role of the researcher and my rationale for choosing pragmatism as the methodology to underpin this study. I then outline the research methods, including data collection, inclusion/exclusion criteria, ethical considerations and data analysis, before concluding the chapter with the impact of the pre-pilot and pilot studies on the final research design.

### 4.1 Role of the Researcher

I am an insider in that I am a senior accredited member of the British Association for Counselling and Psychotherapy (BACP) and a private therapist. Please note that I am not considering myself an insider within this study in relation to having either a former or current relationship to any of the participants. My own preference for my profession is that of statutory regulation and I feel it is appropriate to make this position explicit.

My epistemological position, is interpretive and resonates with Heidegger (2010) and Merleau-Ponty (2013) view that world objects are already there, but are meaningless without the human interaction and generation of meaning. Ontologically, my position is constructionist, in that an individual's reality is experienced within a social and cultural context. Crotty (1998) summaries the constructionist position:

*All knowledge and therefore all meaningful reality as such is contingent upon human practices, being constructed between human beings and their world and developed and transmitted within an essentially social context.*

(Crotty, 1998:45)

Creswell (2002) explains the constructionist view that individual sense of the world is not out there to be discovered, but created through human relating:

*Often these subjective meanings are negotiated socially and historically. In other words, they are not simply printed on individuals but are formed through interaction with others. (Creswell, 2002:20-21)*

I have been influenced by Foucault (1980) and his theory of knowledge being power and by Popper (2011) and his theory of falsification. The membership of the counselling and psychotherapy profession is predominantly female and the work of feminist writers, such as Witz (1992) and Starhawk (1987) are relevant within this paradigm. The constructionist position argues that 'truths', scientific or otherwise are subjective and contextualised within temporal and cultural/historical factors. These 'truths' held by individuals or by groups, are provisional, until challenged and updated by new evidence (Popper, 2011).

This epistemological and ontological stance is evident in my client work with clients presenting fixed beliefs and assumptions, which are no longer productive for them, and I offer an alternative way of experiencing the phenomena. This facilitates the client in reviewing, challenging and potentially updating their beliefs. This epistemological and ontological position is also evident in the aims of my study, as I look to explore the PSA assumption regarding client knowledge, by researching that knowledge and presenting my findings.

Burke Johnson and Onwuegbuzie (2004) discuss the limitations of a strong constructionist ontological stance, suggesting that we must also accept multiple accounts of the same phenomena as shared reality, or multiple opinion and perspective. Dewey (1910) likewise concluded that humans are not free to believe anything they want about the world, if they care about the consequences of acting on these beliefs.

My thesis draws upon theories arising from at least three different disciplines including cognitive psychology, sociology of professions and the history of the psychotherapy and counselling profession, which have been discussed in the preceding chapters.

## **4.2 Pragmatism**

Selecting the methodology was my greatest challenge for this study. I commenced with a naïve assumption that hermeneutic phenomenology (Heidegger, 2010: Gadamer, 2004) would naturally be the methodology, as had been the case with my

bachelor's and master's degree research. It very soon became evident that my thinking needed serious challenge and hermeneutic phenomenology conflicted with the aims of the study. The study was not focused upon 'lived experience', despite my attempts to re-word the research question to make the methodology fit, hermeneutic phenomenology would not generate the data needed to address the research disturbance. I explored grounded theory (Charmaz, 2013) as the next methodological option, but dismissed this due to the focus on theory generation, which did not feel congruent with the study aims. I had also, by that stage, extensively read existing literature and had been influenced by my own experiences as a reflexive therapist in practice. I felt that this knowledge could not set aside to allow theory to emerge from the data. The third methodology I investigated was critical realism (Bhaskar, 2017), which was grounded in the philosophical position of reality existing outside of human interpretation. As such, critical realism was not ontologically appropriate to this study.

Pragmatism eventually emerged as the most appropriate methodology to conduct this research, as it provided a flexible approach, focused on practical application. My research disturbance was centred on the possibility that clients may select a therapist without having the necessary information about their credentials. It was certainly based in the real world of the provision of services for those with mental health and attendant problems, and the paradigm of private provision of counselling and psychotherapy practice.

Pragmatism originated in the United States of America in the 1870s, founded by Charles Sanders Peirce. Peirce's ideas were further developed and evolved by his colleagues, including William James, Chauncey Wright, John Dewey and George Herbert Mead. In his 1904 lecture, James explained pragmatism as a way of making sense of everyday life, as a method of understanding. He suggested that all meaning and knowledge is constructed socially and is tentative, or under constant change. James (1912) felt that '*truth*' should be considered provisional and based upon practical application. Dewey (1997) referred to this concept as "*warranted assertibility*" or being able to accept something as "*a truth*" if this was confirmed by its experience in practice. The founders of pragmatism intended it to be a

philosophical approach focused on action and practical application. Knowledge is argued to be essentially problem solving using philosophical theory (Cornish and Gillespie, 2009; Cohen *et al.*, 2007; McQueen and McQueen, 2010).

In terms of a methodology, pragmatism is a pluralist approach, accepting that there is no one way to conceptualise reality. It breaks down the dualism between realism, with a single objective reality to be discovered, and idealism, with a socially constructed reality. Pragmatism draws upon the strengths of both the positivist and interpretative traditions, and resolves the '*uncomfortable tension*' (Tashakkori and Teddlie, 2005) between the two polarised views. Dewey (1910) argued that essentially the ontological argument about the nature of the outside world and the world of human conception are just discussions about two sides of the same coin. He stated that humans experience the world by the nature of that world, but human understanding of the world is limited to the interpretation of experiences.

Tashakkori and Teddlie (2005) and Robson (2002) argue that pragmatism is a value orientated approach to research and that values are cultural and shared. Pragmatism endorses practical theory, in that it is in the actual process of doing, that we inform practice and it rejects reductionism. Robson (2002) suggests that pragmatic researchers are guided by their own value systems and that this is congruent and evidenced in the study.

Using pragmatism as the methodology to underpin my study provided the flexibility to use triangulation of data selection (material obtained through recruiting clients, therapists and professionals) to best to answer my research question. It enabled me to overcome the challenge for therapist researchers identified by McLeod (2001) regarding methodological conformity. McLeod suggests that counsellors and psychotherapists are challenged as researchers, because the nature of our work in practice is not fixed or focused on scientific progress and developing treatments. McLeod (2001) argues that:

*Counselling and psychotherapy research does not add to an ever-accumulating stock of coherent scientific knowledge of therapy which feeds new treatments. The research we do has a different purpose. Counselling*

*and psychotherapy are activities that are inevitably engaged in a process of continual reconstruction...The pace of social change means that counsellors and their clients are continually faced by issues and possibilities that would be unrecognisable to their predecessors. (McLeod, 2001:203-4)*

McLeod (2001) suggests that counselling and psychotherapy practitioner research is concerned with generating “*knowledge in context*” and that this context is ever shifting. As the efficacy of counselling and psychotherapy is dependent upon the relational factors between therapist and client (Cooper, 2009), it is reflexivity and the practitioner researcher’s ability to engage in a dialogic process with others which need to be central to the methodology. Slife (2004) argues extensively about traditional methodologies and the challenges they present to psychotherapy researchers, suggesting that there is no philosophical framework associated with the practice of psychotherapy. Slife (2004) discusses the assumptions associated with all methodologies as being ‘value-laden’ and argues for a ‘reflective pragmatism’ where researchers, reflect on the constraints and develop variable alternatives. Slife (2004) suggests:

*Without variable alternatives, familiar assumptions appear to be truisms. Popular points of view become refined and one organization of reality becomes the organization of reality. (Slife 2004:76)*

Agar (2013) also identifies with the methodological challenges faced by social scientists, arguing that behavioural social science is an oxymoron, as all social science research takes in the real world and with human subjects. As such, Agar (2013) adopts the term ‘*human social sciences*’, to incorporate Brentano’s (1973) concept of Intentionality and the “*messiness*” of human researchers, researching human subjects. He argues that human social science must be about subject intentionality and lived experience. Underpinning my study with a pragmatic methodology enabled me to contain the challenges and achieve the aims of my study.

Denzin and Lincoln (1994) discuss the idea of the qualitative practitioner researcher using their term ‘bricoleur’ (translation from the French as ‘handyman’ or ‘Jack of all

trades') to describe the process of remaining flexible, multi-skilled and adapting the methods, to get the job done. Crotty (1998) refutes this interpretation of the word 'bricoleur', returning to the original text of Levi-Strauss (1966) and arguing that bricoleur researchers are not self-reflexive, but the opposite and are instead focused on the object and reinventing the meaning of that object. Crotty (1998) suggests that bricoleur researchers are:

*Not to remain straight-jacketed by the conventional meaning we have been taught about the object. Instead, such research invites us to approach the object in a radical spirit of openness to its potential for new or richer meaning. It is an invitation to reinterpretation. (Crotty, 1998:51)*

Pragmatism and its associated methodological freedom is not without its critics from both sides of positivist and naturalistic perspectives. Robson (2002) succinctly summarises the critique:

*Pragmatism is almost an 'anti-philosophy' which advocates getting on with the research rather than philosophizing. (Robson, 2002:30)*

I am aware of my own philosophical position and the impact that this has in terms of research design and in the achievement of research aims, ultimately answering my research question. Feilzer (2010) argues that pragmatism is a grounded methodology and enables the researcher to produce socially useful results. Burke Johnson and Onwuegbuzie (2004) discuss the limitations of a strong constructionist ontological stance, suggesting that we must accept multiple accounts of the same phenomena as shared reality, or multiple opinion and perspective. Burke Johnson and Onwuegbuzie (2004:16) support their argument with the example of the British driving on the left-hand side of the road, as a case of shared reality and the impact if an individual chooses to drive on the right-hand side, this would eventually result in an accident. They conclude that pragmatism offers a middle philosophical methodological position, secured in practical application, leading to an action-based outcome. This resonates closely with my own ontological position and aims of my study.

### 4.3 Ethical Requirements

Approval for this study was provided by University of Brighton's Faculty of Health and Social Science Research Ethics and Governance Committee (FREGC).

### 4.4 Client Participant Recruitment

I recruited 10 client participants, initially identifying private therapists from the online public directory of psychotherapists and counsellors, local to my home county, using a purposive sampling strategy (Noy, 2008; Cohen *et al.*, 2007:158; Punch, 2006:51). These therapists, in an initial assessment session, handed their new client a sealed envelope containing an introduction letter from myself (appendix 5, p191). This letter outlined the aims of my study and asked the client to contact me, if they were interested in taking part. This procedure ensured that the research and the ensuing therapy with the therapist were kept separate. This recruitment method provided limited results and I found that therapists were reluctant to approach their clients' due to concerns about the impact on the working alliance and therapeutic dynamics. To overcome this challenge, I put up posters in the waiting rooms of several local practices advertising my project and appealing directly to clients, rather than involving the therapist gate-keeper. This recruitment method provided the remaining participants. I collected demographic information from these client participants and the results are shown in the table below, using the allocated pseudonyms:

Client Participant	Age	Gender	Ethnicity	Disability	Location	Education	Number of Times Therapy Accessed
Amanda	36	Female	White British	No	PO2	NVQ	3
Betty	71	Female	British	No	PO15	Master's Degree	4
Charles	67	Male	White British	No	PO16	Higher Degree	4
Dorothy	66	Female	White British	No	PO16	O Level	4
Elizabeth	52	Female	White British	No	PO15	O Level	2
Fiona	37	Female	White British	No	HP5	National Diploma	1
Grace	55	Female	White British	No	PO4	Master's Degree	1
Helen	55	Female	White British	No	PO2	A Level	4

Client Participant	Age	Gender	Ethnicity	Disability	Location	Education	Number of Times Therapy Accessed
Ivor	69	Male	White British	Mobility	PO13	Level 4	2
James	68	Male	White British	Diabetes	BN17	None	2

**Table 3. Client Participant Demographics**

Seven client participants were female and three males, with a mean age of 57.6 years and a range between 36 years and 71 years. All client participants described their ethnicity as 'white British' and two identified themselves as having a disability. Educational achievement varied between none and post-graduate Master's Degree level and all client participants lived in the South of England. Most client participants had accessed therapy more than once, with just two stating that they had only accessed therapy the once.

#### 4.5 Therapist Participant Recruitment

I recruited an additional 10 therapist participants, again using the online public directory of psychotherapists and counsellors, local to my home county and using a Purposive Sampling Strategy (Noy, 2008; Cohen *et al.*, 2007:158; Punch, 2006:51). These participants were all counsellors/psychotherapists currently working in a private practice setting. Appendix 6 (p193) shows the proposed interview questions. I collected demographic information from the therapist participants. Two chose not to disclose this information and the results are shown in the table below, using the allocated pseudonyms:

Therapist Participant	Age	Gender	Ethnicity	Disability	Location
Ann	57	Female	White British	No	PO10
Brenda	50	Female	White Dual Nationality	Diabetes	GU31
Cathy	Declined	Female	Declined	Declined	Declined
Diane	54	Female	White British	No	PO10



Therapist Participant	Age	Gender	Ethnicity	Disability	Location
Ellen	55	Female	White British	No	PO6
Freya	51	Female	White British	No	SO20
Georgina	48	Female	White British	No	S021
Harriet	56	Female	White European	No	SO16
Imogen	Declined	Female	Declined	Declined	Declined
Joe	51	Male	White Canadian	Deaf	DT6

**Table 4. Therapist Participant Demographics**

Nine therapist participants were female and one male, with a mean age of 52.75 years and a range between 48 years and 57 years. Five therapist participants described their ethnicity as 'white British' and three as other white backgrounds. Two identified themselves as having a disability and all therapist participants were in the South of England.

#### **4.6 Professional Body Spokesperson Recruitment**

Finally, I approached spokespersons from the largest four professional Bodies, BACP, UKCP, BPS and the BABCP and also the PSA and HCPC, to establish their perspectives on the factors influencing choice. I was interested in learning if any of these organisations intended carrying out research into the impact of the introduction of the voluntary register on therapists and the public. Appendix 4 (p189) shows the proposed interview questions. Two spokespersons agreed to take part in my study, the rest declining my invitation based on not having anything of value to add to my study. All the organisations I approached stated an interest in my study topic and in receiving an overview of my findings.

The two professional body spokespersons who agreed to take part, did so on the basis that their responses were representative of their personal opinions and not representative of the views of the organisations with whom they were employed. Both were explicit in respect for their anonymity and for this reason, I am not disclosing the employer organisation and I did not collect demographic information,

to ensure identity remained protected. I have allocated the pseudonyms 'Bella' and 'Andrew' to identify their data.

#### **4.7 Inclusion/Exclusion Criteria**

Client participants were adults, aged over 18, who had chosen to work with a counsellor or psychotherapist in private practice. Introducing details of my study at the initial assessment session, enabled me to access participants who have recently made the choice of therapist. I did consider approaching clients after their counselling/therapy was complete, so as not to interfere with the therapeutic process, but on reflection, I felt that any such impact would be minimal and the disadvantages substantial. The first disadvantage being that the participant's reflections could be affected by the outcome of the counselling/psychotherapy experience which could affect the results. The second disadvantage is that a considerable period could have elapsed since making the choice of therapist and ending counselling/psychotherapy. If I were to wait to approach potential participants until the end, the accuracy of recollection of factors which affected their choice might not have been as reliable.

The UoB ethics committee (FREGC) made an interesting observation about whether I wanted to ask client participants if the therapy had continued after the initial assessment session and note this, in case it impacted the data then collected. For example, if the participant decided not to proceed with therapy because of a dislike or lack of connection with the therapist, this could have impacted their opinion of the decision to choose that person and affect the results. I added this question to my interview schedule, but was mindful that I would need to keep the participant's response contained, to avoid a discussion about their rationale for not continuing therapy which, would have deviated from my study focus.

The therapist participants were adults aged over 18 years, counsellors and psychotherapists trained to a minimum of diploma level standard and were currently working in a private practice setting. I did not set inclusion/exclusion criteria for practitioner participants regarding professional body membership or voluntary register membership. In practice, however, it was likely that most therapists recruited

from the professional network, would have had at least professional body membership and those holding accreditation with the largest professional body, the BACP, are now obliged to be on the voluntary register as a condition of their accreditation.

The professional participants were associated with organisations involved in supporting members of the counselling/psychotherapy profession.

Being mindful of the implications of dual relationships and informed consent, (BACP, 2013; UOB, 2013a) I did not recruit participants who had a prior professional or personal relationship with me. I did not apply any other recruitment restrictions in terms of gender or age and intended to attract a cross section of the population.

#### **4.8 Data Collection Methods**

I used semi-structured interviews as my data collection method, as this was most appropriate to answer my research question and generate data which supports the study's ontological and epistemological position (Mason, 2002). Appendix 1 (p184), appendix 4 (p189) and appendix 6 (p193) contain the semi-structured interview schedule, I prepared for participants, the professional body spokespersons and therapists respectively. The interview schedule was informed by decision theory; exploring potential heuristics and the weight given to them (Kahneman, 2011) and, by the other cognitive theories discussed earlier in the literature chapter (p48-63). This included the impact of emotion on the choice process (Ariely, 2009) and the social context (Tetlock, 2002; Schwarz *et al.*, 2004). Interviewing enabled me to take an active and reflective role in the process of generating data. Knowledge was co-constructed with the respective institutional norms and values of both researcher and participant, and the narrative created was influenced by constant change and developed together. (Kvale and Brinkmann, 2009; Mason, 2002).

Feminist writers such as Fontana and Frey (1994) suggest that semi-structured interviews minimise the status difference between interviewer and interviewee, with Reinharz (1992) endorsing the use of mutual disclosure as a tool to avoid "*hierarchical pitfalls*". Whilst I was aware of the asymmetrical power dynamics of the

interview (Kvale and Brinkmann, 2009) I felt that sharing my own views would have polluted the data collection. Opposing the stance of Fontana and Frey (1994) and Reinharz (1992), I believe that self-disclosure by the interviewer has the potential to increase the impact of asymmetrical power dynamics, rather than minimalise, as the focus would be directed away from the participant (Gillham, 2005). Morse (1994:237) refers to the concepts of censoring and conforming, suggesting that self disclosure could facilitate the participant in adjusting their views so that they align with that of the interviewer, or withholding their view in the knowledge that it does not concur with the interviewer's own view.

I sought advice from the Mental Health Research Network (MHRN) FAST-R service<sup>6</sup>, regarding the design of my interviews, participant information sheets and consent forms. The feedback suggested some minor adjustments to the participant information sheet, including offering participants the option to opt out of being digitally recorded and making the purpose of the research clearer. I incorporated this feedback into my design, as it felt important to receive external observation and input for the study.

The skills I use frequently as a therapist, such as active listening, reflection, observing the unspoken, awareness of incongruence and facilitating the client in elaboration, were useful in conducting semi-structured interviews. I was however, mindful to remain within the boundaries of researcher and not to stray into the role of therapist. Had an interviewee become distressed I would have offered them the opportunity of pausing or withdrawing from the interview and onward referral to a

---

6

MHRN brings together researchers, clinicians, service users and carers to generate proposals for new research studies to develop a distinctive portfolio reflecting national needs and research strengths. FAST-R (Feasibility and Support to Timely recruitment for Research) offers fast and easy access to people with experience of mental health problems and their carers who have been specially trained. FAST-R service offers expert advice about patient information sheets, consent forms, recruitment strategies and support with the ethical approval process.

colleague. I exercised caution particularly with the client participants who were beginning therapy who were likely to have concerns about being interviewed. The participant information sheet (appendix 3, p187) reiterated that the research was separate from the therapy that they were having or had had with their chosen therapist. I explained that the research intention was to ensure that service users' experience of selecting a therapist could be considered by policy makers for the future.

Using semi-structured interviews as a data collection method enabled me to probe and gain clarity from my participant's responses (Wiles, 2013; Gillham, 2005). For instance, if in an interview, I had asked a participant what factors affected their choice of therapist and they had responded with 'I don't know', I then had the option to explore this with them further. I was, however, mindful of the 'Hawthorne effect' (Mayo, 1949) in that prompting the participant to think about it further, their conscious awareness could be altered. Without prompting however, this response would have remained at 'I don't know' and I would not have had the potential of eliciting richer data.

I did consider alternative data collection methods, including questionnaires (online and paper) and using focus groups. However, questionnaires would not have allowed me to elicit the depth of data required, as there would have been no scope for prompting or encouraging the participant to reflect and expand upon their responses (Barbour, 2013). Having carried out the pre-pilot using questionnaires as the data collection method, I was aware of the limitations that this data collection method would bring to the final study. I had felt quite frustrated with being unable to explore an interesting response further with the participant and had no means to further clarify the meaning (Kvale and Brinkmann, 2009). Focus groups as a data collection method, would have given me the option to probe to clarify the participant's meaning. The responses would however have had greater potential to be impacted by the concepts of censoring and conformity (Morse, 1994:237) and would have raised additional issues around confidentiality.

Positivists would argue that the disadvantage to semi-structured interviewing as a data collection method is that they are subjective and biased. I fully accept that I

influenced the dynamics in the interview and concur with McLeod (2001:138) that semi-structured interviews are concerned with the formation of a relationship between interviewer and interviewee and that data is constructed between them, rather than simply collected. This view concurs with my constructionist and interpretive standpoint and was my rationale for deciding against telephone interviewing. Having in the past conducted some telephone counselling, I am aware of the differences working in this medium, rather than face-to-face. Whilst telephone interviewing can encourage a fuller disclosure and gives the participant greater control over choosing a confidential, safe location, I felt it would have presented a greater challenge in establishing a relationship with the participants. I would have also lost the visual, nonverbal communication which is present when an interview is carried out face-to-face. Establishing a relationship with participants was crucial for me, to build trust, empathy and rapport (May, 2011a; Oppenheim, 1992). These relational qualities could encourage participants to disclose at a deeper level, resulting in rich data. It was however necessary, due to logistical challenges, to conduct one interview, with professional participant Bella, over the telephone.

Interviews on average lasted 30 minutes to complete, and were digitally audio-recorded and then transcribed by a professional third party. The identity of the participants remained unknown to the transcriber, who was only provided with the participant's pseudonym. I informed each participant that a third-party transcriber would be used, including this on both the participant consent form (appendix 2, p186) and participant information sheet (appendix 3, p187). The transcriber agreed to delete the voice recordings and transcriptions from her computer files, once she had forwarded them to me and agreed to keep the content of the interviews confidential. Sharing this level of detail with participants as to the remit of confidentiality is considered necessary (Oliver, 2003) to ensure that consent was as informed as possible.

#### **4.9 Data Collection Process**

Interviews took on average 30 minutes each to complete, and commenced with a review of the participant information sheet (appendix 3, p187) to clarify the participant's understanding, before obtaining signed consent (appendix 2, p186).

Rapport was established at the beginning of each interview, with the first few minutes focused on talking through the purpose and focus. Rapport was an important factor, to ensure the participant felt at ease and comfortable talking to myself, as a stranger (Bryman, 2012; Oppenheim, 1992). The interviews were digitally audio-recorded and then transcribed by a professional transcriber. I had a notepad to hand in the interviews, to make any relevant notes at that time and to debrief my thoughts, observations and reflections, after the interview had concluded. At the end of each interview or closure stage (Gillham, 2005), I concluded by asking whether the participant had anything else to add, whether they would like to see the results of the study, and confirmed consent.

All the participants expressed an interest in receiving the details of the study results.

#### **4.10 Data Collection Location**

Semi-structured face to face interviews took place at a venue chosen by the participant. Due to the asymmetrical power dynamics (Kvale and Brinkman, 2009) where the researcher has academic knowledge, designs the interview, asks the questions and can manipulate the dialogue, it was important to offer the participant the power to choose the location. I offered the suggestion of my own business premises, which are private, professional and centrally located in Hampshire, as a venue for carrying out the semi-structured interviews. As my business premises, might not have been a convenient location for all participants, for several reasons, including mobility or disability issues, I did also offer to visit participants in their own homes or at a public venue of their choice, if required, to carry out the face-to-face semi-structured interview. The risks to me and to participants in relation to interview location are discussed later in this chapter (p, 84). I made the decision not to offer the option to meet client participants at the business premise of their counsellor or psychotherapist. This decision was ethically informed, to keep the risk of any potential conflict of interest or dual relationship (BACP, 2013:9) to a minimum. It also ensured that a commitment to confidentiality and anonymity was upheld.

**Client Participants** Three of the ten client participants chose my business premises as the location for the semi-structured interview and the remaining seven, chose

their home as the location. As already discussed, I was aware of the difference in power dynamics and impact on the co-constructed narrative (Kvale and Brinkmann, 2009; Mason, 2002).

**Therapist Participants** Eight of the ten therapist participants chose their own consultation room, which was in their own homes, as the semi-structured interview location and two chose my business premises. Again, I was aware of the impact of the different locations on the power dynamics and co-constructed narrative (Kvale and Brinkmann, 2009; Mason, 2002).

**Professional Participants** One professional participant chose to be interviewed at their professional premises and one professional participant was interviewed over the telephone, due to logistical constraints. I made the telephone call from my own business premise and was aware that the different environment affected the power dynamics and impacted the co-constructed narrative (Kvale and Brinkmann, 2009; Mason, 2002).

#### **4.11 Data Storage/Confidentiality**

I adhered to the FREGC guidelines for the handling of personal data (UOB, 2013c) which are underpinned by the Data Protection Act (2003). The semi-structured interviews were digitally recorded and transcribed verbatim, by a professional third-party. The recording and the transcriptions were stored on my laptop and the data anonymised to remove any references which could identify a participant. I used a code to identify each participant and deleted any reference to any individual's name in the transcription, to ensure that I upheld the principles of confidentiality (BACP, 2013; UOB, 2013a). The data and information I kept on my laptop was encrypted and password protected. As a backup, in case of technical failure, I kept a duplicate encrypted version on a memory stick, which was kept securely in my locked work safe, to which only I have access. Data which I printed or handwritten notes or records, were stored securely in a locked filing cabinet, which again only I had access to. These hardcopies were shredded, once they were no longer required.



At the suggestion of FREGC I considered the ethical issue of a participant making a disclosure or allegation of therapist malpractice. I consulted with my professional body, the BACP and with my academic supervisors for clarification. The BACP ethical guidelines for researching counselling and psychotherapy (BACP, 2013:7) reminds researchers that confidentiality is not always the primary ethical imperative, in such circumstances. As the counselling and psychotherapy profession is not statutorily regulated, I do not have a legal obligation to report allegations of professional malpractice, but as a BACP member, I have an ethical responsibility to protect all clients from risk of harm by a colleague and to raise concern. My supervisors and I, therefore agreed that in the event of a participant making a disclosure or allegation of malpractice, I would discuss the matter with them in the first instance and decide together what action, if any, to take. The participant consent form (appendix 2, p186) and participant information sheet (appendix 3, p187) were updated to reflect this<sup>7</sup>.

#### **4.12 Consent**

In accordance with UoB ethics committee (FREGC) informed by The Articles of Nuremburg and The Declaration of Helsinki (Soble, 1978:4) voluntary, informed consent was required from participants. In practice, however, I acknowledged that consent can never be fully informed (Sherriff *et al.*, 2014; Wiles, 2013; Mason, 2002) and my role as researcher was to ensure that my participants consented as fully as possible. I reflected upon what I was asking the participants to consent to and that this included; consent to take part, giving me the right to use, analyse and interpret the data and reproduce/publish the results. I designed a participant information sheet (appendix 3, p187) and consent form (appendix 2, p186) in consultation with the FAST-R service and the UoB ethics committee (FREGC). The feedback I received enabled me to reflect upon how I might manage a malpractice disclosure and include details of the process I would follow, in the information provided to participants in advance.

---

<sup>7</sup> Although this precaution was taken, no participant made a malpractice disclosure.

The information sheet included the purpose of my study, highlighted potential risk of distress, details of how to partake, and reiterated that participation is voluntary and that participants can withdraw at any time, without reason. My contact details were included and those of an independent UoB staff member who could be contacted in the event of any concern about the study. The information sheet and consent forms were written in clear, user-friendly English. I opted for a two-staged process (Sherriff et al., 2014) sending out the participant information sheet (appendix 3, p187) by email, in advance of arranging an appointment, encouraging potential participants to raise any issues requiring clarification. At the start of each interview, I went through the information sheet and consent form with the participant to check understanding and again to raise any queries. I drew participant attention to how I would store their recorded data and data produced from analysis, to ensure confidentiality and the measures put into place with the third-party transcriber to protect anonymity (Mason, 2002). I also reiterated that participants could withdraw at any stage of the study.

There were differences between the client participants and the therapist/professional participants which did require careful consideration. I found that the client participants were less interested in the ethical concerns and keen to skip through this stage of the process and I was mindful that this could impact the power dynamics between us (Mason, 2002). With the recruitment of the therapist and the professional body participant, there was no gatekeeper involved and therefore no competing interests to consider. Recruitment of client participants, however, did initially involve accessing potential participants via their therapist. I found that therapists were reluctant to act as gatekeeper due to fears of the impact on the relationship dynamics, and this method also put into question the authenticity of informed consent, if the client participants felt obliged to comply with the therapist's request (Kvale and Brinkmann, 2009). Recruiting client participants using a poster in practice waiting rooms minimalised the potential for coercion, as the participants referred themselves directly, without the therapist's involvement.

All participants were aged over 18 and without intellectual disability and therefore, capacity to consent was not an ethical dilemma (Wiles, 2013). Apart from my offer to

refund any travel expenses, no other incentives to participate were made, to ensure that consent was freely given and not coerced (Denzin and Lincoln, 1994).

As a further measure to ensure consent was continuously valid (Kvale and Brinkmann, 2009) I forwarded the interview transcripts to participants, to read and comment upon, giving them the opportunity to add anything they thought of later, or delete any data they no longer wanted to be included. One participant referred to a brief conversation which took place after the tape was switched off and the details were not included in the transcript. She summarised our conversation and asked that this be included in the analysis. Two participants informed me that they were surprised to discover they had not spoken in grammatical sentences, but accepted that it was a verbatim reflection of the interview. None of the participants asked me to delete any data.

#### **4.13 Analysis**

Data was analysed using thematic analysis, which is a flexible research tool, designed to provide rich, detailed and complex data (Braun and Clarke, 2008). Thematic analysis involves creating themes or repeated patterns of meaning which emerge from the text. It enables the researcher to show links between participant responses. Boyatzis (1998) argues that thematic analysis also facilitates the interpretation of data and is described as a 'contextualised method' (Braun and Clarke, 2008:9) as it is not grounded or restricted in any theoretical framework. My own ontological and epistemological position enabled me to apply constructionist assumptions to data analysis and take an active role in identifying and reporting themes (Tayler and Ussher, 2001). Ely and colleagues (1997) argue strongly that themes do not emerge from the data in a passive manner, but are created by the researcher. To answer my research question, I used a latent approach (Braun and Clarke, 2008) to thematic analysis, looking at underlying ideas and assumptions within the data and identifying therapist selection factors. I familiarised myself with the existing literature before commencing data analysis, to sensitise my focus (Tuckett, 2005).

Boyatzis (1998) acknowledges that although thematic analysis is a widespread method used to analyse qualitative data, historically there has been little written instruction for researchers to follow. I have discovered several Thematic Analysis manuals written more recently (Harding, 2013) (Silverman, 2006); Gregory *et al.*, 2012), but used the Braun and Clarke (2008:15-23) six-stage model for my data analysis process, which I will now outline:

### **Phase 1 – Familiarisation with the Data**

I audio recorded the semi-structured interviews and iteratively listened to the recordings several times. Having used a third party to transcribe my interviews, I again listened to the recordings when I received the typed transcripts, to ensure they were verbatim and an accurate reflection (Mason, 2002; Miles and Huberman, 1994). At that stage, I also sent a copy to participants to enable them to validate the contents (Kvale and Brinkmann, 2009).

### **Phase 2 – Generating Initial Codes**

Miles and Huberman (1994:50) describe this stage as the early data analysis where the initial areas of interest to the researcher start to emerge. Having familiarised myself with the interviews, I initially made margin notes of anything that interested me. I did consider using the computer software programme NVIVO to support this process of searching, reviewing and defining codes in the data. There were obvious advantages to using NVIVO (Bryman, 2012), including manual labour time saving and ease of retrieving quotations. I tried out the programme using my pilot interviews, which enabled me to confirm that my preference would be for a manual process, to ensure that I did not become detached from the data and remained aware of the themes as they emerged.

### **Phase 3 – Searching for Themes**

I used a creative method of mind mapping for each interview, which involved printing the transcripts and using scissors to cut out key-words and quotations (Mason, 2002.) I then brought them together assembling and reorganising the extracts, until I had established clusters of codes.

## **Phase 4 – Reviewing Themes**

From the initial clusters of codes (appendix 8, p197), I continued using the mind mapping method described above to condense blend these into coherent patterns, eventually forming four main themes and 13 sub-themes. This phase involved going back to the transcripts and re-reading, to validate the themes to the whole data set (Braun and Clarke, 2008).

## **Phase 5 – Defining and Naming Themes**

In this phase of data analysis, I returned to my research question and identified how the themes were answering it. Braun and Clarke (2008:22) suggest that the sub-themes help to give structure and clarity to a large complex theme.

## **Phase 6 – Writing up the Report**

This is the production of my thesis, chapters which have been written, revised, edited and re-written with the support of my academic supervision team.

I endeavoured to approach the data analysis with a hermeneutic of suspicion (Josselson, 2004), with the knowledge that I can never be consciously aware of the rationale for my interpretation of the data, or the meaning I make from the words in front of me. Josselson (2004) suggests looking for the hidden meaning in the text and with a "*hermeneutic of faith*". As discussed previously, ontologically, my stance is that interviews produce co-constructed data from which I, as researcher, interpret and make sense. The results of this study are then, a critical construction between myself and the participants, rather than an absolute truth.

### **4.14 Risks to Researcher and to Participants**

I considered the potential risks to participants referring to both University of Brighton Guidance on Good Practice in research Ethics and Governance (UoB, 2013) and BACP Ethical Guidelines for Researching Counselling and Psychotherapy (BACP, 2013)

I did not envisage any physical risk to participants and a negligible risk of psychological harm. The questions I asked client participants in interview (appendix 1, p184) were intended to elicit information and opinions. In the event participants were not previously aware of the regularity status of the profession, this could have caused alarm, were they to question in retrospect, the validity of the therapist with whom they had engaged. As the researcher, I am an experienced therapist and would have shown empathy in containing the situation. I would then have checked out that the participant was able and willing to continue the interview, terminating if requested to do so. Client participants were likely to still be in therapy/counselling and would, therefore, have had this additional support available. I would have been happy to signpost for alternative therapeutic support if required to have done so. Being mindful of issues of coercion and dual relationships (BACP, 2013; UOB, 2013a) I did not approach my own current or former clients or therapists within my close professional networks.

I approached spokespersons from the largest four professional Bodies, BACP, UKCP, British Psychological Society (BPS) and the British Association for Behaviour and Cognitive Psychotherapies (BABCP) and the Professional Standards Agency (PSA) and Health Care Professions Council (HCPC). I carried out face-to-face interviews, to explore the subject from their perspectives, and a copy of my semi-structured interview questions (see appendix 2, p186). Again, this process could have theoretically caused psychological distress and in this event, I would have used my skills as a therapist to contain the situation and offer to terminate the interview.

I did offer to meet participants to carry out the face-to-face semi-structured interviews at a location of their choice and was aware of the potential risks to both participants and myself in doing so, in terms of personal safety and lone working. I offered my own business premises, which are private, professional and centrally located in Hampshire, as a venue for carrying out the semi-structured interviews. The benefit to doing so, is that my colleagues are on site and available, in the unlikely event of any risk to personal safety. My own business premises might not have been convenient location for all participants for number of reasons, including mobility or disability

issues. I therefore, offered to visit participants in their own homes or at a public venue of their choice, if required, to carry out the face-to-face semi-structured interview. I was aware of the increased risk to my personal safety in doing so and as suggested by the University of Brighton (2013a:5), set up a 'buddy system' to keep this risk to a minimum. This entailed leaving details of my location in a sealed envelope with an associate who I would call after the interview, within an agreed timescale. In the event, I did not call within an agreed timescale, my associate would have opened the envelope to discover my whereabouts and raise concern. I did have a short discussion with participants who chose to be interviewed at home about their domestic situation – enquiring very tactfully of course if there are others living in their home. This was so that I could ascertain whether the interview could be overheard, or if they had other calls on their time (such as children, dependent relative, animals) which might have led to them feeling compromised. This was to ensure that participants would feel comfortable in allowing the interview to take place as far as possible, without conflicting demands on their time or being worried about breach of confidentiality.

I did not envisage any physical risks to the participants in undertaking this study. In the event the outcome of my study challenged the regulatory status of my profession, there was a risk to myself of receiving critical acclaim from those colleagues, peers and others in my profession who support voluntary registration. I was not aware of any way this risk can be negated and accepted that studying at doctorate level or indeed of putting one's research into the public domain, there is an inevitability of attracting potentially hard-hitting feedback. I did, however, have the support of my supervisor and my own therapist, as well as a supportive family, friendship and collegial network to assist in managing any such a response.

#### **4.15 Validity and Reliability**

The concepts of validity and reliability are most often associated with the positivist philosophical position. McLeod (2001) discusses the two-fold challenge of validity, with the assumption of no fixed reality and qualitative research reliance on words (as opposed to quantitative numbers) and rhetoric being subject to interpretation and sense being made by the reader. Guba and Lincoln (1989) suggested alternative

concepts for research undertaken with the interpretative paradigm; credibility, transferability, dependability, and confirmability, however, from my constructionist stance, these concepts are equally challenging to adopt. Credibility is concerned with the relation of congruence of the findings to reality, but whether this reality relates to the researcher, the participant or the reader is unclear. Transferability would be almost impossible to demonstrate with my study's small sample size and repeating the study in another situation, would produce data based upon those participant's realities, so the data and results could be very different. Likewise, dependability, would be difficult to demonstrate with the findings being interpreted from a different reality. As the data is co-created between researcher and participant, my bias will be evident. Existing literature (Miles and Huberman, 1994) argues that it is possible (or even desirable) for the characteristics of the researcher to be omitted, but that the researcher's predispositions should be included reflectively. Rolfe (2006; Sandelowski and Barroso, 2002; Koch and Harrington, 1998) conclude that the judgement on quality is co-created between the researcher and the reader, with Rolfe (2006) arguing that each individual study should be appraised on its own merits. The BACP (2013) maintains that:

*A firm commitment to striving for fairness and honesty in the collection and analysis of all data and in how these findings are presented, as fundamental to the integrity of research. (BACP, 2013:9)*

BACP (2013) expands further on commitments to openness, transparency and applicability of the findings. In view of this, despite the challenges of my constructionist ontological stance, I felt it was important to support my study with a framework to assess robustness and integrity. I, therefore chose the criteria for qualitative research offered by Lucy Yardley (2000). Yardley outlines four principles for assessment, which include:

- Sensitivity to Context;
- Commitment and Rigour;
- Transparency and Coherence;
- Impact and Importance.



I remained mindful of this framework throughout my study and used the support of my Action Learning Set, my academic supervisors, peer network and reflection in my journal as measures to challenge and evidence the robustness and integrity of my study. Mason (2002) debates at length the complexities of validity and reliability for qualitative researchers. She concludes that justification as to the methods and methodology (as outlined in this chapter) are crucial as well as transparency in the data interpretation. Once I had completed the data analysis, I arranged for a colleague to review my results and coding process to ensure that she could make sense of how the themes had emerged from the data and that I had not missed anything significant.

#### **4.16 Benefits to Participants**

I offered to cover participants reasonable travel expenses but otherwise there was no financial incentive for choosing to take part in this study. University of Brighton guidelines (2013a:9) are explicit in terms of reciprocity and inducement, with the potential impact on participant ability to give voluntary consent. I hoped that participants would feel a positive emotional benefit from partaking in this study, in terms of having their views heard/valued and in contributing to research (Denzin and Lincoln, 1994; Wiles, 2013). During the interview, I offered participants access to the results of this study, if required once the thesis is complete and the professional doctorate awarded.

#### **4.17 Pre-Pilot Study**

I carried out a pre-pilot study to ascertain levels of public knowledge in my area of interest. This consisted of a brief questionnaire, attached (appendix 7, p195). I circulated the questionnaire via a local sports club whose membership consists of men and women with an age range of 18 to 85 plus. I received 19 responses, summarised below. The purpose of my pre-pilot was to explore a small sample of public knowledge and use the results to shape my pilot interviews questions (Gillham, 2005). Public participation in the study design was an important factor.

The first question, asked the respondents where they would look for a private practitioner. Over half the respondents said that they would ask for a recommendation, either from a GP or a friend, family member or colleague. The remainder stated that they would use the internet to either look up an online directory to find a therapist, or make a search using an online search engine. This concurs with decision theory and relativity, the view that people do not make decisions in social isolation and are influenced by the opinions and values of others (Kahneman, 2011; Ariely, 2009).

The second question asked the respondents to comment on expected levels of therapist educational standing. Nine respondents stated that either a Bachelor's or Master's degree would be expected, whilst three respondents stated that qualifications held by the therapist were irrelevant or unimportant to them. This result surprised me, as I had thought that standards of education and training would be a significant selection factor and I was very interested to see if this response was replicated in the final study. Two-thirds of respondents said that they would not need to validate the therapist's qualifications or professional standing and the remaining third, stated that they would validate either by asking the therapist or by looking them up on the internet. The final question asked respondents to consider how they would differentiate between potential therapists and the overwhelming majority said that recommendation or previous client feedback would be the most important factor, the second most cited factor was the rapport or friendliness of the therapist in response to a telephone or email enquiry. Only one respondent cited cost as a deciding factor, and only one other suggested level of education or experience.

The results from this very small-scale pre-pilot study are concurred with prospect theory (Kahneman and Tversky, 1979), which suggests people frame their choices, before weighing up the options and apportioning value to them. Obtaining recommendations from others, could be interpreted as a way in which to frame options and ascertain the value others have apportioned. The pre-pilot study generated my interest into exploring which factors are valued highly and which less so, in the larger study. Carrying out the pre-pilot study enabled me to hone my interview questions (Creswell, 2014; Gillham, 2005) to ensure I asked the

participants of the main study which choice factors were of greater value to them. It was also a sharp reminder that I do have my own assumptions which needed to be set aside during the interviews, so that I could remain open to hearing alternative viewpoints of participants and “*decentering*” from myself (Gillham, 2005).

#### **4.18 Pilot Study**

The pilot study involved interviewing two participants, Ann a therapist participant and Amanda a client participant. I used the interview schedule (appendix 1, p184), which was modified slightly following the pre-pilot study, to check that the questions I asked would generate the data required to answer my research question. Robson (2002) suggested piloting a study is an essential exercise, enabling the researcher to be flexible and adapt the design if required. Barbour (2013:121) refers to using the pilot study for ‘*capitalizing on fresh insights*’. The pilot study enabled me to check practicalities such as using a voice recorder, provide an estimated time duration for future interviews and that the questions flowed comfortably and made sense to the participant (Oppenheim, 1992). Carrying out the pilot interviews gave me the confidence in my interviewing skills which was needed to proceed with the full study. As there were no significant changes to the semi-structured questions, because of the two pilot interviews carried out with Ann and Amanda, the data was analysed and included in the results chapter.

The next chapter presents the study results and the positioning within the context of existing literature.

## Chapter 5 – Findings

This chapter outlines the thematic analysis results of the participant interviews, commencing with a summary of the four selection factor themes which emerged; ‘third party recommendation’, ‘location’, therapist previous experience’ and, ‘ability to relate to me’.

The diagram below demonstrates the main themes and the associated sub-themes:

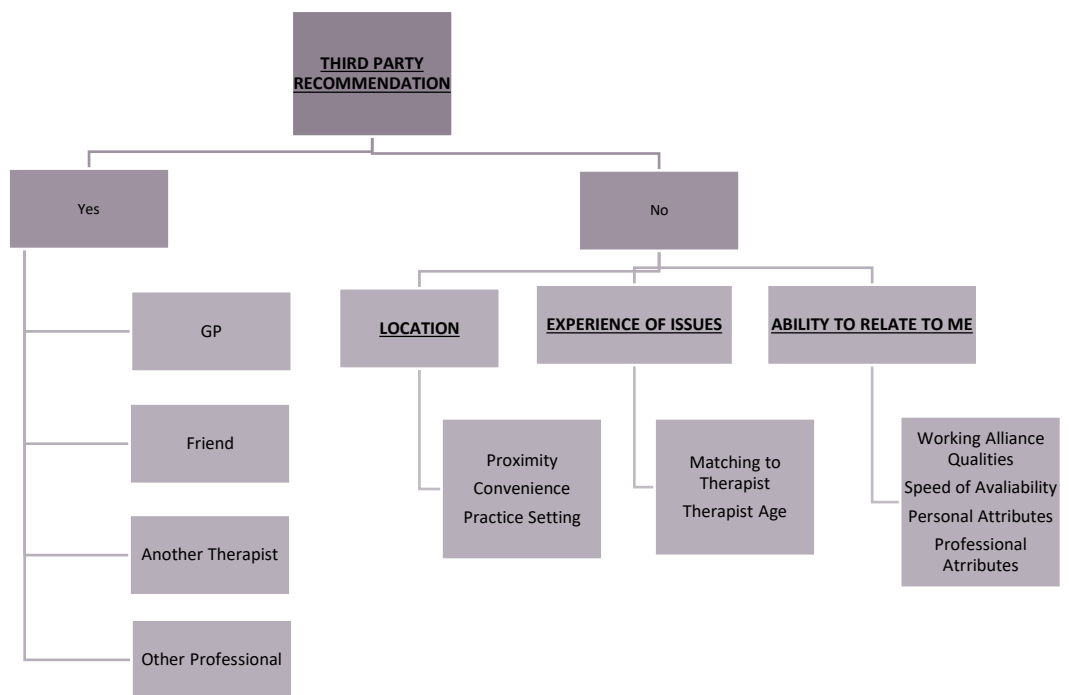


Figure 4. Thematic Analysis Results

I will now concisely summarise the findings, firstly, defining the main themes:

### Main Theme - Third Party Recommendation

This theme represented participants approaching a third party for advice and suggestion as to who might be suitable as a therapist. The findings emerged into four sub-themes; ‘GP’, ‘friend’, ‘another therapist’ and, ‘other professional’.

The participants provided a rationale for selecting a therapist recommendation, which will be presented in a further four sub-themes; ‘desperation and need for

urgent need for help', 'lack of confidence and faith in another's knowledge', 'outcome was positive or it informed me next time' and, 'drawbacks of recommendation'

### **Main Theme - Location**

This theme represented the physical proximity of the therapist's consultation room and the geographical area within which they practised. This theme emerged into three sub-themes, 'proximity to home', 'convenience' and 'practice setting'.

### **Main theme - Therapist Previous Experience**

This theme represented the therapist's existing clinical knowledge and potential ability to understand/empathise with the client's presenting difficulties. This theme developed into two sub-themes; 'matching my issue to therapist experience' and, 'therapist age'.

### **Main Theme - Ability to Relate to Me**

This theme represented personal and professional qualities which clients considered in their selection process. The theme developed into four sub-themes; 'working alliance qualities' 'speed of availability', 'therapist personal attributes' (as relevant to the client) and, 'therapist professional qualities' (as relevant to the client).

I will now present the findings in more detail, taking each main theme respectively and associated sub-themes. This chapter then concludes with an overview of findings related to the regularity status of the counselling and psychotherapy profession and the implications for voluntary registration.

## **5.1 Main Theme – Third Party Recommendation**

Third party recommendation was the first of the four main themes to emerge from the data, being mentioned by 15 of the 22 participants as a significant factor in the selection process. Seven of the 10 client participants stated that recommendation had been a selection factor for them. Client participant, Betty, explained:

*Yes, each time it has been because I've been looking to resolve a particular issue...so I chose someone with those skills and also someone who came with personal recommendation. (Betty- Client)*

Likewise, Eight of the 12 therapist and professional participants mentioned third party recommendation as a selection factor. Therapist participant, Ann, suggested that recommendation of a therapist is a similar process to looking for a tradesman:

*And that's the same out there when you're looking for a decorator, somebody to work on your house or a company if you're buying something, you're looking on the computer at the feedback, even a holiday aren't you, you're looking at the feedback and reviews and that sort of thing. (Ann - Therapist)*

Bella also mentioned the internet as a search tool, but stated in her experience, recommendation was the priority factor for clients, over any other selection criteria:

*lots of people talk about recommendation so I think that's one of the things is if they know somebody who's had therapy or counselling and I think when I've read more than what I know because it's not so clear from clients is that recommendation tends to take precedence over the internet. (Bella – Professional)*

Decision theory (Kahneman, 2011) suggests that humans are complacent when it comes to making choices and that '*fast thinking*', where we can make an immediate decision, without the necessity of reflection or contemplation, this will be the preference, '*slow thinking*' only comes into effect when:

*Spontaneous search for an intuitive solution fails – neither an expert solution or a heuristic answer can be found. (Kahneman, 2011:13)*

Decision theory resonates closely then with the findings from this study, with two-thirds of the participants mentioning recommendation as a key factor affecting selection. The results suggest that if the option of recommendation is available, or desirable, it will be taken. I mention desirability because several client participants

stated that they were aware of the recommendation option, but chose not to pursue it and instead, draw upon their previous experience, to make a personal selection.

Third party recommendation was mentioned by the participants as coming from several different sources and four sub-themes emerged from the data; 'GP', 'other professional', 'another therapist' and 'friend'. I will now discuss the four sub-themes in turn:

### **5.1.1 Sub-Theme - GP**

The GP was mentioned by three client participants as a common source of recommendation, who all agreed that this is a popular source of recommendation amongst the public:

*Why I chose her, she was local and she was recommended by the local GP...and I think a lot of people will ask GPs. (Ivor - Client)*

Two of the therapist and professional participants also mentioned the GP as a recommendation source. Therapist participant, Ellen, suggested this might be due to the GP being able to share knowledge about her with the client:

*Occasionally I get people sent through GPs so they will have got some information on me before they come. (Ellen - Therapist)*

Therapist participant, Georgina, was surprised to be receiving GP recommended clients, suggesting she had no existing relationship nor affiliation with the surgery:

*I've had a few recommendations that have amazingly come from either a GP, now I'm not registered with any GP surgery, but they've come specifically because they've been sent by a GP. (Georgina - Therapist)*

### **5.1.2 Sub-Theme - Other Professional**

The second sub-theme, other professional, was mentioned by five participants, with three client participants naming different gatekeepers, including the military welfare service and for Grace, a minister of religion;

*OK, so when I was looking for a therapist I was relying solely on recommendation. So that came at that point, it actually came from the vicar.*  
(Grace - Client)

Two of the therapist participants mentioned other professional referral sources. Harriet stated that her previous career was in medicine and that this resulted in former medical colleagues recommending clients with related issues. This suggested that for Harriet, recommendations were based upon prior knowledge of her experience and skills. Likewise, therapist participant, Georgina, suggested that other professionals who have knowledge of her specialism, refer clients to her requiring this expertise:

*I've had a few psychiatric who've been sent by a psychiatrist because of the fact that I do specific work and I've had several people sent by the police as well.* (Georgina - Therapist)

### **5.1.3 Sub-Theme – Friend**

The third sub-theme to emerge from both client participants and therapist/professional participants was recommendation by a friend, cited by six as a factor. Three client participants mentioned that a friend's own experience of a therapist appeared to add weight to the recommendation. James referred to his friends' prior experiences of a therapist influencing his choice:

*I knew what she'd done previously, very good references from other people, and because I'd known of her for a few years, she sounds perfect.*  
(James – Client)

Three therapist/professional participants also shared common experiences of recommendation by a friend as a selection factor. They suggested that a friend's prior working knowledge of a therapist in some way adds credibility to that person. Therapist participant, Ellen, stated that the friend can share their own experience of the therapist:



*Some people come by personal recommendation so they have a second-hand knowledge of me. (Ellen - Therapist)*

#### **5.1.4 Sub-Theme – Another Therapist**

The fourth sub-theme was recommendation by another therapist, which was mentioned by seven participants. Two client participants said that they had received a recommendation from another therapist. Client participant, Dorothy, mentioned that she initially saw a therapist for assessment and that this therapist referred her on to a colleague, who had specialist expertise in the area required:

*the therapist was definitely the right person that morning but afterwards, it was her who suggested that perhaps it would be better for us to see Fred when my husband found that he was ready. (Dorothy - Client)*

Similarly, five of the therapist participants admitted that they received referrals from other therapists. They suggested that other therapists are well placed to make a collegial recommendation, as they have professional awareness of other practices. Therapist participant, Diane, stated that another therapist will often have insider knowledge, or an awareness of a colleague's specialism and refer the client on to match this:

*The referrals that come through other therapists are then sort of on the basis of the therapist knowing me or my particular skillset so they will come on the basis of that recommendation. (Diane - Therapist)*

#### **5.1.5 Rationale for Third Party Recommendation Option**

In addition to identifying the main theme of 'Third Party Recommendation', the findings also suggested the participants' rationales for using recommendation in the therapist selection process and discussed the impact on the outcome of therapy. These findings became four sub-themes: 'desperation', 'outcome positive or informed', 'drawbacks' and 'lack of confidence' which, I will now discuss in turn:

#### 5.1.5.1 Desperation and need for urgent need for help

10 of the 22 participants mentioned a desperation and an urgent need as rationale for seeking a therapist recommendation. Six of the client participants described their distressed mind-set as a factor, with Amanda explaining:

*I was in a state where I really needed help... Yes, so there wasn't any sort of "I'll just look into this", because I wasn't functioning very well as it was so there wasn't really any sort of looking into things, it was just a case of "I really need some help, I'll go to my GP... I just jumped in and followed what we were told. At the end of the day I don't think unless you're suffering you don't go to a counsellor, do you? Nobody who is 100% happy thinks "Oh actually, I think I'll go and see a counsellor this week." It's not going to happen, you go because there's something wrong at some level from like what you say, "Ooh, maybe I could work on this" to "Oh my good Lord, the floor's just been knocked out from underneath me, I need help".*

(Amanda - Client)

Other client participants discussed having been struggling for some time, before reaching a state of desperation, where seeing a therapist became an urgent necessity: Client participant, Grace, explained:

*and then absolutely at that point, I just wanted to see anybody.*

(Grace - Client)

Betty described how this desperation can lead to an urgency to be seen, which potentially could influence the choice of therapist:

*These things are quite urgent sometimes, obviously causing one a great deal of distress and so, therefore, it's about trying to make sure it's the best person to get through it as quickly as possible. That's always been my rationale anyway, I'm not terribly patient.* (Betty - Client)

Four of the therapist/professional participants also recognised the impact of desperation and urgency, on the therapist selection process. Freya discussed the relevance as a therapist, to responding to this client need:

*Speedy response yes and actually being able to get them in, being able to work with that how quickly they want to come, whether it can be the next day or it might be next week. In my experience, it rarely goes much further than that. There's something about urgency and about needing to get used to the idea – the mental preparation. (Freya – Therapist)*

Therapist participant, Imogen, shared her view that this desperate mindset can influence the client's ability to make an informed choice, concurring with the theory of irrationality (Ariely, 2009) mentioned earlier in the literature review chapter.

*People don't think about counselling at all, until they desperately need it in some cases and it's suggested to them that it really would be good for you and they don't know anything about it at that point do they and they're probably too caught up in the issue to do that kind of research, or for it to mean anything to them. (Imogen – Therapist)*

The findings suggested, that participants are making the decision to choose a therapist in a distressed state of mind which, affects their ability to be rational or informed (Ariely, 2009) (Lemersie and Arsenio, 2000). Furthermore, the urgency and need for a speedy resolution, makes fast thinking and therefore recommendation, a likely option (Bargh and Chartrand, 1999; Gilbert and Gill, 2000; Hogarth, 2001). This again suggests that the process of choosing a therapist is neither informed nor rational.

#### *5.1.5.2 Lack of confidence and faith in another's knowledge*

The client participants talked about naivety when they first made the decision to have therapy and how their first experiences later informed their subsequent choice processes. There was a sense that the desperation and lack of knowledge the first time around led them to take whoever was offered:

*Looking back and also, I know obviously it's purely my experience but also as a Mum, I've assisted one of my children with help and what I know now about counsellors and the BACP and all the rest of it and how people can call themselves counsellors with very very few qualifications, yes, I don't think it was good enough at all and I wish I'd have known and I would have looked into things a lot more than I did. (Amanda - Client)*

*Well I personally, if I didn't know anything about any of them and didn't have any other information, would have been a "put the tail on the pig" exercise. (Charles - Client)*

Trust in the relationship with the recommender and in their judgement, was a strong factor for several client participants. This need for trust in the recommender's knowledge of the therapist, or belief in the therapist's expertise was evident in all sources of recommendation; GP, friends, another therapist and other professionals:

*Someone I completely and utterly trusted...because he knew everything that was going on at that time, and I felt aware that I was taking up a lot of his time and also, you know, he's a busy man and it was kind of on his recommendation – he said "well why don't you try this lady who is a brilliant therapist" and it was from there, and because I trusted him so completely I said "OK, give me her number" and that's how I did it. (Grace - Client)*

*Initially, it had to be because we didn't know them so it was done purely on the advice that he had expertise in that field so it was in that sense, a shot in the dark really. (Charles - Client)*

Having trust in her GP to appropriately recommend, was specifically mentioned by Amanda, who reflecting on her own experience said:

*I kind of put my faith in the GP, and I put my faith in the military service to come up with something that was good and that was going to work... Yes, they would know what was best for me (laughs)...and I didn't really know about options and things, I just, I erm just put my faith in my GP to point me in the right direction and give us the best support there was to have.... It was*

*the worst time of my life, to be frank, and there was no rational thought going on at all so I just had to put my faith in the doctor and everybody that they sent me to. (Amanda - Client)*

The therapist/professional participants identified a similar need for faith in the recommender and their knowledge:

*I think they then trust that that specialist would understand what they were looking for and would therefore then make a decision accordingly.*

(Georgina - Therapist)

*I think we are very privileged, I think people do have an awful lot of trust in us and hopefully usually well placed but I do think so and I think clients trust us with a lot... I've met a lot of counsellors over the years and some I have some reservations sure, but on the whole I do think that we all take this trust very seriously. (Harriet – Therapist)*

Trust in the recommender, was a factor particularly pertinent when it related to the GP. Imogen explained that the GP is seen by the public as a gateway to other services, which makes them the obvious initial choice when seeking a recommendation. She also stated that the public do look to their GP for instruction and that it is this power dynamic that attracts clients to seek advice from their GP:

*I suppose that's why a lot of them go to their GP first because they're used to going to a GP for something like that and whatever their recommendation is they're likely to follow that initially. (Imogen - Therapist)*

Resonating with decision theory (Kahneman: 2011), a lack of insider knowledge and the need for an expert, trusted advisor was widely referred to as rationale for seeking a recommendation. These findings support prospect theory (Kahneman and Tversky (1979) and the desire for certainty when decision making, and with other studies recognising the role of trust in decision making (Spalter, 2013; Schwarz *et al.*, 2004; Tetlock, 2002). Spalter (2013) suggested that clients seek advice about their choice

of therapist from a friend/family member because this person would have an awareness of their relational needs and recommend on this basis.

#### *5.1.5.3 Outcome was positive or it informed me next time*

The client participants had mixed therapeutic outcomes from third party recommendation and for several, recommendation had a positive outcome:

*the recommended therapist was the right person for us. (Dorothy – Client)*

*we knew the practice was here, we showed up, we got a bit of advice on arrival and took it from there really and it's all worked out very well. (Charles - Client)*

Other client participants did not find recommendation so useful, with an unsatisfactory therapeutic outcome that informed the next time they were choosing a therapist:

*The lady I went to see, she was very nice but, I kind of felt that, I don't know, we didn't really sort of fit very well, you know? It was that kind of thing...maybe there was a bit of a personality clash or something or just the way she did things just didn't sort of sit right with me. (Helen - Client)*

*It didn't turn into an inappropriate relationship but it didn't work particularly well for me. (Ivor – Client)*

These poor therapeutic outcomes, did appear to impact subsequent choices of a therapist, which were more deliberate, built upon the learning from earlier therapeutic experiences. The data suggested that recommendation is especially relevant when a client is looking for a therapist for the first time and is unsure what factors to consider. Client participants who had made a choice previously, said that this prior experience had influenced the relevance and preferences of specific choice factors when making subsequent choices. Betty was informed about therapist modality, Ivor and Helen were informed about gender, James and Helen about practice environment and Amanda about the professional standing and education.

*I did have some counselling and that was with a man which I didn't really like, so which is probably what also influenced me in my later counselling.*  
(Helen – Client)

*it was because my previous experience of counselling was a female and it didn't turn into an inappropriate relationship but it didn't work particularly well for me.* (Ivor - Client)

Interestingly, Imogen was the only therapist/professional participant to comment upon clients prior learning about choice from previous experiences. This could be because clients do not feel it is an appropriate issue to discuss with a new therapist.

*Well, I think based on my own experience I think it depends on where they are personally, whether they've had counselling before.* (Imogen - Therapist)

These findings do concur with Spalter (2013) who concluded that clients are informed by previous therapist choices and that this impacts the decision process thereafter, by setting realistic expectations. Knowledge could be further enhanced with additional studies focusing in this area.

#### *5.1.5.4 Drawbacks of Third-Party Recommendation*

Client participants highlighted downsides of a third-party recommendation, with suggestions that GPs are not always best placed to recommend, or do not have enough knowledge of therapy themselves. The faith and trust that clients place in GPs were questioned by client participants. Client participant, Ivor, stated that in his case, the GP was biased and the recommendation was personally motivated, rather than professional:

*it became very apparent that her relationship with I think one of the partners was a bit more than professional, it was a personal relationship, but apparently not a constant personal relationship and I found all this out and as I say it wasn't a very pleasant experience.* (Ivor - Client)

Client participant, Amanda, reflected with hindsight of a poor outcome experience, upon the extent to which GPs have expert knowledge:

*on the word of the GP “We will send you here and you will go and access this treatment” and I’ve gone “OK” and off we trot and I have no idea of these people’s qualifications, nothing, I don’t know anything. I don’t know how qualified they were for the job, absolutely nothing and I took my daughter to that. To me that was the best thing to do, went to the GP, GP said “Right go here” and we went and in honest faith, I just thought, “We’ve got to do something, we’ll go and try this” so yeah I really do kick myself in hindsight for that one. (laughs) (Amanda - Client)*

The therapist and professional participants agreed with the client results, suggesting that GPs are not as well informed as the public might think:

*I think there’s a general sort of ignorance among the general population, even in terms of GP referrals I don’t think a lot of GPs would have much idea about what accreditation or registration means... Certainly a lot of my friends who are GPs they wouldn’t really have much idea. I think it might be different if they have a good counsellor in their practice who is passing on the information to them but no I don’t think they do.... but I think the whole CBT debate probably hasn’t furthered our cause particularly because I think what it has done is it’s given most GPs and I think they’re often the signposting portal, it’s given most GPs the idea that counselling and therapy is CBT, and the idea that there’s anything else they don’t understand it. (Diane - Therapist)*

*I suppose that’s why a lot of them go to their GP first because they’re used to going to a GP for something like that and whatever their recommendation is they’re likely to follow that initially until they realise it might not be working for them and then they research it themselves. (Imogen - Therapist)*



*it's just as difficult isn't it for a GP, if they haven't had a particular interest in counselling or therapy, to figure out who would be a good person to refer a client to. (Bella – Professional)*

It could be argued that when GPs are asked for a therapist recommendation, they are just as likely to opt for fast thinking (Kahneman, 2011) and recommend the first therapist who comes to mind. If they do not have the expert knowledge to match a client's needs to a variety of available therapists, then they too make a fast thinking decision, based on their experiences of making a previous recommendation. It is questionable whether such recommendations are in the clients' best interest or deserving of the faith put in them by their patient. Kahneman (2011:201) suggested that when we have limited information, we fill in the knowledge gaps to convince ourselves that the decision we have made is the best one and in effect, fast thinking is irrational and flawed. GPs are also likely to be influenced by the accountability factor and a need to be able to justify a recommendation, which is likely to encourage them to select a safe option (Schwartz *et al.*, 2004). Spalter (2013) also found that recommendation did not always lead to a positive therapeutic outcome.

## **5.2 Main Theme - Location**

Returning to the main themes, the second to emerge from the data was the location, with half of the participants (12 of the 22) stating that the physical location of the therapist's consultation room was of paramount importance. The findings suggested that where recommendation was either not available, or not sought, participants turned to the internet and searched for a therapist, initially using the town/city name in the search engine.

Client participant, Grace, said that recommendation was her first choice in therapist selection, but when I asked what she would have done if a recommendation had not been possible, she responded:

*I think I would have gone online and I think my priority, ridiculously, it would have to have been local. I wouldn't have wanted to travel very far because at that point I wasn't in a frame of mind that I wanted to travel. I just didn't*

*want to go out really so if I could keep it as local as possible that would have been my priority and then absolutely at that point I just wanted to see anybody. (Grace – Client)*

Helen said that she opted against recommendation and instead undertook an internet search, initially using her local town, to find a therapist:

*I looked online. I didn't sort of discuss it with anybody else, I didn't ask anybody if they had any recommendations. I started off looking at what was available in the area. (Helen - Client)*

Surprisingly, therapist location is not a selection factor which regularly appears in the existing literature (Elliot (1972). Spalter (2013) acknowledged location as a practical selection factor, factor arguing that clients tend not to select therapists who were difficult to travel to, unless the therapist offered something else exceptional, making the travel worthwhile. The findings from this study suggest therapist location is one of the first selection factors clients consider and use this to select personal preferences, such as physical proximity to home or work and a need, or not, for anonymity. The client participants in this study all undertook face to face therapy, which took place in the therapist's consultation room. The therapist and professional participants work primarily on a face-to-face basis, although it needs to be noted that therapy is also widely available electronically using applications such as Skype and VSee and over the telephone. Location as a selection factor, might not be appropriate to clients who are not travelling to a therapist's office for their appointment.

If recommendation was not sought, the findings strongly suggested that participants then turned to the internet and searched for a therapist initially using the location. I have divided this main theme into three sub-themes; 'proximity to home', 'convenience' and 'practice setting' which, I will now explore in more detail:

### **5.2.1 Sub-Theme - Proximity to home**

Most client participants who referred to location as an important factor, stated that a local therapist had been the priority for them. Client participant, Fiona, recalled that it

was the proximity to home, that initially prompted her to engage in therapy in the first place and also kept her committed to attending:

*Well this is strange but a practice suddenly set up at the end of my road....And I thought, OK I'll do some research online to have a look at this practice and actually it was just the first name that came up and I thought I'll contact him and see just because he was down at the end of the road, I thought "OK well I could just ask at least" and that's how it started... Because I was somewhat reticent about going to counselling, I think that's fair to say, I thought because it was at the end of the road I thought I won't have an excuse not to go. If I had to drive to the next town every Thursday or something then I could always talk myself out of it, but if it was right there, there would be no reason not to go. (Fiona – Client)*

Similarly, client participant, Dorothy spoke about her priority for a therapist that was near to home:

*I looked online to see if there were any counsellors in my town, I found the practice and I read the people who were counsellors there, I came down, quite early that morning and they weren't open so I rang and they very kindly agreed to see me almost straight away so that was my choosing because it was close to home. (Dorothy – Client)*

Betty was the only client participant to state that she would travel any distance to work with a therapist, if necessary:

*I don't mind how far I travel if I get the right person... I suppose that I was prepared to travel as far as needed. (Betty – Client)*

The therapist and professional participants did have awareness as to the relevance of proximity to home as a selection factor:

*People living reasonably nearby so it's convenient for them to come.  
(Harriet – Therapist)*

*I think cost and location because people do think “Can I afford it and can I get there”?* (Bella – Professional)

### **5.2.2 Sub-Theme – Convenience**

The second sub-theme was convenience of location, a factor mentioned by several of the client participants. Charles suggesting that being able to walk to the therapist’s office was an advantage for him:

*we certainly wouldn’t have wanted to undertake any regular counselling at a great distance but, no, I mean it simply was there... Yes, in previous problems we have been in to counselling in a different town, so I wouldn’t like to overplay the geographical location thing too much but the fact that it was here, we knew of it and it was walkable, was certainly a help.*

(Charles – Client)

Client participant, Amanda, reiterated that a convenient location was certainly a factor for her, but not too close to home:

*Probably location as well as I don’t want to be travelling millions of miles to see somebody but I also need it to be far enough away so I’m not going to be bumping into them because that would be horrific, to pour out your heart to somebody and they’re walking down the road and going “Hello!” (laughs)*

(Amanda – Client)

The therapist/professional participants also acknowledged the convenience of location as a selection factor. Ann made an interesting point, stating that whilst most clients do choose a therapist close to home, some deliberately select a therapist at distance, to ensure they would be less likely to accidentally encounter each other socially. This suggested that convenience means different things to different clients:

*I imagine there’s quite a few things in the mix there like location. That’s interesting really because some people want somewhere local and then other people want somewhere out of their area because they want the anonymity of that so some people are very different.* (Ann – Therapist)

For clients who are commuting, therapist participant, Ellen, highlighted that sometimes a convenient location, is not necessarily near home, but could be anywhere on route from work to home:

*I get people who say this is between work and home so they think it will be quite convenient. Location does play a part with some people.*

(Ellen – Therapist)

Harriet mentioned practical factors affecting convenience and that travel arrangements were relevant also:

*People living reasonably nearby so it's convenient for them to come... Interestingly I would never have thought of it but I was asking people what kind of things should I put on my website and one thing my husband said was that there's parking. It had not occurred to me at all but I think those kind of practical things, like I'm on a bus route and that's certainly important for one of my clients. (Harriet - Therapist)*

Andrew suggested that the ability to search for a therapist was one of the limitations of the statutory regulations, with the facility not offered to clients by the regulator:

*I think one thing that a statutory regulator doesn't do and can't do which isn't helpful for a patient, is actually allowing people to find a therapist in their area. So, you can do that through UKCP and BACP, you can't do that for a counselling psychologist. (Andrew – Professional)*

### **5.2.3 Sub-Theme – Practice Setting**

The third sub-theme was practice setting, with personal preferences differing between the client participants. Dorothy, Elizabeth and Fiona all referred to the concept of an 'institutional buffer' (Syme, 1994) stating that an established group practice suggested professionalism and gave them reassurance of standards:

*Although I suppose that they were a group there and I would like to think that someone had checked those out working there. (Dorothy - Client)*

*I suppose if it's more in a clinic setting then I kind of feel that there's more, I don't know, there's possibly a more secure environment...I think it was good to know that there was a whole group of people there. I have done an individual one many, many years ago and that was a bit like a finger in the air job... So, this sounds really weird, but I suppose if something was to go wrong, then you can speak with the clinic whereas if it's maybe an individual working out of their home, it's going to be a little bit more difficult and trickier, so I suppose I feel a bit more confident about going somewhere where there's several people together. I would assume that within a clinic setting that the clinic would make sure that only the relevantly qualified people were in residence. (Elizabeth – Client)*

The environment or the atmosphere of the practice setting was also relevant to client participants. Several stated that the practice setting needs to be relaxed and comfortable, rather than medicalised or clinical:

*Erm, yes I think, from what I can remember now, what came across I think was that it did sound that the environment was quite, I suppose, informal, relaxed, yes there was something about the way it was described that made me feel like that I could relate to that....a sort of chill-out, type of relaxed-feeling environment, that kind of thing and informal in a way. (Helen - Client)*

*the environment as well is quite important because if it's a bit too cold and clinical you just feel like you're going to the Doctor's rather than trying to sort out a few issues and problems, so that's important as well I think....I think setting is quite important, it's got to feel comfortable and relaxing because you're revealing a lot of yourself in these sessions so it's not like you're having a trip to the Doctor's or something where you're quick, in and out. (Elizabeth – Client)*

Amanda, Betty, Ivor, Helen and James stated that their preferences related to practice setting were because of a previous experience of therapy and awareness of which factors had made them feel uncomfortable in the past.

The therapist/professional participants also reflected on the comfort factor. Cathy stated

that the practice setting needs to be relaxed and comfortable:

*it's very important that they feel not only they can trust but they feel comfortable sitting there, you know not cosy but feel "I feel OK with this person" and feel they can ask questions. (Cathy – Therapist)*

Therapist participant, Joe, shared his experiences of clients preferring his home practice setting because it offered privacy and anonymity:

*As I said at the time, I practice in my home and it's quite anonymous, it's just like going to somebody's home and so on. (Joe – Therapist)*

Therapist participant, Ellen, suggested that the 'feel' of the practice was of great importance to her when she was selecting a therapist for herself:

*just their environment as well, speaks volumes to me, maybe not correctly, and the way they greet me at the door, just the whole package is really important to me and it's a bit like when you walk into a house and you know within a few seconds whether you want to buy it. I think when I've been looking for therapists myself, then I've known pretty much before I've got into the room whether this could be a possibility or not. (Ellen – Therapist)*

The findings under the sub-theme of 'practice setting' do suggest that environmental factors are relevant, and concur with the existing literature (Spalter, 2013; Manthei, 2006). Some of the participants stated their preferences for a group practice, or professional clinical settings and others, for a homely, private space. Clients are then weighting characteristics differently (Kahneman and Tversky, 1979) which, surprised me, when I reflected on my own experiences. I had always assumed that clients would prefer a professional office setting, over and above a therapist working from their own home. I had based my assumption on my own preference for a therapist working in an office setting, which suggested to me that they were a professional, modelling firm boundaries, keeping work and home separate. It was my view that a

therapist working from their own home, did not take themselves quite so seriously and blurred ethical considerations. I recall whilst working with my own therapist, he closed his office and moved practice to his home. This had a major impact on me as I felt I was forced to learn personal information about him, I did not wish to know, such as what car he drove (it was in the driveway), that he had a partner (I could hear someone else in the house), and his financial standing (evident from décor, the street he lived in and the furnishings). He used to joke with me about my adamant refusal to use his bathroom which was informed by my not wishing to learn anything else, including the brand of shampoo, toilet paper or soap he uses and worse still, catching sight of his underwear preferences from witnessing dirty pants in a washing basket! I have realised that I hold a strong preference for an office setting, which is not shared by all, and that other preferences in contrast to my own are also justifiably held.

### **5.3 Main Theme - Therapist Previous Experience**

The next main theme to emerge from the findings was 'therapists' previous experience'. The finding suggested that clients using the internet to search for a therapist, without a prior recommendation and after having established the desired location, were then looking to resonate the therapist's experience of working with their presenting issues. Two sub-themes emerged; 'matching my issue to therapists' experience' and 'therapists' age' which, I will now discuss.

#### **5.3.1 Sub Theme - Matching my Issue to Therapist Experience**

15 of the 22 participants mentioned therapist experience of the presenting issue, suggesting that this is a weighted characteristic. Seven client participants stated that this had been a selection factor. Client participant, James, described the relevance of the chosen therapist needing to be familiar with the presenting issue:

*I think the most important thing would have been that they would have had to have dealt, as I said before, with the complaint that I was having and the experience I had with that. (James – Client)*



Grace stated that for her, it was therapist disclosure which, gave her reassurance of her personal experience of her issues:

*I found it very reassuring as the counselling was progressing that she was able to say that you know, her father had died and she knew what it was like to grieve and bereavement so that was reassuring. (Grace – Client)*

Eight therapist/professional participants mentioned therapist previous experience as a selection factor and that matching areas of expertise had attracted clients to work with them:

*and I think the idea that someone has worked in the field for 10 or 20 years, I think that gives a sort of sense of experience and wisdom that brings something to the frame so, yes I do think they like that. (Diane - Therapist)*

*and I think many of them are more interested in what I've worked with before, so if I have anything written on my website specifically that they are coming for, I think that would pick up for some people. For instance, I do quite a lot of psychotherapy for trauma and abuse and so people specifically seem to be seeking me out for that. (Georgina – Therapist)*

Although having experience of working with the presenting issues did appear to be an important factor to clients, therapist participant, Imogen, argued that previous experience working with a particular issue is not necessarily always significant for a therapist:

*if they're looking for something specific they might want somebody who says they're a psychosexual counsellor or somebody who has something like EMDR or specific trauma training if they've been told that that might be what you need...because I would feel comfortable talking to somebody about something I don't have any experience of. But I know that as a counsellor that I could do that whereas a client may or may not appreciate that. It's difficult, I think it's down to informing your clients, it's difficult really. (Imogen - Therapist)*

There is existing literature on the importance to clients of being understood by their therapist (Castonguay and Beutler, 2006) and it could be argued that matching previous experience is driven by this motivation.

Braaten *et al.* (1993) argued that clients are keen to know a therapist's professional history in advance and that this does inform the relationship. Following their extensive meta-analysis, Lambert and Ogles (2004) concluded that high levels of training correlate with better therapeutic outcomes, which might include a therapist who is more experienced, having invested in longer-term education, although there is no evidence to suggest that this would make a client more likely to choose them. Orlinsky *et al.* (2004) argued that it was the therapist's application of skill which affects the outcome, but again although this could be interpreted as therapist experience. This study also focused on therapeutic outcome and not choice factors. Christensen and Jacobson (1994) controversially concluded that little value existed in training psychotherapists to doctoral level, as professional experience did not correlate with positive client outcomes, although this study interpreted advanced training to mean experience.

### 5.3.2 Sub-Theme - Age

The data suggested clients use their perception of the therapist's age as an indicator of life experience:

*Age. I wanted somebody who was a bit more mature than me... I just felt the topic we were talking about which was bereavement and family, I just wanted to feel that this woman was in a place where maybe she may have experienced some of what I was talking about. (Grace - Client)*

*I think an elderly person with lots of experience and they could relate to what was happening to me at the time. If that came over I would have been happy. (James - Client)*

*this sounds really terrible, but probably their age, because that would highlight the amount of experience maybe they would have had and maybe life experience as well... I think so. If I was in my 50s it would seem strange*

*talking to a 25-year-old about some of the issues that I was talking about. A 25-year-old wouldn't necessarily get it. (Elizabeth – Client)*

Client participant, Fiona, suggested that she was looking for a parental figure in her therapist and therefore made a judgement about age, which facilitated a paternal transference:

*He was smiling and he was older, patently older – not quite my Dad's age but – sort of parental kind of thing and I thought, "Yes definitely".*

(Fiona - Client)

Interestingly, Ivor was the only client participant to state that in direct contrast to the other participants, he was making a judgement on therapist age, but, specifically looking for a therapist who was younger than him. He suggested that a more mature therapist might have become stale or out of touch, whereas a younger therapist was likely to be modern in their approach. For Ivor, youth was a more desirable quality in a therapist, than life experience:

*I didn't want to talk to a man of my age, I wanted to talk to somebody a bit younger. The reason for that being that I thought a younger person would have qualified more recently and probably be more up to date with any techniques or tools that were available. (Ivor - Client)*

Half of the therapist/professional participants (Diane, Freya, Harriet, Imogen and Joe) mentioned the relevance of age in therapist selection, which might suggest this is not something client's generally make them aware of. Therapist participant, Harriet, said:

*And maybe the fact that I'm experienced, I'm not a youngster and I think that's probably made a difference to me in the past if I think about it. I would be reluctant, but wouldn't rule it out completely but if somebody was only in their early 20s or so, at my time of life, I might feel reluctant to see them.*

(Harriet – Therapist)

Joe, a therapist participant, said that he has been asked his age by clients and explained why he felt they needed to know:

*I've have had clients ask me how old I am...I think purely because they may feel intimidated by age, I don't know. I have heard stories about clients feel uncomfortable with younger therapists because they haven't had the life experience and when I've told them I'm this age and they're "oh right that's alright" and I think that probably helps them feel at ease. (Joe – Therapist)*

Therapist participants Freya and Diane, mentioned the significance of therapist age in relation to the potential client proactive transference:

*somebody that is of a certain age – not too young and not too old – but I believe there's something going on, there is a transference relationship starting there... I've had one client that said it was because it was a picture of an attractive woman at a certain age so that was kind of wedded to his issues. He was a philanderer for want of a better word. (Freya - Therapist)*

*I remember one person said to me "I thought you looked quite maternal" so that was something that appealed to them. (Diane - Therapist)*

The Cooper (2009) meta-analysis of existing studies, which explored the relevance of therapist age to the outcomes of therapy, concluded that client's experience therapist maturity as a positive factor impacting outcome. As therapists' do not generally state their actual age in their advertising literature, establishing a therapists age will be because of client perception.

The findings suggested that a therapists age was used to determine life experience and whether the therapist might then be able to resonate with the issues they are presenting. It has previously been shown that age is not relevant (Beutler *et al*, 2004) provided the therapist can relate to the client and comprehend their life stage. The results from my study suggest that age is very relevant, as this is how clients made their assessment of a therapist's ability to empathise. Interestingly, I had a conversation recently with a young colleague, aged 25, who had applied to train as a psychosexual therapist and had her application declined. The organisation advised

her that they do not accept anyone for training aged under 30 years, as their experience suggests that clients with psychosexual difficulties do not take younger therapists seriously and dismiss them on the basis that they could not possibly empathise with their position. Despite the implications in terms of age discrimination legislation (Equality Act, 2010) the organisation considered this assumption amongst their client base was so significant, that they no longer consider applicants under the age of 30 years.

#### **5.4 Main Theme - Ability to Relate to Me**

The final main theme to emerge from the findings was the therapist's ability to relate to the client. The findings suggested that clients using the internet to search for a therapist, without a prior recommendation, were attempting to ascertain whether the therapist would be able to relate or connect to them. This main theme involved into four sub-themes, 'working alliance qualities', 'speed of availability', 'therapist personal attributes' and 'therapist professional attributes' which, I will now discuss.

##### **5.4.1 Sub Theme - Working Alliance Qualities**

Horvath and Bedi (2002) define the working alliance as: "*The quality and strength of the collaborative relationship between therapist and client*" and Clarkson (2003) states that the working alliance:

*Is the part of client-psychotherapist relationship that enables the client and therapist to work together, even when either or both of them do not want to.*  
(Clarkson, 2003:8)

Bordin (1979) suggested a three-way model to conceptualise the working alliance, to include:

1. The therapist's and client's agreement on the goals of therapy: i.e. the targeted outcomes of their work;
2. Therapist and client consensus on the tasks of therapy: i.e. the in-therapy behaviours and processes that form the substance of their work and;

3. The existence of a positive affective bond between therapist and client, including mutual trust, acceptance and confidence.

The findings suggested an absence of assessing the first two criteria above in the therapist selection process, but for criterion three, named many different working alliance qualities, needed to establish the boundaries of a professional, safe, contained relationship. Qualities such as trustworthiness, non-judgement, calm, confidential, warm and a held environment were described by all participants, as required to create the therapeutic relationship.

All the client participants described personal attributes they desire in a therapist and below is a sample of the client participants' statements on the working alliance qualities they considered when selecting a therapist:

*I think the first one is definitely trust. Trusting a practitioner, then listening, being aware that they are actually listening to you and my understanding of that came from how they responded to what I was saying so trust, their ability to listen, their empathy; feeling that there was an empathy between us. (Betty - Client)*

*Umm, it was just, I just felt safe. I felt safe with her and I really felt that I could immediately tell her anything and she wouldn't, it wasn't going to go any further and she wasn't judging. She wasn't judging me. I felt there was no judgement there at all. (Grace - Client)*

*I needed to establish a relationship with somebody who would listen and offer me some tools to use to discover things about myself that I perhaps wasn't aware of. (Ivor - Client)*

The therapist/professional participants also clearly recognised the importance of establishing rapport and these working alliance qualities, using similar descriptive adjectives:

*I think definitely having a calm influence, a lot of people say to me that I come across as being very calm and I think that helps them to feel safe and*

*secure, so it's providing all that isn't it? That safe environment, that confidential environment obviously offering the empathy and the understanding. (Ann – Therapist)*

*For myself, it's been important that I'm not being judged, that it's confidential. I'm making assumptions that this is something that this is what my clients want as well and that's what I've got on my web page. (Harriet - Therapist)*

These findings firmly correlate with the existing literature and meta-analysis related to therapy efficacy (Cooper, 2009; Lambert and Ogles, 2004; Norcross, 2009; 1988) which suggest the relationship being the key factor. It could be argued that the cultivation of the working alliance strongly affects the outcome of therapy and the findings of this study do suggest that this was a significant factor in the participants' therapist selection process. The findings only partially supported the Swift *et al.* (2011) meta-analysis, suggesting that the matching of therapist and client personal attributes was only relevant to a minority of participants. As discussed, therapist age and gender were in some cases relevant as a selection criterion, but in correlation with the client assessing whether the therapist would be able to make a relationship and understand their world view.

#### **5.4.2 Sub-Theme - Speed of Availability**

Speed of availability was the second sub-theme to emerge, supporting the main theme of ability to relate to me. 12 of the 22 participants referred to a prompt response from the therapist in replying to an enquiry and in setting up the initial appointment as another important factor in therapist selection. This suggested a desperation or that a crisis had occurred, which required an urgent intervention.

Seven of the ten client participants stated that there was an urgency to their therapist selection and a therapist offering a prompt response was a factor affecting choice:

*These things are quite urgent sometimes, obviously causing one a great deal of distress and so, therefore, it's about trying to make sure it's the best person to get through it as quickly as possible. That's always been my rationale anyway, I'm not terribly patient. (Betty – Client)*

*but I didn't want to wait. I didn't want to have to wait for, sometimes it's six weeks or more isn't it because of the demand and that kind of thing so that is kind of what prompted me. (Helen - Client)*

The therapist/professional participants also recognised this, urgency factor, in respect to replying to messages and fitting clients in at a convenient time to suit them. Five therapist/professional participants referred to this selection factor:

*because I did answer my phone and I think genuinely it probably was, that was probably the one criteria, I answered my phone as opposed to the others didn't. (Georgina – Therapist)*

*I understand there is an issue with waiting lists, whereas I can see the client straight away. (Joe – Therapist)*

Freya reflected upon her own experience as a client, when a therapist failed to return her message, causing her to feel rejected and question her self-worth. She explained that this experience has directly influenced her own practice and that empathising with how her clients might feel, she always answers messages quickly:

*A speedy response...As soon as I notice the email, the message, whatever, I respond to it and that is something that is valued. Yes, when I did my degree, because TA is my model and we had to work with someone TA and I contacted somebody in this area who is really very expensive and one thing and another, never heard back whatsoever, and that was like – (sighs) well, for me, it was a relief because, they were very expensive, but I just wonder what that would do to somebody less aware, because for me it was, "am I not good enough"? – so, it tapped into my not good enough stuff, so it immediately tapped into that. (Freya – Therapist)*

Speed of availability does not seem to have been identified in previous studies, as an important factor in therapist selection. Half the participants referred to needing an urgent response to their enquiry and choice being made in favour of those therapists who met this need. The findings suggested that the therapist participants were partially aware of this expectation, and the importance of meeting this need if they



wanted the enquiry to become a paying client. This finding does have implications for services who hold a waiting list, suggesting that in view of the urgent need, clients are not prepared to wait where alternative, immediate resources are available.

#### **5.4.3 Sub-Theme - Therapist Personal Attributes (as relevant to the Client)**

Therapist personal attributes was the third sub-theme which emerged as a factor in assessing the main theme of therapist ability to relate to the client. The data suggested that for a minority of participants, some therapist personal factors are important to either match or take into consideration. The complexities around sociodemographic factors were mentioned in chapter 3, in relation to the Health Belief Model (HBM) (Glanz, *et al.* 2002) and the Theory of Planned Behaviour (TPB) (Ajzen, 1991). These factors included; gender, religious belief, ethnicity, sexual orientation and disability which, I will now discuss.

##### 5.4.3.1 Gender

Gender was mentioned by a small number of client participants as a selection factor and that they set out to choose a male or female therapist.

*To be honest, at that point I think I'd have gone for a woman. (Grace - Client)*

*I particularly wanted a male counsellor... it was because my previous experience of counselling was a female and it didn't turn into an inappropriate relationship but it didn't work particularly well for me. Yes, I needed to talk to a man. (Ivor - Client)*

The findings suggested that the relevance of the gender, like age factors discussed previously (5.3.2, p113

) might be dependent upon the transference needs of the client. Client participant, Fiona, reported awareness of wanting to work with a mature, male therapist as a father figure or paternal transference and explicitly not as an erotic transference:

*I always thought as well that I'd like to speak to a male counsellor.... Also, I know this sounds funny but actually, you mentioning a male practitioner, I*

*really was like looking for someone I actually didn't have any kind of crush on or couldn't possibly have a crush on. I suppose I thought "No I couldn't possibly ever slightly even fancy you" so it could just be quite straightforward and actually like you say, possible fatherly thing. (Fiona - Client)*

The therapist/professional participants also suggested that some clients are selecting a therapist based on gender and that this might be a transference need. Joe shared his experiences of client's choosing him so that they could work through an erotic transference issue. Freya also recalled her own experiences of client's choosing her in response to both maternal and erotic transference projection:

*On reflection, I wonder is it because the opposite sex feel comfortable talking to me? Erm, do I come across as ideal quality that their other half are not providing? I really don't know. It did cross my mind was it that that they fancied me? ...Or a sexual attraction to me? I have noticed a few of the female clients' kind of behaviour towards me in that way. But I know there are boundaries in place. So, I think that's maybe what it is. (Joe - Therapist)*

*I think there's some sort of attachment stuff going on, whether it's as a mother figure, there's some of that, but the range of clients I have are from 18 to 60s so there's all sorts of different things going on. (Freya - Therapist)*

Existing studies looking at the impact of gender have primarily focused on outcome measures. They have investigated whether matching client and therapist gender effects the quality of the therapeutic outcome and have resulted in a confused picture. Sue and Lam (2002) found that matching client and therapist gender could have a positive impact on the therapeutic outcome, but these findings were then contradicted by the later meta-analysis (Beutler *et al.*, 2004) which found that gender was not a contributing factor to therapeutic outcome.

#### 5.4.3.2 Religious Belief

Matching religious belief was mentioned by just one client participant as a selection factor she considered:

*She had a Christian side about her, which, at that point in time, was very important to me. (Grace – Client)*

Religious belief was not a selection factor mentioned by any of the therapist/professional participants. It is usual for a therapist's own religious or spiritual belief to be set aside when working with clients and it could be argued that because of this, religious belief is not figural in their minds, when reflecting on client choice.

Worthington and Sandage (2002) concluded that clients with strong religious beliefs are likely to seek support from their own religious community, rather than externally. The findings from this study are too limited in this area, to position within the existing literature.

#### 5.4.3.3 Ethnicity

Ethnicity was not a selection factor cited by any of the client participants, however, two therapist/professional participants referred to it. Freya explained that she seemed to attract a high percentage of clients, who, like herself, have Scottish nationality. She said that this perplexed her, as her nationality is not mentioned in her literature and there is no mention on her website, so this is not because of the client consciously selecting her on this basis. Freya suggested that this was a transpersonal or unconscious aspect to therapist selection, but that matching nationality enabled her to have greater empathy for her clients:

*And something else that is fascinating about my clients is that more than 50% of them are Scots...There's something there. I don't know what it is. My belief is that the universe is sending them to me because I would understand their frame of reference. There is so such a difference culturally, yeah...they don't know until we meet because quite often I find people want to communicate by email. (Freya – Therapist)*

Harriet, a therapist originally from Germany, reflected on the impact of being non-native enabling her to resonate with her non-native clients and that this could be a factor they consider when selecting to work with her:

*I have had a client who specifically chose me because I speak German and I'm from Germany originally, but there's only been one who chose me explicitly for that purpose, but I'm not sure, possibly it may have been a factor for other clients who weren't born in this country, but I don't know... so maybe I have more of an understanding of what it's like to be not a native if you like, what it's like integrating. (Harriet – Therapist)*

Existing opinion (Norcross *et al.*, 2002; Murphy *et al.*, 2004) suggests that matching ethnicity is not thought to correlate with a positive therapeutic outcome. The findings of this study are too limited to position them against existing literature. It is interesting to note, however, that ethnicity was noticeably absent from the results, being completely unmentioned by the client participants and a factor suggested by just two of the therapist participants. I would speculate that this could be due to the cohort living on the South Coast of England, which is not an ethnically diverse area and that if the study was repeated in the South East of England or London, that the results might reflect a greater emphasis on ethnicity as a selection factor.

#### 5.4.3.4 Sexual Orientation

None of the participants mentioned matching sexual orientation as a factor affecting therapist selection. It could be argued that these findings might just reflect this cohort of participants. Certainly, existing studies suggest that therapist sexual orientation is a relevant factor to lesbian, gay and bisexual (LGB) clients, particularly lesbians, but that this depends on the kinds of issues they would like to present in therapy (Burkell and Goldfried, 2006). King and colleagues (2007) concluded that it was not the therapist's sexual orientation that needed to be matched, but more the therapist's ability to accept and understand the client or to be LGB affirming. Likewise, Liddle (1996) found that it was the therapist's attitude and knowledge of LGB issues which needed to be established, rather than a matching of sexual orientation.

It is an interesting observation that when collecting demographic information, I did not ask the participants to disclose their own sexual orientation, which, upon reflection was due to me not wishing to be intrusive and feeling that the information

was too sensitive. An example perhaps where I have allowed my own researcher bias to affect the data collection.

#### 5.4.3.5 Disability

This selection factor was not cited by any of the client participants, despite two client participants identifying themselves as having a disability. Only one therapist/professional participant, Joe, discussed the matching of disability as a selection factor, in relation to his own experiences as a hearing-impaired therapist. Interviewing a disabled therapist brought a depth to the study findings, which would otherwise have been absent. Joe suggested that in his experience, deaf clients did choose to work with him because of his deafness. He said that there were several reasons for this, including being able to understand their frame of reference:

*it is made very clear on my website that I'm deaf and I can use BSL (British Sign Language) signing level three, and I also have an understanding of the deaf culture, their issues and stuff. (Joe - Therapist)*

Joe also explained that confidentiality within counselling, taken for granted by hearing clients, is not possible for the hearing-impaired client, if an interpreter is present in the therapy room. Joe stated that as he can offer sign language and negate the need for an interpreter, this is a strong selection factor for deaf clients. He explained that translation by an interpreter dilutes the communication between therapist and client:

*if they have a hearing therapist in the room with a deaf client with an interpreter you're talking about a third party or third person in the room. What is really interesting is that when you reflect back, convey or communicate whatever the therapists say, it has to be translated over to the deaf person to be able to understand, and of course when that person says something, it has to go back, you lose a lot of time on that, whereas I can provide that instantly. Probably that's one of the benefits I can offer to as to why clients come to me in private practice. (Joe – Therapist)*

Whilst Joe felt that matching their disability was important to his deaf clients, he reported feeling surprised that hearing clients also chose to work with him, and that when they discovered his disability, it was of no relevance: Joe explained that in his experience, hearing clients did not find his deafness a factor against his ability to understand their frame of reference, in the same way, that deaf clients would, a hearing therapist:

*When I started practising, I had it in my sights that I would counsel clients with hearing loss, with lip reading or signing. But when I started counselling, it was quite a while before I got a first client with hearing loss. What surprised me was that in one week I had three new clients and they were all hearing. It was normal issues like depression and stuff. It is my intention not to ask clients "why did you choose me?" First off I did say "are you aware that I am profoundly deaf"? and they say "no, they weren't aware, but it didn't bother them". (Joe - Therapist)*

There is a scarcity of existing literature exploring the impact of disability on the therapeutic relationship (Shaw, 2014; Miller, 1991) and difference in the findings of studies looking at client preferences. Allen and Cohen (1980) found that able-bodied clients preferred to work with able-bodied counsellors, whereas Brabham and Thoresen (1973) concluded to the contrary. Other studies concluded that matching disability between counsellor and client, enabled the counsellor to act as a role model for the client (Brearly, 1980; Grantham and Joslyn, 1981) and resonate with the client's inner world (Shaw, 2014; Conyers, 2006).

Summarising, Bella suggested that where demographics were relevant for clients, they do not always choose a therapist who matches gender, sexuality, age, cultural background, but sometimes, deliberately choose the reverse. Bella, a professional participant, explained:

*I've had clients there say to me "I wanted to see somebody who wasn't from my background" because they had a sense of somebody coming from their background and making certain judgements... it seems to be much more about the client's perception of judgement "Am I going to be judged by this*

*person?” and that might be that they want somebody similar or it might be that they want them to be different. (Bella - Professional)*

#### **5.4.4 Sub-Theme - Therapist professional attributes – as relevant to clients**

The fourth sub-theme to emerge from the main theme of ‘ability to relate to me’, was ‘therapist professional attributes, as relevant to the client’. These professional attributes included ‘cost’, ‘modality’ and ‘education & training’ which, I will now discuss.

##### **5.4.4.1 Cost**

Four client participants specifically cited cost as a factor they considered, receiving therapy at a reasonable financial rate and choosing against the more expensive therapist:

*Cost is also an issue. I looked at somebody recently and they were £50 an hour and I was talking to a girl at college and she’s seeing somebody and they’re charging £35 and that’s quite a difference as well. So, obviously, I want something as good as it can be but at the same time, I also want to not be paying over the odds. (Amanda – Client)*

*Also, the cost. I contacted him by phone and he phoned me back, he said if you want to come and see me it’s going to be £65 an hour and that’s the first thing he talked about was the price and I thought probably that’s not the person for me... Yes and I think that I went to the counsellor I went to for the other reason that he offered a 30-minute chat before we entered into anything. (Ivor - Client)*

The therapist/professional participants were also aware of the impact of cost for some clients, with several offering concessions to support clients in affording therapy and others accepting that high fees would either dissuade some clients from selecting to work with them, or encourage clients to believe the service offered was of a premium standard:

*Obviously, cost will come into it because if somebody is coming on a regular basis, say weekly, then it's also about negotiating how much can they afford on a monthly basis, that sort of thing. So, I think that will come into it.*

(Ann - Therapist)

*I know for some people that can be a sign of quality, the fact that if they charge a lot of money they must be really good. I think it has made a difference to some of my clients that I'm able to offer concessions.*

(Harriet - Therapist)

Cost was a significant factor and the findings resonated with existing studies, which found clients search within their affordability limitations and can be enticed with introductory concession rates (Spalter 2013).

#### 5.4.4.2 Modality

Modality was mentioned by three client participants as a selection factor, all who had insider knowledge of the profession, having worked in the past with therapists of different modalities. Betty was especially well informed, and revealed that after her first therapy experience, she undertook counselling training herself:

*I did have some understanding because my background was in teaching anyway so I normally check up on things. I did do a diploma in counselling at a College of Education but that was subsequent to this, probably as a result of this actually, I wanted to understand better what the processes were. (Betty – Client)*

Although client participant, Helen, did not name the modality she had experienced in her first episode of therapy, she learnt from this experience about the type of counselling that was not helpful for her and what specific skills she was looking for the second time:

*and I'm the sort of person, that I feel I need a little bit of feedback so I wanted it to be more of a two-way kind of conversation rather than me just*



*sitting there and spouting it all out and not getting much back.*

(Helen - Client)

James, a client participant, described a similar learning experience, having tried group therapy first time round and discovering a preference for one-to-one work:

*And I think it was Group. I think I got six sessions from them but I only went for the first one, I didn't carry on with it at all... You don't want the other people to hear or you might embarrass yourself and you just think "no I can't deal with that". I think a lot of people would be like that because to me it's private.* (James - Client)

In contrast, seven of the therapist/professional participants commented on modality suggesting it could be an important selection factor, but one mostly unknown to clients:

*I'm not sure for some people how much it would matter to them what you know orientation or modality they came from but actually, I think the more I worked in it, the more it really does matter in terms of what they're getting and what they can expect to get from the person.* (Andrew - Professional)

*and I don't think that some of the things that are important to counsellors come into it like what model people use. Relatively few clients are so knowledgeable about that.* (Bella - Professional)

Therapist modality has attracted a great deal of research within the profession over the years and has resulted in superiority battles, as to which modality has better outcomes for clients. Cooper (2009) concluded that these historic studies have been biased and recommended an independent review, to settle the matter. This study found that whilst theoretical orientation is very important to the profession, it is of limited concern to participants when selecting a therapist. This study's findings do support the view that modality is generally an unknown factor to clients and only have a limited effect on the selection process. The sociology of the professions

discussed in chapter 2, offers an explanation for the superiority battles (Morrell, 2013).

#### 5.4.4.3 Education and Training

Apart from Betty, the client participants voiced an ambivalence about therapist education and training. There was an assumption that a therapist would be adequately educated and that was not an issue requiring question:

*I never asked if she had any. I didn't. It didn't occur to me but I obviously thought that she must have because she wouldn't be allowed to go drive round and do her job. (James – Client)*

Four of the client participants admitted to a lack of understanding what level of education was necessary or what letters after a name meant:

*Do you know what I have no idea? I have no idea on that one but obviously, you would want somebody that's highly qualified in what they're doing because again, you're putting yourself out there and whatever they put in can alter things quite dramatically if you're vulnerable so I would want somebody that's really, really well qualified that knows what they're doing. (Amanda - Client)*

*Erm well one assumes one has followed various qualifications. You kind of assume, and I can't remember if there were letters after their name or whatever so yes it's an assumption that things are in place – a bit wishy-washy on my part. I'm not sure because the bulk of them are just letters and you wouldn't necessarily know what they stood for unless you google them and check what they were. (Elizabeth – Client)*

This result especially surprised me, having myself focused a great deal of time, energy and money on advanced education. It had not occurred to me previously, that clients would not consider therapist education to be an important selection factor.

Five of the client participants (Fiona, Grace, Helen, Ivor and James) explained that they felt experience or recommendation was far more important than standard of education when selecting a therapist:

*I think I was aware beforehand that actually to counsel there's not necessarily qualifications that you need, you could just set up and say "I'm a counsellor" but obviously it really helps to have qualifications so I think when he said it I thought "Oh that's good" considering he might not have them but I don't think it was absolutely vital, I think it was more important that I got on with him. (Fiona – Client)*

*It wasn't really something that I considered. I just trusted her that she was qualified and trained and because she'd come on such good recommendation, I didn't ask to see any qualifications. (Grace – Client)*

Client participants also pointed out that qualifications alone are not a quality standard for a therapist and that being well educated was not necessarily an indicator of a good therapist:

*No, honestly, because I don't think I would have known what the qualifications would have meant. I know from my own professional experience you can have a row of qualifications that goes over to the other side of the envelope and still be useless. (Charles – Client)*

*Yes, I mean some people sell themselves on their qualifications rather than themselves... The counsellor I saw was professionally qualified, she was a very well-dressed lady and she had her fingernails were painted with different pictures on them... She also offered me information about herself which wasn't appropriate. (Ivor – Client)*

The therapist/professional participants were aware of client disregard for educational attainment. They stated that their clients do not think to ask about qualifications and assume that anyone calling themselves a therapist, would be suitably qualified:

*It's not something I've ever really discussed with a client...All that information is on my website and I assume that they are reading that but they may well not be. (Harriet - Therapist)*

*It's not true for private practice though is it, as you say the average person comes in off the street and doesn't know what to look for. (Bella – Professional)*

There was also agreement that qualifications alone are not a quality standard for a therapist and that being well educated was not necessarily an indicator of a good therapist:

*I went for somebody, with lots of qualifications and stayed there for quite a long time and so I now would definitely look for the type of qualification but I wouldn't necessarily rule out somebody who had a diploma because it doesn't necessarily work like that because again, it's down to the individual counsellor isn't it? (Imogen – Therapist)*

*I think that's quite hard though because it may infer that they're a specialist in a certain area when they're not necessarily, because their specialities aren't codified in a way that they are in the medical profession for example, they're more that actually, they may have a lot of experiential knowledge and have built up experience in a certain area, it might not mean that they have a specialty qualification and I think that's quite tricky. (Andrew - Professional)*

Existing studies suggest a strong correlation between high standards of education and positive therapeutic outcome (Orlinsky *et al.*, 2004; Lambert and Ogles, 2004; Stein and Lambert, 1995) but the findings of this study question the relevance of education to clients making choices. Without standardised educational attainments set for therapists, it is left to the individual therapist to decide to which level they wish to train (if at all) and to make their own assessment of competence to practice. With the non-existence of professional minimum education standards and the term 'fully qualified' being meaningless, the findings of this study are concerning in terms of client vulnerability. Arguing against the introduction of minimum education standards,

Burrage and Torstendahl (1990) suggested that professions use these to restrict access and bar entry to the profession, ensuring membership remains elite. Without minimum education standards however, the untrained therapist is at liberty to practice, particularly in the private arena.

## 5.5 Assessment of Selection Factors

Having identified the four main themes ‘third party recommendation’, ‘location’, ‘experience of issues’ and ‘ability to relate to me’ and associated sub-themes, the data analysis also revealed how the participants went about assessing the selection factors. Sources of recommendation were discussed earlier in this chapter and location was limited to existing knowledge of the geographical area, plus in this age of technology, to internet searching and use of online maps. Clients assessment of the ‘therapists experience of issues’ and ‘ability to relate to me’ suggested the impact of them using the therapist’s website/profile in the selection process. The photograph, rhetoric and the initial face-to-face meeting were all highlighted as important tools in assessing whether a therapist had capacity to meet the client’s needs which, I will now discuss.

### 5.5.1 Photographs

Four client participants mentioned the relevance of the therapist’s photograph on the website as a factor affecting selection. Fiona said:

*also as I remember he had a photo, a sort of portrait photo and I thought “he kind of looks nice”... it was just the first name that came up and I thought I’ll contact him...It’s awful to admit it but I think it would be the photo, it would be that face. If I could imagine myself sitting there talking to an open, warm face, that’s it I think. (Fiona – Client)*

Client participants talked about what they were looking for in the photograph and, in particular, which personal or professional qualities they are projecting into this image. The findings suggested that the photograph enabled clients to resonate in some way with the image of the therapist and what qualities they wanted to find in a relationship with that person:

*I think I probably picked the one that I did because of his age or apparent age because all I had to go on was a photograph. (Ivor – Client)*

The client participants stated that a photo could evoke a negative response and that this would cause them to discount that therapist and move on with the search:

*Generally, it's positive but yes, if I was to get a bad vibe, then, it's not something I've experienced very often, (laughs) but yes. (Elizabeth - Client)*

*there was an element of "did I like the face of the person"? Well, at a first pass, it's sort of gauging from their face what sort of person they would be...That does come into it, I'm not sure how but that was only for the last two...Without going back on the website and looking at it now, I couldn't tell you why but definitely I had that gut response that they weren't the right person for me. (Betty – Client)*

The findings from the therapist/professional participants revealed a greater awareness of the power of a photograph to influence client choice. Several mentioned clients naming the therapist's online picture as the reason for choosing to work with them:

*Some people have said to me "I saw your picture and you know I automatically thought I'd be able to talk to you." (Ann – Therapist)*

*some people have been openly honest and said "I liked your picture" so I think that is quite interesting. (Georgina - Therapist)*

Therapist participant, Freya, suggested that she now expects clients to mention her photograph, when asked why they chose her:

*I think it's the picture, because one of our questions in my initial sessions is "why me"? I'll get things like "oh location" and "I'll say, yeah, and"? Or "all the different things you deal with" which doesn't make sense and eventually we will get to the picture. (Freya - Therapist)*

Referring to one client's powerful experience of looking at his photograph, Joe recalled:

*He said "I've looked at others and I can tell that they're doing selfies or they look like they're coming back from a party and I don't want that. But, when I look at your picture" and I thought "whooh". (Joe - Therapist)*

Several other therapist participants suggested that the photograph brings the therapist to life and makes them genuine:

*it's nice to put a face to a name I think, and like most things these days, it's nice to be able to see who you would be or are speaking to.*

(Elizabeth - Therapist)

*they look at the picture on my website and "you look like a nice guy". It's a picture of me in my wellies in one of those country parks, I look like a farmer but I'm not and they say, "I really like that" and it's interesting.*

(Joe - Therapist)

The therapist/professional participants talked about what clients are looking for in the photograph and which personal or professional qualities they are projecting into this image. The data suggested that the photograph enabled clients to resonate in some way with the image of the therapist and what qualities they wanted to find in a relationship with that person:

*I wonder if they're looking for something... I guess with the photograph, is there some kind of recognition of something in there or is there something in there for them that they might feel that they could work with that person.*

*Whether that's some kind of response they have to the person's picture.*

(Georgina – Therapist)

*I think, I guess, as you probably know yourself, if you look at a picture of somebody you're drawn to someone's picture more than others, and I think that can sort of draw the client in initially start looking at your profile, and then they start reading it and I then I think there's certain things that will*

*stand out. It's very much about them identifying with something... I think it's something about them making a connection. (Ann – Therapist)*

Therapist participant, Harriet, cautioned about taking responsibility for the type of picture a therapist uses and the response this is likely to attract:

*there was a thread online about somebody talking about how she keeps getting these inappropriate approaches but when you looked at the picture, you could kind of see it was a fairly seductive kind of pose, glamorous. From that point of view, it's probably important. (Harriet - Therapist)*

There was also evidence to suggest that the therapist/professional participants were aware that not having a photo, could evoke a negative reaction for a client. As a result, care had been taken when choosing the pictures for their own websites:

*And I think that when I was in the process of developing my website for my private practice, my wife helped me put together the website and we have gone through hundreds and hundreds of other therapy websites and think, "hmm don't like it", and then we came across some websites that had no picture of the therapist and if I was the client I'd think "no, that's a no-no, I don't like that". (Joe – Therapist)*

The existing literature discusses the photograph phenomenon and the associated ontological/epistemological issues. Tinkler (2013) argues that photographs do not have one meaning, but are “*polysemic*” and that people see different things in a picture, dependent upon their interests and experiences. She suggests that the viewer of a photograph does not just experience it visually, but that it evokes emotion and memory. Barthes (2000) refers to a “*punctum*” which he describes as a detail in a photograph, which produces an individual or subjective response in the viewer. The capacity of a photograph to connect the view to the unconscious is widely acknowledged (Kuhn 2007; Rose, 2004; Mason, 2002; Pink, 2007). Mason (2002) summarises this concept as:

*The visual is not necessarily visible. (Mason, 2002:106)*



Mason (2002) discusses the ontological concerns related to the use of photographs, suggesting that the effect they produce is quite profound and subjective. Tagg (1988) argues the “*indexical properties*” mean that sense of a photograph can only be made by what the viewer thinks they see, rather than factual evidence. Tagg illustrates his argument with the example of a photograph of the Loch Ness Monster, suggesting that interpretations are made within the discourse of the situation the photograph was taken in. Tinkler (2013) supports this view, stating that photographs are perceived by the viewer, dependent upon their ontological and epistemological position.

It could be argued that the photograph on the therapist’s website is a key selection factor and that it needs to be open, friendly, warm and welcoming, to facilitate positive projection from the client.

### 5.5.2 Rhetoric

The data suggested that likewise, the words on the therapist’s website or directory profile, spoke to the client in a similar way as the photograph. Clients appeared to resonate with the rhetoric and used the words to assess the therapist’s ability to meet their needs and experience of the issue. Four client participants reported awareness of the impact of the rhetoric as a selection factor:

*That’s a hard one. I don’t know because you’re only going by the words on the page, their photo maybe, and how the kind of dialogue that they provided it’s not been formalised – their little bio would be quite important because one would assume that it’s written by them; as they would speak, so it would depend on how approachable their words seemed. (Elizabeth - Client)*

*Well, I certainly read about their experience. I think you do get a feel for the sort of person when you’re reading about them. (Dorothy – Client)*

The therapist participants did report significantly greater awareness of the importance of their photograph and website/profile as their advertising tool and method of connecting with potential clients. 10 of the 12 therapist/professional participants commented directly:

*Your website is your shop front so how do I put that out there, both not only physically on the computer but also in quite a trans-personal sort of way.*  
(Diane - Therapist)

*The last person I had for an assessment noticed something very small on the design of my website and just said she identified with that particular part of a picture... it's something that speaks to them. I think sometimes it's the way I phrase myself, I have a photograph on there and I guess some people look at that... Yes or in something unintentional like the design example, made by someone else (laughs), but something speaks to them and I've had clients who have said "I've looked at your website time and time again over several months and I kept coming back to that one having looked at lots."  
So, there's some connection there. (Ellen – Therapist)*

The difference in awareness between client and therapist/professional participants as to the relevance of photographs and rhetoric could be because of therapist/professional participants being responsible for marketing their own businesses. It is in their interests to be consciously aware of how to attract clients, whereas clients themselves have no need to educate themselves in skills of marketing. My sense was that the therapist/professional participants had listened to client feedback in the past and that this had informed their practice:

*Quite often what they say is that they've identified with something, so I think when they're reading your profile they're identifying with something... even like the first line that you put on the Counsellor Directory or something to draw people in, you know "Have you got problems or difficulties with something?" "That's me, I've got that, that's how I feel", so it's something in there that they're really identifying with. (Ann - Therapist)*

*I think they kind of take a stab at it based on what they see and probably some of it is quite unconscious. I don't know if you read something and it resonates with you or you see a photo of the place on the website.*  
(Bella – Professional)

Hermeneutics is the study and theory of interpretation and originated from the need to make sense of biblical texts. Many scholars and philosophers have developed the ideas and Gadamer (2004) saw a connection between Hermeneutics and Phenomenology, the philosophy of lived experience or existential meaning (Moran, 2000; Van Manen, 1997).

Cognitive psychology offers a plethora of literature related to emotions and the evocative power of verbal and written word. Prospect Theory (Kahneman and Tversky, 1979) argued that perceived stimuli evoked an effective evaluation, which is not always conscious. Braun (2015) suggests that this theory can be applied to verbal and written words and that the emotion eliciting power of words is pre-verbal in nature.

It is interesting that Spalter (2013) in his prior study, did not mention the relevance of a therapist's photograph or rhetoric in the selection process. This difference could be because of my inclusion of therapists as participants, whereas Spalter (2013) restricted his recruitment criteria to clients only.

### **5.5.3 First Meeting**

The client participants also revealed that the initial face-to-face contact and first session were significant factors in the selection process. Nine of the ten client participants stated that they were uncertain they had chosen the 'right therapist' and did not make a full assessment of their suitability until they had met in person:

*Yes, I mean sure, if it became clear during the assessment interview that there was something that wasn't going to work, then obviously, we would have jumped ship at that point...If at the end of an assessment interview either of us had been left with a feeling that they hadn't got a clue about, and I must admit it was a complex situation, very complex, so yes, that would have been another factor. (Charles - Client)*

*You can only read their history of counselling really, what they specialise in and there's always the opportunity for a first appointment isn't there and then*

*obviously if they're not the sort of person you think is going to be right for you and vice versa then you have a choice, don't you? (Dorothy – Client)*

The findings also suggested regardless of how they assessed therapist suitability, clients recognised that they did have to put trust in their own judgement:

*I absolutely trusted her, I absolutely trusted her completely. Yes, as soon as I saw her, I just knew. It was the way that she looked. She was very welcoming and she just had a trusting kind of face and she smiles a lot, which was very reassuring and when I started to talk she listened, she really, really listened and I loved her for that, and I loved her for not interrupting. So, the first time that we met I think we had both agreed that we were both kind of sussing each other out at that point but from that first time I thought, "this is the lady I will tell everything to". (Grace - Client)*

*Yes, and that you can trust them. It's a very vulnerable situation to be in and you need to know, as best as possible, because obviously, people can hide all different sorts of things, but as best as that they are what they say on the tin, they will do the job. (Amanda – Client)*

The therapist/professional participants were also aware of the importance of first contact and four citing this as a relevant selection factor:

*you've got the first initial part of perhaps liking the look of the person and then looking at the information but the next thing is to actually meet the person and I think from that initial consultation by coming here, we discuss the issue that they've come for and then I explain how I work.*

(Ann – Therapist)

*think it's something about that initial contact that they make with you that will resonate and about at a gut instinct level, they will like the sound of that person. (Diane - Therapist)*

Historically, theories supporting first impressions were informed by psychological models of threat perception (Stein, 2013; Tetlock, 2002). Todorov and colleagues

(2015) explored facial characteristics and the role of gender, with the links between emotions and personality traits. They concluded that some facial structures evoke a strong approach or avoidance in the perceiver. Walker *et al.* (2011) found that trustworthiness is derived from facial expression and features. Holmes (2016) concluded that first impressions are quick judgements, which are made within milliseconds of meeting, colour future interactions and assess trustworthiness without conscious, rational thought. Spalter (2013) concluded that the first meeting enabled the client to assess observable features, including tone of voice, appearance and the setting, from which information related to age, intelligence, socio-economic status and educational attainment were gained.

## **5.6 Implications for Voluntary Register**

The purpose of this study was not only to explore how the participants selected a therapist, but also the implications of this selection process in terms of the regulatory status of the profession. I asked the participants direct questions to explore their awareness and current understanding of key areas, including assessment of professional standing, existence of professional bodies, complaint making, and regulatory status. I will now discuss the analysis of the data generated by these questions.

### **5.6.1 Assessment of Professional Standing**

Four of the client participants said that they had delegated this task to the person who had recommended the therapist, trusting that the therapist was credible, in the judgement of the recommender. Amanda explained how checking the professional standing of her therapist had not occurred to her:

*It never crossed my mind. I went to the GP and therefore they would offer what was good and I went to the military and they would offer what was good and that was just my total faith that what would be given would be very good.*

(Amanda - Client)

*It wasn't really something that I considered. I just trusted her that she was qualified and trained and because she'd come on such good recommendation, I didn't ask to see any qualifications. (Grace – Client)*

As discussed earlier, the client participants who had chosen a therapist within a group practice, took this environment to suggest an '*institutional buffer*' (Syme,1994) and that this in some way validated their professional credentials:

*Hmmm.....I think you can probably only go by what they've written about themselves and how you can verify whether they've actually got the qualifications they say they have, I don't know. Yes, good point. Although I suppose that you were a group here and I would like to think that someone had checked those out working here. (Dorothy – Client)*

*No, I would assume that within a clinic setting that the clinic would make sure that only the relevantly qualified people were in residence. (Elizabeth – Client)*

Similarly, four of the therapist/professional participants stated that they felt that their previous employment histories suggested the '*institutional buffer*' (Syme,1994) to prospective clients and validated their professional standing:

*I think that's kind of a social construction isn't there, about if you are a certain kind of professional, you have a certain kind of job, so you're probably alright... I have a feeling that's what people look at, what they see, what information they have and how does that relate to anything else they know in the world, for example, if you say "I've worked part-time, I'm a lecturer in Psychology and I work in a GP practice," then they'll probably think "oh that sounds like somebody who is responsible" as opposed somebody who just says "I see clients." I don't know, but that's what it looks like to me. (Bella – Professional)*

Prior association with the National Health Service (NHS), seemed to suggest credibility to prospective clients:

*I guess, as I mentioned the fact that I am a registered member, accredited by the BACP, the fact that I have worked in the NHS for 30 years... I might have been thrown out of course, but it's part of who I am so that's what people are getting. (Harriet – Therapist)*

*And my experience I would say as well, because I had an NHS background initially and then moved into private practice and people have mentioned that to me "You've worked in the NHS right"? (Georgina - Therapist)*

Most of the therapist/professional participants stated that they felt the therapists professional standing was irrelevant and clients were ambivalent to the need to verify:

*I think they take it at face value from my website. (Georgina – Therapist)*

*Well, they could but I'm not sure they would. I'm not sure it's high on most people's list of priorities. Partly I think because they might have an assumption that it's a given, that that's how the profession would be. Just as you wouldn't go to see a doctor or a physiotherapist or a dentist who wasn't trained, they may well assume. (Ellen – Therapist)*

### **5.6.2 Awareness of Professional Bodies**

There was limited awareness within the cohort of client participants as to the existence of professional bodies. Betty and Ivor, who, as mentioned previously, had existing insider knowledge, had some awareness, but the other client participants either responded with uncertainty or with the word no:

*I wouldn't have known; it wouldn't have been on my learning as it were, but we would obviously have done some kind of internet search and looked up what the professional regulatory bodies were, but I will admit, frankly, that I certainly haven't a clue what those were. (Charles – Client)*

*Well I have seen it written down and heard of that actually, but I wouldn't have been able to tell you, but I have seen it written down and heard of it. I*

*wouldn't have been able to actually tell you what each letter means.  
Insurance comes into it too doesn't it? (Dorothy – Client)*

*I am aware that there are various governing bodies and, sort of, internal things, as I have a few other friends who have been in the world and I've done newsletters and stuff for people that do psycho drama and stuff so I am aware.... They make sure that no one does anything that they're not supposed to and mess people up, for want of a better description.*

*(Elizabeth – Client)*

Reflecting on experiences in their own practices, the therapist/professional participants reiterated this view:

*No, my clients don't seem to, it's never been mentioned, nothing we've ever talked about. (Brenda – Therapist)*

*I don't think clients have any idea what BACP registered or UKCP registered means at all. I think there's a general sort of ignorance among the general population. Certainly, if you go on to the BACP website then you start to get a sense of what you should be looking for but no I don't think clients do.*

*(Diane - Therapist)*

### **5.6.3 Making a Complaint**

With a lack of awareness regarding the existence professional bodies, most client participants initially said they would not know where to address a complaint, had it been necessary to do so. Three client participants suggested they would have gone online to find out information and the remaining client participants, suggested they would have asked a practice manager or GP.

*because in the first session I was given information and stuff to do with her and the register. I think if that had arisen, I would have resorted back to looking online and seeing where I would need to go. (Helen – Client)*

*I think I would have gone online and I'd have googled how to complain about a therapist. (Grace – Client)*



With awareness of the existence and purpose of professional bodies, Betty and Ivor, both stated they would refer a complaint to the professional body. James and Betty both described experiences of unsatisfactory therapy, about which they did not complain, but chose instead not to go back:

*I think I got six sessions from them, but I only went for the first one, I didn't carry on with it at all. (James - Client)*

*if after several sessions, I didn't feel that it was living up to that then I would have stopped. I did stop one actually, after about three or four weeks, because I just felt that those qualities weren't there. (Betty – Client)*

Amanda assumed that the BACP would investigate a complaint about any practising therapist and I informed her that the remit of the BACP only extends to therapists who hold membership. In response, she said:

*That's really scary. That is really scary. To think that you could go and see somebody and go "Oh my good Lord, that was terrible" and then not put it somewhere so that other people can find that, that's very wrong. (Amanda - Client)*

The therapist participants all said that this information was either given to their clients at assessment and/or is available on their websites:

*there is that difficulty, I'm guessing, that if the client's not happy about something whether they would feel confident enough to take that step, but like I say, I put it in my contract. It's something I talk about when we go through it and hopefully I can convey the openness in our relationship for them to speak about it if they're not happy about something. (Ann - Therapist)*

In agreement with Betty and James (client participants), Brenda and Georgina (therapist participants) both stated that they felt a client probably would not complain, but instead just walk away from therapy:

*I've had client relationships come to an end and the person has felt that I haven't been able to help them or whatever, but I don't know that they would necessarily want to make a complaint, but my sense is that they would just withdraw and stop coming to therapy so I don't know is the answer.*

(Brenda – Therapist)

*I wonder whether at the point where they had cause for complaint whether they would go searching, however, I think some people do but I doubt that everybody would. I think a lot of people would just walk away and think "I'm never doing that again".* (Georgina – Therapist)

#### **5.6.4 Awareness of Regulatory Status**

Of the 10 client participants, only two, Betty and Ivor, were aware that the counselling and psychotherapy profession is not statutory regulated at the time they chose a therapist working in private practice. Betty stated that her daughter was aware and Ivor stated that he had worked alongside counsellors within the NHS and was therefore subjected to insider knowledge:

*and it's always been a bit of a mystery to me why counsellors are not regarded as a profession in the same way as doctors and everybody else....*

*No, I mean, anybody can call themselves a counsellor which is terrifying.*

(Ivor – Client)

Two of the client participants Amanda and Fiona, said that they had since undertaken introductory counselling training and now had some understanding which they did not have at the time the therapist selection was made:

*I'm not sure but I've got the feeling it's not strongly regulated. If, like we say, there's nowhere to complain to, if somebody's not registered then that doesn't really smack of being... I think that's horrendous. No, I don't think it's known at all. I wouldn't have known. Like I say, I just assumed that if you go and see a counsellor, in my mind anyway, I should say before I started on my course, if you go and see a counsellor you are seeing somebody who is trained, up to date with all their training and suitable for purpose and fit for*

*that purpose. Trustworthy and regulated and a safe place to be and it's quite scary to think that they're out there and they're not, that's pretty awful.*

(Amanda – Client)

*that seems ludicrous but well because really with counselling, I would expect to be faced with a counsellor, I would expect to be faced with fairly vulnerable people and the fact that you might be in a position to cause them further damage that's crazy, but at the same time as I say, I was aware that you didn't necessarily need qualifications to call yourself a counsellor, so thinking about it... (Fiona - Client)*

When asked whether he had awareness of the regulatory status of the profession, Charles responded:

*Not in detail. I know that there are such things as regulatory bodies and I know that all my colleagues in the NHS would have been members of regulatory bodies but, it's all a bit misty after that really. (Charles – Client)*

*I just wonder if it surprises you to know that we're not statutory regulated as a profession, is that something you're aware of? (Researcher)*

*Statutory? So not in the same sense as the General Medical Council or General Dental Council? No, no, I didn't know that. (Charles – Client)*

The other client participants assumed that the profession was already statutorily regulated:

*Not in any great depth. I would assume and know you would be but no, not in any great depth. (Helen – Client)*

*No idea. I would imagine that you are. You must have Big Brother. (James – Client)*

Amanda felt very strongly that following her experiences with her young daughter, the profession should be statutory regulated:

*Yes, at the time I was just very desperate to make things right and do right by my child but looking back now, and especially about looking at how my child disliked her, yeah, it should be regulated and you should know that who you're going to. (Amanda – Client)*

The therapist/professional participants unanimously concurred that, in their own experiences, clients generally have no awareness of the regulatory status of the profession and that, on the rare occasion it is mentioned, assume that it is already statutory regulated:

*I really think they probably assume that we are regulated to some extent, or that a lot of people do but not everybody. For some people, they might not even think about, that but on the other hand, for others, because somebody is calling themselves a counsellor or psychotherapist so therefore they must have a stamp of approval from somewhere. (Harriet – Therapist)*

*I think most clients are quite naïve about that. I think they probably assume that we're all very highly trained and very professional and very highly regulated. (Ellen – Therapist)*

There was strong opinion voiced by the therapist/professional participants in favour of statutory regulation:

*I think it would be better if, as a profession, we were regulated. I think there are a lot of people who make some valid points for us not to be regulated, but I just have to say I really think that it would be better.*

(Brenda – Therapist)

*think in the society that we live in at the moment, where regulation is everywhere, then I think we are better to be on board with it and make the regulation work for us as a profession. I think to stand apart from that, I think we're not doing ourselves any favours. (Diane - Therapist)*

Reflecting on the current system of voluntary registration, therapist participant, Freya said:

*I don't think it's any better than what we had before. Being a member, an accredited, a senior accredited, I think it's for a pretty little logo but I don't think it carries any meaning. I don't like to be quite so cynical but that's how it is, unless I'm missing something, and I don't think I am... and I mean, there is the risk of things that can happen to clients. If you let your mind run away with it, it becomes quite frightening. (Freya – Therapist)*

The therapist/professional participants highlighted several other limitations of the voluntary register, including inconsistent training standards:

*the proliferation of professional bodies makes it incredibly hard to know who's qualified, who's not, who's credible, who's not. It means there are widely ranging inconsistencies in standards and entry levels and I think only a central statutory register would have been able to tidy those kinds of things up. (Andrew – Professional)*

The therapist/professional participants also highlighted experiences of colleagues working outside of competence in private practice:

*Il don't think the courses are truthful enough, and I don't think they make them ready enough either, and many of these courses, you can do a Diploma and then you don't have to be a member of any regulatory body at all, so you don't have to do any therapy, any supervision, any CPD, anything, but you can carry on in private practice and I'm not sure that that's healthy. (Georgina – Therapist)*

*I don't go on Facebook too much these days but I think there was a huge debate on one of the private counselling, you probably saw it if you're on that website, about this person who was in training and she was actually seeing clients already. She was just in her first year or something. So, I think if you're sitting in a room with somebody and they seem to be nice and friendly and helping you, you're not going to worry about whether they're regulated. (Cathy – Therapist)*

*now of course the market is quite saturated with people with some level of counselling training and so it's hard for people to get work, and mostly they end up doing unpaid work, and I think that probably motivates people who aren't really ready for private practice to give it a try, and I don't recommend that at all. I can imagine that that is something that happens.*

(Bella – Professional)

### **5.6.5 Therapists responsibility to inform their clients**

Four of the client participants mentioned that they were given literature by their therapist, which outlined their level of qualification and professional membership and career history. Ivor however, shared his experience of incorrect website information:

*I contacted another counsellor who was professionally qualified but wasn't in the directory that I finally used and his entry was full of qualifications, actually on his website he said he was a university lecturer. When I went through to the university he hadn't been lecturing there for two years. (Ivor – Client)*

The therapist/professional participants suggested that responsibility for informing and educating clients about the regulatory status of the profession and expected standards for ethical practice, rested with them. They said that this information is available on their websites, although this information generally could not necessarily be considered accurate or verifiable.

*Well I'm sure from what I've seen, and I've got a link to the BACP ethical framework, and I think I mention it on my literature and I'm sure that most of the websites of other counsellors I've seen say something similar.*

(Imogen - Therapist)

*Yes, I think the responsibility, certainly at this time, really feels like it sits with us as practitioners. I think we hold a big responsibility for making sure we are yes, managing that vulnerability so that our clients are as well supported and informed as they need to be. (Diane - Therapist)*

The therapist/professional participants did acknowledge that dissemination to the public was difficult and that both BACP and UKCP are making some effort, but more needs to be done:

*I think the profile is rising and we are more a political issue and I think what's happening within IAPT you know I think our profile is being raised and I think certainly there is a lot BACP and UKCP are doing, we're getting in there and doing some stuff about that and I think that will have a spin-off effect. (Diane – Therapist)*

*No, but it's a real challenge I would say, because I guess none of the statutory regulators are taking out, like, TV adverts about it. No, I don't. I think the only thing you could do is, all we tend to do, is just raise awareness through intermediaries so it's more like when people need to know, they're going to turn to a Citizen's Advice Bureau or a charity like MIND or that kind of signposting route, but I think the existence of assured voluntary registration is well known in the professions when they've got it, and amongst the kind of regulatory policy community and I'm not really sure it's known anywhere else. (Andrew – Professional)*

*I think it's about educating not just the public and probably not even primarily the public, but professionals who might make referrals about standards. (Bella – Professional)*

To summarise, the findings in this section suggested an ambivalence to the relevance of ascertaining a therapist's professional standing, limited awareness of the existence of complaint procedures and professional bodies or their function, and a widely-held assumption that the profession was already statutorily regulated. The findings suggested a lack of awareness of the responsibility to validate a therapist's credentials and a naivety that all therapists are competent, adequately trained, trustworthy professionals. It was also evident that responsibility to inform clients belongs to therapists, which is unlikely to happen, if the therapist is untrustworthy, leaving the client vulnerable. These findings concur with the existing opinion that the array of professional bodies is confusing to clients (Spalter, 2013; Munro, 2009).

In the next and final chapter, I will now discuss these findings.



## Chapter 6 – Discussion

In this final chapter, I will discuss the findings and highlight the new knowledge which has emerged, the implications for voluntary registration, dissemination and conclude with my recommendations for the future.

The data was analysed using thematic analysis and the process of coding explained in depth, alongside issues of reliability and validity in Chapter 4, Methodology.

### 6.1 Summary of Results – Factors Influencing Client Choice



Figure 5. Factors Influencing Client Choice

The findings suggested that participants, particularly first-time therapy clients, preferred to use a third-party recommendation to select a therapist, which concurred with decision theory (Kahneman, 2011). Where a recommendation was not sought, participants used a set of heuristics which they weighted differently. The first heuristic, which appeared to be common to all, and the one used to perform an internet search, was location. Once a therapist in the desired location was found, the next most popular heuristic was experience of issues, which included ascertaining therapist age and life experience. Finally, participants were selecting therapists based on calculating the ability of that therapist to be able to relate to themselves. This factor included the working alliance qualities, speed of availability, personal and professional attributes, as relevant to each client making the search. These findings support the outcome of Castonguay and Beutler (2006) research which identified criteria relevant to therapeutic change. It is very interesting to note that the participants named many similar attributes as heuristics in their selection process which Castonguay and Beutler (2006) had identified to be 'participant factors' and 'relationship factors' in therapeutic change. There was also some limited reference to the 'technique factor' also being assessed by clients who had previous experiences of therapy, with Betty and Grace both considering modality in their selection process. This would suggest that the participants are aware, to some extent, as to which qualities they are looking for in a therapist, although the process of assessing these factors is not necessarily conscious or well informed.

All these heuristics were assessed with the participants using the therapist's photograph, words on the website/profile and then the first session. The role of photography to connect with the unconscious is widely accepted in the existing literature (Tinkler, 2013; Kuhn, 2007; Pink, 2007; Rose, 2004; Mason, 2002) but the potent impact photos can have on therapist selection has not been acknowledged directly by the counselling and psychotherapy profession.

## **6.2 Transference and the Unconscious Process**

Including a disabled therapist participant, richly added to the study findings, and gave insight to matching qualities that I had not considered previously. Joe, a deaf therapist, revealed that hearing-impaired clients did indeed specifically choose to

work with him based on matching the disability. He explained that this was because he can communicate using British Sign Language, meaning that he can communicate one-to-one, rather than through a third-party interpreter, with all the implications of confidentiality and miscommunication that this may entail. Furthermore, Joe felt that being deaf himself, enabled him to empathise with the experiences of fellow members of the deaf community, achieving a deeper understanding and connection. So, for deaf clients, the fact that Joe was deaf himself, was a factor of paramount importance to be matched. Interestingly, however, Joe stated that for his hearing clients, his deafness was a complete irrelevance. This finding suggests that matching attributes are only significant, if it is of relevance to the client concerned. It would appear then, that matching attributes, which has been the focus of so much previous research, is only relevant to therapist selection, if it is a factor the client needs, to make a relationship and feel that the therapist will understand them. For instance, if a client needs a therapist to empathise with the death of a child, they could consider a therapist's age and gender, to select a therapist with that level of life experience and parental potential.

I resonated these findings with the process of how clients assess the main themes of factors of 'therapist previous experience' and 'therapist ability to relate to me' discussed earlier in Chapter 5. I have concluded that whilst clients do have awareness of the factors which affect therapeutic change, assessment of these factors in therapist selection is predominantly an unconscious, transference process. The findings suggest that the therapists photograph and rhetoric on the website/profile are very powerful tools, which clients use to project into and ascertain if their needs will be met by entering a relationship with that person. If a client needs a father figure, they might select a male therapist of a relevant age, if they need a therapist to work through sexual difficulties, they will project an erotic transference into the photograph and select a therapist who appears to mirror their sexual preferences. The website or profile wording is also of relevance because it validates the transference, suggesting that the therapist will resonate and meet their need to be understood. The first meeting is also an important factor in validating the choice which has already been made.

Spalter (2013) does suggest a potential transference aspect in the selection process, as he describes participants who found it difficult to articulate why they had chosen their therapist. I also experienced participants who found it difficult to put into words how they chose a therapist, to explain what factors they were looking for, and why it was that the photograph and website/profile words resonate. I have concluded, that whilst the participants did have awareness of the factors they were looking for in a therapist, but that the processing of accessing these factors is not completely conscious, and somewhat driven by transference needs.

### **6.3 Implications for Voluntary Registration**

The results of this study suggest that whilst a minority of the participants made a well-researched, informed choice, these were experienced clients who have learnt about what they do and do not like from their previous encounter. Most participants made a therapist selection either based on a third-party recommendation or projection of their needs (known or unconscious) and using a photograph or profile/website to resonate with something or someone they believe can meet these needs. The findings also suggested that heuristics of limited interest to participants included therapist's standard of education, modality, professional standing, credibility or competence. These factors were taken on trust and assumed to be in place. There was an onus on therapists to inform clients of their professional credentials and ethical obligations, with no evidence of client awareness of a need to validate or investigate the legitimacy of a therapist.

In view of the voluntary register, these findings are unsettling. If a therapist has an attractive friendly photograph, a profile/website that is appropriately worded, has an office in a popular location, pitches their fees appropriately to clients and can offer to see them quickly, clients are likely to choose to work with them. The fact the therapist might not have appropriate training and experience, professional body membership enforcing ethical considerations, or supervision arrangements in place would be irrelevant because the client, if they consider these factors at all, will assume that are already in place. Furthermore, the data suggests strongly that it is the therapist who has responsibility for educating the client on professional ethics and the existence of professional bodies and the voluntary register. If a therapist is

not adequately trained or ethically aware, the client would not receive this education and continue the therapy in ignorance. In a profession that lacks minimum education standards and offers an unregulated private practice, these findings are concerning.

The assumption that underpins the voluntary register is that clients are making informed, educated choices when selecting a therapist. The findings of this study very strongly suggest that this not the case and has implications for the credibility of the voluntary register. It could be argued that, particularly in the private practice arena, clients are vulnerable to untrained, incompetent, unethical therapists, with the potential to cause psychological harm. The current system of voluntary registration does nothing to safeguard the vulnerable, to promote benchmark education standards and prevent abusive therapists from continuing to practice. This view has been endorsed by Dore and Williamson (2016) who found that 25% of therapists who had their memberships annulled by the BACP and UKCP following complaint and investigation, continue to practice in defiance of their professional body's recommendation. Dore and Williamson (2016:17) concluded their report strongly arguing for statutory regulation of the counselling and psychotherapy profession, describing the voluntary register as a "*complete failure*".

#### **6.4 Developments**

Since publication of the Unsafe Spaces report in May 2016 (Dore and Williamson, 2016) the findings were discussed in a meeting between the Government Healthcare Select Committee and the Professional Standards Agency (PSA) who are responsible for managing the voluntary register. During this meeting, the PSA advised that it is currently developing a risk assessment model, to ascertain which professions are suitable for voluntary registration and which are more appropriate to statutory regulate. The model, still currently in development, will include three elements: the risk of the intervention, the context in which it takes place, and the vulnerability of the patient or service user. The PSA stated that it is looking likely that counselling and psychotherapy will be a profession recommended to move from the voluntary register, to statutory regulation (Dore and Williamson, 2016).

I did invite the PSA to take part in my study in 2015, but having reviewed the semi-structured interview questions (appendix 4, p189) they declined my interview request. The PSA stated that whilst they would be interested in the results, they did not feel they had anything of interest to contribute. Perhaps then, the risk assessment model discussed in parliament in July 2016 had not at that time been considered, and awareness of client vulnerability, outside of their awareness. Nevertheless, the focus of my study is under researched and the findings are very timely. They could inform the PSA, at this critical point in reviewing the regulatory status of the counselling and psychotherapy profession.

## **6.5 Study Limitations**

This is a small-scale study with just 22 participants and the results cannot be generalised across the profession, or the opinions of participants said to represent the public. I have throughout drawn against my own experiences as a therapist in private practice and in line with my constructionist perspective, am aware that my views and opinions are created from my own reality, which will differ to others. It is because of this, I am recommending a profession-wide referendum to explore opinions and give a voice to all therapists, so that a majority view becomes known.

This is a qualitative study and I set the study question based upon my own research disturbance, in a topic about which I hold strong views. I designed the interview questions and undertook the semi-structured interviews with participants, setting the direction of data collection. I also analysed the results using thematic analysis and drew the conclusions. The qualitative research process can never be impartial and is completely influenced by myself and my biases.

## **6.6 Impact on Researcher**

I commenced this study in October 2011, from a naive position in terms of the potential impact on my personal and professional development. Throughout my career, I had after all experienced many hours of personal therapy, had attended personal development groups and endured many years studying counselling and psychotherapy theory at diploma level, continuing with a Bachelor's and then

Master's degree. At the start, I anticipated that this would be an academic journey, not a personal one. On my very first day of attending lectures for the Professional Doctorate at the University of Brighton, I wrote in my reflective diary:

*How refreshing to be studying along with non-therapists! For the first time as a student, I can focus on what's really important and not be distracted by my every move being micro-analysed, being judged and having to deal with other peoples projected stuff. No-one will be asking me "How do you feel about that Julie" or "What I think is actually going on here is," I can relax, keep myself safe and enjoy the learning!! (May, 2011)*

Reading this six years on, made me smile. It highlighted my black and white thinking at the time, and how I thought I could separate academia from myself and my own process. My study peers were a fantastic support and the group become a healthy place to thrash out ideas and gain insight. I developed an especially deep friendship with a colleague who stayed at the same hotel during the study days. We would discuss philosophy and theory over dinner and try and make sense of the world. Over the years, I realised that the study and I were not separate entities, one reflects the other. The issues I battled with throughout the study, where projections of myself. The impact of studying philosophy and my ontology sent me into a questioning the meaning of life and who am I at a profoundly spiritual level. I reflected on what was important to me in my work and the relationship, the unconscious connection with my client being at the core. I went through the painful process of re-evaluating personal relationships, which resulted in the termination of unhealthy friendships, emotional distancing from destructive family members and the end of my 20-year marriage.

The personal development journey has been deeply profound, and several times in my reflective diary, I used the words, "*gruelling*", "*arduous*" and "*a test of endurance*" to describe the ongoing internal conflict with my self-worth. I regularly reminded myself, that a doctorate is earned and the cautionary words of a lecturer that, "*the cost can be measured in blood, sweat and tears*", rang in my ears. Repeatedly, I experienced the cycle of putting my all into a piece of academic writing, having it returned, obliterated with critical feedback and feeling rejected by the devastation with 'not being good enough'. Three times in the six years, I became so disheartened

that I seriously considered leaving the course. I am, however, a very stubborn person, and the determination not to be beaten, motivated me to see it through. Interestingly, the positive outcome of this cycle became apparent during my recent supervision training. Unlike my peer group who were paralysed with the fear of their work being rejected by the tutors, I felt complacent and calm. If my work was not to the required standard, I would be given feedback on how to improve it, I would do the required changes and resubmit. I was very struck by my new-found tolerance to criticism and rejection and recognised that this study has helped me to depersonalise feedback, and mature. Mathiesen and Binder (2009) summarise the learning from the doctorate journey:

*Apart from stretching yourself academically, you will also gain personal insight, self-understanding and grow as a person. You will know a lot more about yourself than when you started. And that alone is often worth the journey. (Mathiesen and Binder, 2009:53)*

The other theme that has always been present throughout my personal doctorate journey is one of owning my power and authority. At the start of my doctorate training, my therapist used the metaphor of a trumpet to describe my process. He suggested that I own a trumpet, but kept it a locked box, hidden under the floorboards. My journey would involve acknowledging the trumpet's existence, digging it out and start tooting so loudly, that those around would have to hear it. I have repeatedly reflected upon this analogy over the six years of my study and it still resonates very clearly with me.

As well as my own issues with personal power, I have been acutely aware of others' vulnerability. I have encountered several individuals who have been exploited by training organisations offering sub-standard training for extortionate fees, read the professional body malpractice cases and the impact on clients causing me great sadness, experienced an unstable therapist in my own practice and being powerless to stop her harming others. I am a very compassionate woman and witnessing the suffering of others has compelled me to complete this study and ensure that the issues I am raising are acknowledged by my profession. The process of study also



inspired me to undertake long overdue supervision training, so that I can make some small difference from within the profession, with the supervisees I work with.

## **6.7 Reflections for Practice and Recommendations**

The study findings have contributed to our understanding and knowledge into how clients select a therapist, map out the factors they consider and how these are assessed. The findings suggest that clients are not necessarily making informed, rational choices, but are relying upon third-party recommendation in the first instance, and then unconscious projection in response to website photographs or rhetoric. The clients were not aware of the complexities surrounding voluntary registration and assume that the counselling and psychotherapy profession is already statutory regulated, in line with other medical professions. They are unaware that in the arena of private practice, the onus is on them as the client, to validate the therapist's professional standing, educational attainment, and competency to practice.

The findings suggest it may be important to make more information available to GP's to ensure that they are making a recommendation based on sound judgement and not personal preference. GPs could be better informed and educated about the different forms of counselling and psychotherapy available, so that they can appropriately signpost patients to a private practice therapist. They should be able to advise their patients that the profession is not statutory regulated and as such, there is a need to validate and properly assess a therapist's credentials, before contracting to work with them. The findings will be shared with the General Medical Council (GMC), who are responsible for managing the UK Medical Register and with the Royal College of General Practitioners (RCGP) the professional body responsible for GPs. Both organisations have a role in providing education and training to their members and could disseminate guidance information. The existing training for GPs (RCGP: 2016) does include a section focusing on mental health and suggests trainees consider cross-agency communication and partnership working, including familiarising themselves with professionals from health, social care and the third sector. The training includes direct instruction related to primary care services and IAPT, but awareness of the services outside the NHS would appear to be at the

discretion of the trainee. Incorporating direct guidance into training material, would enhance GP's knowledge and longer term, ensuring that patients are appropriately referred on.

The findings also point towards making GP patient reading material available in the surgery to educate the public. On visiting several GP surgeries in my local area, I was only able to locate a leaflet in one surgery advertising the NHS funded counselling service, I-talk, but no information in any offering guidelines on selecting a private therapist. The Adept project (Adverse Effects of Psychological Therapies) (2015) have produced a website because of their study and summarising this into a leaflet readily available to GP surgeries, would be a helpful next step.

For therapists in private practice, the study findings suggest they need to focus on building solid relationships with potential recommendation sources and pay attention to the images and words used on their websites. I have shared my findings with my group practice colleagues and for my own website, replaced my photographs with ones professionally produced. The findings point towards developing criteria for new recruits to group private practice, so that practice managers can provide a gatekeeping role, ensuring that minimum training, competency and ethical requirements are in place for private therapists practising from their premises.

The study findings support a rationale for statutory regulation of the counselling and psychotherapy profession, providing clients the peace of mind they assume they already have. Statutory regulation would assure minimum education standards and the facility to remove unethical, incompetent therapists from being able to practice. For professional bodies and the policy makers, the findings highlight client ignorance and vulnerability in the process of therapist selection. This creates an uncomfortable realisation that as a profession we are enabling the inadequately trained, incompetent and unethical therapists an expanding arena of private practice, within which to exploit client vulnerability and potentially cause harm, in direct violation of the profession's ethical duty of care. The sociology of the professions offers an explanation as to how the profession has facilitated an environment for this to occur (Morrell, 2013, MacDonald, 1995; Larson, 1977).

Because of these findings, one important recommendation could be debating the issue of statutory regulation within the profession and canvass members to identify the views of the majority. To date, only the voice of the Alliance for Counselling & Psychotherapy (ACP), whose membership represented just 2% of professional body membership in 2009, has been heard. The findings of this study highlighted overwhelming support for statutory regulation for the counselling and psychotherapy and a profession wide referendum could be undertaken, as a matter of urgency. I will disseminate the study findings with the PSA, the professional bodies and Unsafe Spaces to increase our understanding and contribute to an overdue debate on the issues. The findings suggest that a research project could be commissioned to explore in more depth the views of therapists and what they would like to see for the future.

The findings pointed towards clients believing that the profession is already statutory regulated and as such, there was no recognition of responsibility to check out a therapist's credentials. This further supports the rationale for statutory regulation, which would provide clients with the reassurance and trust in the profession, which, they assume already exists. I aim to use the study findings to ensure that I become a voice within the counselling and psychotherapy profession, keeping statutory regulation a headline issue, under constant debate and focus. This could ultimately lead to policy change and to the avocation and commitment to statutory regulation for the future.

The study findings might also be relevant to other professions which are not currently statutory regulated, but whose professional bodies hold voluntary registration with the PSA. These include professions such as acupuncture, aromatherapy, audiology, homeopathy, hypnotherapy, massage therapy, play therapy, reiki and sports rehabilitation. Many of these professions practice within a private setting and the issues of practitioner selection, trust, decision making, and risks associated with private practice are shared with counselling and psychotherapy. Decision theories (Kahneman, 2011; Ariely, 2009; Schwarz, 2004; Anderson, 2003) discussed in the literature review chapter, equally apply to these allied professions and their

associated professional bodies, share commitment to upholding high standards of ethical practice.

## 6.8 Dissemination

I will share the findings with all the professional bodies I originally approached including the BACP, UKCP, BPS, BABCP and the PSA, HCPC and Department of Health. The timing of completion of this study is extremely pertinent with the recent PSA developments and I hope these organisations will be interested in working with me to achieve my recommendations. I will also share my study findings with Unsafe Spaces and support this organisation with their statutory regulation vision for the profession.

The BACP organises an annual research conference and the Association for Independent Practitioners (AIP) a BACP division, organises an additional annual conference, at which I intend to apply to present my study findings in 2018. The BACP also publishes a monthly journal *Therapy Today* and a quarterly journal dedicated to research *Counselling and Psychotherapy Research Journal*, which is forwarded to all members, and the AIP publishes a quarterly journal which is distributed to its members, who all have a specialist interest in private practice. I will disseminate my results through these journals. The UKCP also organises an annual research conference and publishes its own journal *The Psychotherapist* three times a year. Other journals I have considered could be interested in the results of my study include *British Journal of Psychotherapy* and *British Journal of Guidance and Counselling*. I am preparing an article based upon the study findings which I will be distributing shortly to these journal editors.

As already discussed (page 162) the results of this study might also be of interest to other professions which are not currently statutory regulated, but whose professional bodies hold voluntary registration with the PSA. I therefore intend to share the results with the Academy for Healthcare Science, Alliance of Private Sector Practitioners, British Acupuncture Council, British Association of Sports Rehabilitators and Trainers, Complementary and Natural Healthcare Council, Federation of Holistic Therapies, National Hypnotherapy Society and Play Therapy UK.

## 6.9 Conclusions

The findings of this study uniquely offer insight into how clients take a private practice therapist on trust, whether following a recommendation, or when making a personal choice. I have highlighted the heuristics which were important to clients in the selection process and those professional factors which, within the auspices of voluntary registration, were concerning, of limited interest to clients. Clients lacked awareness of the regularity status of the profession, and alarmingly, that the onus was on themselves to confirm a therapist's professional standing, before engaging in therapy. This study has contributed to the professions knowledge as to the importance of the therapist's website photograph, website rhetoric and the first meeting, as factors used in therapist selection, with transference or unconscious processes, rather than rational, informed decision making. The study has also demonstrated client assumption that the counselling and psychotherapy profession is already statutorily regulated and as such, the trust placed in therapists is merited.

It is clear, that the environment for clients is concerning, particularly at some of the most vulnerable times in their lives. In the ever-expanding private practice market, there is potential for untrained or inadequately trained therapists to offer their services and for client exploitation and harm. It is important that clients are protected by the law, to raise standards across the profession in the same way as other professions, making therapists accountable for their practice. This study raises several uncomfortable realisations for the profession to acknowledge and discuss, strongly supporting statutory regulation as the only responsible way forward.

My study is extremely timely and the issues I have raised, need urgent action by the profession. I hope that my study speaks with a very loud voice and is heard by a profession, who have been in denial of the issues raised, for some time. I feel extremely passionately about the topic of this thesis and hope to be an advocate for improving standards for clients, into the future.

## References

- Addis, M.E. & Jacobson, N.S. (1996) 'Reasons for depression and the process and outcome of cognitive-behavioural psychotherapies'. *Journal of Consulting and Clinical Psychology*, 64, 1417-1424.
- Adlam, J. (ed) (2014) *The Therapeutic Milieu Under Fire: Security and Insecurity in Forensic Mental Health*. London: Jessica Kingsley.
- Adverse Effects of Psychological Therapies (2015) *Supporting Safe Therapy*, University of Sheffield. Available at <http://www.supportingsafetherapy.org/> (accessed 28/10/16)
- Agar, M. (2013) *The Lively Science: Remodelling Human Social Research*. Minneapolis: Mill City Press.
- Ainsworth, M. D. S., Blehar, M. C., Walters, E. and Wall, S. (1978) *Patterns of Attachment: A Psychological Study of the Strange Situation*. Hillsdale, NJ: Lawrence Erlbaum.
- Ajzen, I. (1991) 'The theory of planned behavior'. *Organizational Behavior and Human Decision Processes*. 50 (2): 179–211
- Alderdice, J. (2001) *Psychotherapy Bill*, London: Her Majesty's Stationers.
- Aldridge, S. (2010) *Counselling, an Insecure Profession? A Sociological and Historical Analysis*. Unpublished doctoral thesis, University of Leicester. Available at <http://hdl.handle.net/2381/10261> (accessed 16/01/16)
- Aldridge, S. (2009) 'Making your mind up'. *Therapy Today*, Vol 20(4), 26-31.
- Aldridge, S. and Pollard, J. (2005). *Interim Report on the Mapping of Counselling and Psychotherapy*. Department of Health, London: The Stationery Office.
- Allen, H. A. and Cohen, M. S. (1980) 'Client preference for a disabled counsellor'. *Rehabilitation Counselling Bulletin*, 23, 165–168.
- Alliance for Counselling and Psychotherapy (2009) *Against Statutory Regulation*. Available at: <http://www.allianceforcandp.org/> (accessed 01/02/15)
- Anderson, C. J. (2003) 'The psychology of doing nothing: Forms of decision result from reason and emotion'. *Psychological Bulletin*, 129, 139-167.
- Ariely, D. (2009) *Predictably Irrational*. London: Harper Collins.
- Arnkoff, D.B., Glass, C.R., Shea, C.R., Mckain, T. L. and Sydnor-Greenberg, J.M. (1987) 'Client predispositions towards cognitive and social skill treatments for shyness'. *Journal of Integrative and Eclectic Psychotherapy*, 6, 154-64.

- Arrow, K. J. (1951) *Social Choice and Individual Values*. New York: Wiley & Sons.
- Asay, T. P. and Lambert, M. J. (1999) 'The empirical case for the common factors in therapy: quantitative findings'. In M. Hubble, B.I. Duncan and S.D. Miller (ed.) *The Heart and Soul of Change: What Works in Therapy*. Washington DC: American Psychological Association, 531-57.
- Ballinger, L. and Wright, J. (2007) 'Does class count? Social class and counselling'. *Counselling and Psychotherapy Research*, 7 (3) 157-163.
- Balmforth, J. (2009) 'The weight of class: Client's experiences of how perceived difference between counsellor and client affect the therapeutic relationship'. *British Journal of Guidance and Counselling*, 37:3, 375-386.
- Barbour, R. (2013) *Introducing Qualitative Research*. London: Sage.
- Bargh, J. A. and Chartrand, T. L. (1999) 'The unbearable automaticity of being'. *American Psychologist*, 54, 462-479.
- Barthes, R. (2000) *Camera Lucida: Reflections on Photography*, London: Vintage.
- Bates, Y. (2006) *Shouldn't I Feel Better by Now?* London: Palgrave.
- Beck, D. F. (1988) *Counselor Characteristics. How do they affect outcomes?* Milwaukee, W.I.: Family Service of America.
- Becker, G. S. (1976) *The Economic Approach to Human Behaviour*. Chicago: University of Chicago Press.
- Benson, H. (1992) *The professions. Official report 5th series*. Parliamentary debates 1992-93, Lords Vol. 538 Jun 15, 1992, July 9, 1992.1208-10.
- Beutler, L. E., Malik, M., Alimohamed, S., Harwood, T. M., Talebi, H., Noble, S. and Wong, E. (2004) 'Therapist Variables', in Lambert, M.J. (ed.) *Bergin and Garfield's Handbook of Psychotherapy and Behaviour Change* (5<sup>th</sup> edition). Chicago: John Wiley and Sons.
- Bhasker, R. (2017) *The Order of Natural Necessity: A kind of Introduction into Critical Realism*, London: Creative Space Independent Publishing Platform.
- Bohart, A. C. and Tallman, K. (1999) *How Clients Make Therapy Work: The Process of Active Self-Healing*. Washington DC: American Psychological Association.
- Bond, T. (2004) *Ethical Guidelines for Researching Counselling and Psychotherapy*. Rugby: BACP.
- Bond, T. (2000) *Standards and Ethics for Counselling in Action*. London: Sage.

Bordin, E. S. (1979) 'The generalizability of the psychoanalytic concept of the working alliance'. *Psychotherapy, Theory, Research, Practice, Training*, 16 (3): 252-60.

Bowlby, J. (1979) *The Making and Breaking of Affectional Bonds*. London: Routledge.

Boyatzis, R. E. (1998). *Transforming Qualitative Information: Thematic Analysis and Code Development*. Thousand Oaks, CA: Sage.

Braaten, E. B., Otto, S. and Handlesman, M. W. (1993) 'What people want to know about psychotherapy'. *Psychotherapy: Theory, Research, Practice*, 30, 4.

Brabham, R. E. and Thoresen R. W. (1973) 'Relationship of client preferences and counsellor physical disability'. *Journal of Counselling Psychology*, 20(1), 10–15.

Braun, M. (2015) 'Emotion and Language – When and how comes emotion into words'. *Physics Life Review*, 04.006 Available at:

<http://ds.doi.org/10.1016/plrev2015.04.006> (accessed 10/12/16)

Braun, V. and Clarke, V. (2008) 'Using thematic analysis in psychology'. *Qualitative Research in Psychology*, Vol 3 (2) 77-101.

Brearily, C. (1980) 'The need for disabled counsellors'. *Sexuality and Disability*, 3, 212–214.

Brentano, F. (1973) *Psychology from an Empirical Standpoint*. Routledge: London.

Brim, O. G. (1962) *Personality and Decision Processes: Studies in the Social Psychology of Thinking*. Stanford: Stanford University Press.

British Association for Counselling and Psychotherapy (2016) *Ethical Framework for Good Practice in Counselling and Psychotherapy*. Rugby: BACP.

British Association for Counselling and Psychotherapy (2015) *Accreditation Criteria*. Available at:

<http://www.bacp.co.uk/accreditation/Counsellor%20&%20%20Psychotherapist%20Accreditation%20Scheme/criteria.php> (accessed 14/02/15)

British Association for Counselling and Psychotherapy (2015a) 'New focus: When therapy does harm' *Therapy Today*, 26 (5) 8-9.

British Association for Counselling and Psychotherapy (2014) *Conduct Notices*.

Available at: [http://www.bacp.co.uk/prof\\_conduct/notices/termination.php](http://www.bacp.co.uk/prof_conduct/notices/termination.php) (accessed 16/01/15)

British Association for Counselling and Psychotherapy (2013) *Ethical Guidelines for Researching Counselling and Psychotherapy*. Available at:

[http://www.bacp.co.uk/admin/structure/files/pdf/9479\\_ethical%20framework%20jan2013.pdf](http://www.bacp.co.uk/admin/structure/files/pdf/9479_ethical%20framework%20jan2013.pdf) (accessed 06/04/13)



British Association for Counselling and Psychotherapy (2009) *Westminster meeting 2<sup>nd</sup> November 2009*, Available at: <http://www.bacp.co.uk/news/index.php?newsId=1617&count=132&start=81&filter=&at=&year> (accessed 20/01/15)

Brogen, M. M., Prochaska, J. O. and Prochaska, J. M (1999) 'Predicting termination and continuation status in psychotherapy using the transtheroretical model'. *Psychotherapy*, 36, 105-113.

Bryman, A. (2012) *Social Research Methods*. Oxford: Oxford University Press.

Burke Johnson, R. and Onwuegbuzie, A. J. (2004) 'Mixed methods research: A research paradigm whose time has come'. *Educational Research*, Vol 33, 7: 14-26.

Burkell, L. A. and Goldfried, M. R. (2006) 'Therapist qualities preferred by sexual minority individuals'. *Psychotherapy: Therapy, Research, Practice, Training*, 43(1):32-49.

Burrage, M. and Torstendahl, R. (ed.) (1990) *Professions in Theory and History*. London: Sage.

Carlin, J. (1962) *Lawyers on their own*. New Brunswick, N.J: Rutgers University Press.

Careers in Psychology, (2015) *Private Practice as a Psychologist*. Available at: <http://www.careersinpsychology.co.uk/private-practice-psychologist.html> (accessed 17/01/16)

Carroll, M. (1996) *Counselling Supervision: Theory, Skills and Practice*. Sage: London.

Castonguay, L. G. and Beutler, L. E. (2006) *Principles of Therapeutic Change*. Oxford: Oxford University Press.

Chakraborty, A., McManus, S., Brugha, T.S., Bebbington, P. and King, M. (2011) 'Mental health of the non-heterosexual population of England'. *The British Journal of Psychiatry*, 198 (2) 143-148.

Chambless, D. L. (2002) 'Beware the dodo bird: The dangers of overgeneralization'. *Clinical Psychology: Science and Practice*, 9(1):13-6.

Chambless, D. L. and Ollendick, T. H. (2001) 'Empirically supported psychological intervention: Controversies and evidence'. *Annual Review of Psychology*, 52:885-716

Charmaz, K. (2013) *Constructing Grounded Theory (Introducing qualitative Methods Series)*, London: Sage.

Christensen, A. and Jacobson, N. S. (1994) 'Who (or what) can do psychotherapy: The status and challenge of nonprofessional therapies'. *Psychological Science*, 5, 8-14.

Clarkson, P. (2003) *The Therapeutic Relationship*. Oxford: Wiley-Blackwell.

Coe, J. (2014) 'Your friends and neighbours'. In Adlam, J. (ed.) (2014) *The Therapeutic Milieu Under Fire: Security and Insecurity in Forensic Mental Health*. London: Jessica Kingsley.

Cohen, L. Manion, L. and Morrison, L. (2007) *Research Methods in Education* (5<sup>th</sup> edition). London: Routledge.

Coleman, H. L. K., Wampold, B. E., Casali, S. L. (1995) 'Ethnic minorities' ratings of ethnically similar and European American counsellors: A meta-Analysis'. *Journal of Counselling Psychology*, 42, 55-64.

Conyers, M. (2006) 'The crouching monk: Disability in the consulting room'. In Bishop, B., Klein, J., Foster, A. and Dickinson, A. (ed.), *Difference: An avoided Topic in Practice*. London: Karnac Books.

Cooper, M. (2009) *Essential Research Findings*. London: Sage.

Cornish, F. and Gillespie, A. (2009) 'A pragmatist approach to the problem of knowledge in health psychology'. *Journal of Health Psychology*, 14 (6) 1-10.

Council for Healthcare Regulatory Excellence (2012) *Accreditation Standards for Organisations that Hold Voluntary Registers for Health and Social Care Occupations*. Available at: [http://www.hpc-uk.org/assets/documents/10003B91120416\\_-\\_standards\\_for\\_consultation\\_-\\_PDF%5B1%5D.pdf](http://www.hpc-uk.org/assets/documents/10003B91120416_-_standards_for_consultation_-_PDF%5B1%5D.pdf) (accessed 17 February 2017)

Council for Healthcare Regulatory Excellence (2011) *Voluntary Registers – Setting the Bar*. Available at: [http://www.chre.org.uk/img/pics/library/Item\\_10\\_Paper\\_04\\_Voluntary\\_Registers\\_setting\\_the\\_bar.pdf](http://www.chre.org.uk/img/pics/library/Item_10_Paper_04_Voluntary_Registers_setting_the_bar.pdf) (accessed 12 December 2011)

Council for Healthcare Regulatory Excellence, (2010) *Right Touch Regulation*. London: CHRE.

Counselling Resource (2015) *Professional Licensing in Mental Health*. Available at: <http://counsellingresource.com/lib/therapy/aboutcouns/licensure/> (accessed 22/01/15)

Creswell, J. W. (2014) *Research Design*. London: Sage.

Creswell, J. W. (2002) *Educational Research: Planning, Conducting, and Evaluating Quantitative and Qualitative Research*. Upper Saddle River, NJ: Pearson Education.

Crotty, M. J. (1998) *The Foundations of Social Research: Meaning and Perspective in the Research Process*. London: Sage.

Daily Mail (2014) *Struck off and Shamed*. Available at: <http://www.dailymail.co.uk/health/article-2726594/Struck-shamed-groping-psychotherapist-free-treat-women-today-Victims-said-asked-undress-lack-regulation-means-firm-abusing-trust-operating.html> (accessed 17/06/15)

Data Protection Act (2003) *Data Protection Act 2003*. London; The Stationery Office. Available at <https://www.gov.uk/data-protection/the-data-protection-act> (accessed 01/03/14)

Dauphinais, P., La Fromboise, T. and Rowe, W. (1980) 'Perceived problems and sources for help for American Indian students'. *Counselor, Education and Supervision*, 20, 37-46.

Dembo, R., Ikle, D.N. and Ciarlo, J. A. (1983) 'The influence of client-clinician demographic match on client outcomes'. *Journal of Psychiatric Treatment and Evaluations*. 5, 45-53.

Denzin, N. K. and Lincoln, Y. S. (1994) *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage.

Department of Health (2012) *Health and Social Care Act*. London: The Stationery Office.

Department of Health (2011) *Health and Social Care Bill*. London: The Stationery Office.

Department of Health (2011a), *Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers*. London: The Stationery Office.

Department of Health (2010) *Review of the Regulation of Public Health Professionals*. London: The Stationery Office.

Department of Health (2007) *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21<sup>st</sup> Century*. London: The Stationery Office.

Department of Health (2001) *Health and Social Care Act*. London: The Stationery Office.

Devine, D. A. and Fernold, P. S. (1973) 'Outcome effects of receiving a preferred, randomly assigned or non-preferred therapy'. *Journal of Consulting and Clinical Psychology*. 41, 104-107.

Dewey, J. (1997) *Experience and Education*. New York: Pocket Books.

Dewey, J. (1910) 'How we think'. *Middle Works*, Vol 6, 177-536.

- Dore, P. and Williamson, A. (2016) *Unsafe Places: Why the Lack of Statutory Regulation in Counselling and Psychotherapy is Endangering Vulnerable People*, Available at: <https://notsobigsociety.files.wordpress.com/2016/05/unsafe-spaces-report-may-2016.pdf> (accessed 24/07/16)
- Dunnett, A., Cooper, M., Wheeler, S., Balmountjoy, S., Wilson, C. and Hill, A. (2007) *Towards Regulation: The Standards, Benchmarks and Training Requirements for Counselling and Psychotherapy*. Rugby: BACP.
- Durkheim, E. (1958) *Rules of the Sociological Method*. New York: The Free Press.
- Durkheim, E. (1957) *Professional Ethics and Civic Morals*. New York: The Free Press.
- Eames, V. and Roth, A. (2000) 'Patient attachment orientation and the early working alliance – a study of patient and therapist reports of alliance quality and ruptures'. *Psychotherapy Research*. 10 (4): 421-34.
- Elkin, I., Yamaguchi, J. L., Arnkoff, D. B., Glass, C. R., Sotsky, S. M. and Krupnick, J. L. (1999) 'Patient-treatment fit and early engagement in therapy'. *Psychotherapy Research*. 9, 437-451.
- Elliott, P. (1972) *The Sociology of the Professions*, London: The Macmillan Press Ltd.
- Ely, M., Vinz, R., Downing, M., and Anzul, M. (1997). *On Writing Qualitative Research: Living by Words*. London: Routledge/Falmer.
- Equality Act (2010) *Equality Act 2010: Commencement No 11 (Order 16)*, Government Equality Office and Equality and Human Rights Commission, London: The Stationery Office. Available at <https://www.gov.uk/guidance/equality-act-2010-guidance> (accessed 14/02/17)
- Feilzer, M. Y. (2010) 'Doing mixed methods research: Rediscovery of pragmatism'. *Journal of Mixed Methods Research* 4(1) 6-16.
- Feltham, C. (2000) 'Settings and opportunities for employment'. In: Feltham, C. and Horton, I. (ed.) *Handbook of Counselling & Psychotherapy*. London: Sage.
- Fontana, A. & Frey, J. H. (1994) 'Interviewing: the art of science'. In Denzin, N. K. and Lincoln, Y. S. (ed.) *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage, 361-76.
- Foster, J. (1971) *Enquiry into the Practice and Effects of Scientology*. London: Her Majesty's Stationery Office.
- Foucault, M. (1980) *Power and Knowledge; Selected Interviews and Other Writings 1972-77*. New York: Pantheon Books.

- Freidson, E. (1986) *Professional Powers: A Study of Institutionalization of Formal Knowledge*, Chicago: The University of Chicago Press.
- Gadamer, H. G. (2004) *Truth and Method (Continuum Impacts)*. London: Continuum International Publishing Group.
- Gilbert, D. T. and Gill, M. J. (2000) 'The momentary realist'. *Psychological Science*, 11, 394-398.
- Gillham, B. (2005) *Research Interviewing; The Range of Techniques*. Maidenhead: Open University Press.
- Glanz, K., Rimer, B. K. & Lewis, F. M. (2002) *Health Behavior and Health Education. Theory, Research and Practice*. San Francisco: Wiley & Sons.
- Grantham, R. S., and Joslyn, M. S. (1981) 'Modelling implications for rehabilitation counselling process and outcome'. *Rehabilitation Counselling Bulletin*, 24, 342–353.
- Gregory, S., McQueen, K. M., and Namey, E. E. (2012) *Applied Thematic Analysis*. London: Sage.
- Guardian (2014) *Mentally Ill People at the Mercy of Untrained Therapists*. Available at <http://www.theguardian.com/commentisfree/201014/feb/24/mentally-ill-people-at-mercy-of-untrained-therapists> (accessed 16/01/15)
- Guardian (2014a) *Misguided Counselling and Therapy can be Harmful*. Available at <http://www.theguardian.com/society/2014/may/26/misjudged-counselling-psychological-therapy-harmful-study-reveals> (accessed 26/01/15)
- Guba, E. G and Lincoln, Y. S. (1989) *Fourth Generation Evaluation*. Sage: Newbury Park.
- Hadfield, H. (2015) 'When CBT doesn't help'. *Therapy Today*, May 2015, Vol 26, 4:16-20.
- Harding, J. (2013) *Qualitative Data Analysis from Start to Finish*. Sage: London.
- Hawkins, P. and Shohet, R. (2006) *Supervision in the Helping Professions*. Open University Press: Maidenhead.
- Health Care Professions Council (2011) *Statutory Regulation of Psychotherapists and Counsellors: Executive summary and recommendations*. Available at <http://www.hpc-uk.org/assets/documents/10003436Item29-anyotherbusiness.pdf> (accessed 26/01/15)
- Health Care Professions Council (2011a) *Psychotherapists and Counsellors Professional Liaison Group 2<sup>nd</sup> February 2011*. Available at [http://www.hpcuk.org/assets/documents/100032E3psychotherapists\\_and\\_counsellors\\_professional\\_liaison\\_group\\_20110202\\_enclosure05\\_workplan.pdf](http://www.hpcuk.org/assets/documents/100032E3psychotherapists_and_counsellors_professional_liaison_group_20110202_enclosure05_workplan.pdf) (accessed 01/02/15)

Health Professions Council (2009) *Summary points of the event on the statutory regulation of psychotherapists and counsellors by the HPC, hosted by Anne Milton MP*. Available at <http://hcpc-uk.blogspot.co.uk/2009/11/summary-points-of-event-on-statutory.html> (accessed 20/01/16)

Health Professions Council (2009a) *The Statutory Regulation of psychotherapists and counsellors: Response to the consultation on the recommendations of the Psychotherapists and Counsellors Professional Liaison Group (PLG)*. London: HCPC. Available at [http://www.hpcuk.org/assets/documents/10002D85psychotherapists\\_and\\_counsellors\\_plg\\_20100512\\_enclosure05\\_responses\\_to\\_consultation\\_and\\_conclusions.pdf](http://www.hpcuk.org/assets/documents/10002D85psychotherapists_and_counsellors_plg_20100512_enclosure05_responses_to_consultation_and_conclusions.pdf) (accessed 30/01/15)

Health Professions Council (2009b) *Conclusions on the proposed statutory regulation of psychotherapists and counsellors*. London: HPC. Available at <http://www.hpcuk.org/assets/documents/10002BD6psychotherapistsandcounsellorsconclusionsdocument-enc6.pdf> (accessed 30/01/15)

Heidegger, M. (2010) *Being and Time*. New York: State University of New York Press.

Hemmings, A. and Field, R. (ed.) (2007) *Counselling and Psychotherapy in Contemporary Practice*. London: Sage.

Hogarth, R. M. (2001) *Educating Intuition*. University of Chicago Press:Chicago

Holmes, M. (2016) 'You never get a second chance to make a first impression? First encounters and face-based threat perception'. *Journal of Global Security Studies*, Vol1, 4: 285 – 302. Available at <http://jogss.oxfordjournals.org/content/1/4/285.full> (accessed 07/12/16)

Horvath, A. O. and Bedi, R. P. (2002) 'The alliance'. In Norcross, J. C. (ed.) *Psychotherapy Relationships that Work: Therapist Contributions and Responsiveness to Patients*. New York: Oxford University Press.

Hubble, M. A., Duncan, B. L. and Miller, S. D. (1999) *The Heart and Soul of Change: What Works in Therapy*. Washington: American Psychological Association.

Hunsley, I. and Di Giulio, G. (2002) 'Dodo bird, phoenix or urban legend'. *Scientific Review of Mental Health Practices*, 1 (1):11-22.

Ipnosis (2007) *The Hamburgerization of Personal Development — Be Very Careful What You Wish For*. Available at <http://ipnosis.postle.net/pages/Sept1807RefGRPHamburg.htm> (accessed 01/02/15)

It's Good to Talk (2015) *Counselling and Psychotherapy*. Lutterworth: BACP. Available at <http://www.itsgoodtotalk.org.uk/therapists> (accessed 22/03/16)

James, W. (1912) *The Will to Believe and Other Essays in Popular Philosophy*. New York: Longmans Green and Co.

- Johnson, T. J. (1972) *Professions and Power*, London: The Macmillan Press Ltd.
- Josselson, R. (2004) 'The hermeneutics of faith or the hermeneutics of suspicion'. *Narrative Inquiry*, 14(1), 1-29.
- Kahneman, D. (2011) *Thinking Fast and Slow*. London: Penguin.
- Kahneman, D. and Tversky, A. (1979) 'Prospect theory; an analysis of decision making under risk'. *Econometrica*, 47(2), 263-292.
- Kearney, A. (2003) 'Class blindness: class and counselling' in Lago, C. and Smith, B. (ed.) *Anti-Discriminatory Counselling Practice*. London: Sage.
- Kent Online (2013) *Teenager Anthony Dunne Hanged Himself in Cell at Rochester Young Offenders' Institution After Affair with Counsellor Anita Setz, Inquest Told*. Available at <http://www.kentonline.co.uk/medway/news/anthony-dunne-6256/> (accessed 16/01/15)
- King, G. (2007) 'Career Development of Counsellors'. *British Journal of Guidance and Counselling*. 34(4) 389-405.
- King, M., Semylen, J., Killaspy, H., Nazareth, I. and Osborn, D. (2007) *A Systematic Review of Research on Counselling and Psychotherapy for Lesbian, Gay, Bisexual and Transgender People*. Rugby: BACP.
- Koch, T. and Harrington, A. (1998) 'Reconceptualising rigour: the case for reflexivity'. *Journal of Advanced Nursing*. 28(4), 882-890.
- Kuhn, A. (2007) 'Photography and Cultural Memory, a methodological exploration'. *Visual Studies*, 22: 283-92.
- Kvale, S. and Brinkmann, S. (2009) *Interviews: Learning the Craft of Qualitative Research Interviewing*. London: Sage.
- Lambert, M. J. and Barley, D. E. (2001) 'Research summary on the therapeutic relationship and psychotherapy outcome'. *Theory, Research, Practice, Training*, Vol 38(4), 2001, 357-361.
- Lambert, M. J. and Ogles, B. M. (2004) 'The effectiveness of psychotherapy supervision'. In Lambert, M. J. (ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behaviour Change*. Chicago: John Wiley and Sons, 421-46.
- Larson, M. S. (1977) *The Rise of Professionalism: A Sociological Analysis*, Berkeley: University of California Press.
- Layard, R. (2005) 'Mental health: the choice of therapy for all'. *Centrepiece*, 10 (3). pp. 19-21. ISSN 1362-3761.

- Lemersie, E. A. and Arsenio, W. F. (2000) 'An integrated model of emotion processes and cognition in social information processing'. *Child Development*, 71, :107-118.
- Levi-Strauss, C. (1966) *The Savage Mind*, Chicago: University of Chicago Press.
- Liddle, B. J. (1996) 'Therapist sexual orientation, gender and counselling practices as they relate to ratings on helpfulness by gay and lesbian clients'. *Journal of Counseling Psychology*, 43 (4): 394-401.
- Loganbill, C. J., Hardy, E. and Delworth, U. (1982) 'Supervision, a conceptual model'. *The Counseling Psychologist*, 10(1), 3-42.
- Lyotard, J. F (1988) *The Differend: Phrases in Dispute*. Minnesota: University of Minnesota Press.
- Macdonald, K. M. (1995) *The Sociology of The Professions*, London: Sage.
- Manthei, R. J. (2006) 'What can clients tell us about seeking counselling and their experience of it'. *International Journal for the Advancement of Counselling*, 13-5.
- Manthei, R. J. (1988) 'Client choice of therapist: Rationale and Implications'. *Psychotherapy: Theory, Research and Practice*, 25-3.
- Manthei, R. J. (1983) 'Client choice of therapist or theory'. *Personnel and Guidance Journal*, (61): 334-340.
- Manthei, R. J., Vitalo, R. L. and Ivey, A. E. (1982) 'The effect of client choice of therapist on therapy outcome'. *Community Mental Health Journal*, 18 (3), 222-229.
- Martin, L. (2013) 'Counselling in Canada'. *Therapy Today*, vol 24, issue2, March 2013, Lutterworth: BACP.
- Martinez, F. I. (1991) 'Therapist-client convergence and similarity of religious values. The effect on client improvements'. *Journal of Psychology and Christianity*, 10. 137-143.
- Marx, K. (1990) *Capital: Critique of Political Economy*. London: Penguin.
- Mason, J. (2002) *Qualitative Researching*. London: Sage.
- Masson, J. (1988) *Against Therapy*. Glasgow: William Collins and Sons.
- Mathiesen, J. and Binder, M. (2009) *How to Survive Your Doctorate: What Others Don't Tell You*. Maidenhead: Open University Press.
- May, J. (2011) *Reflective Diary*. Unpublished professional Doctorate Journal.
- May, T, (2011a) *Social Research: Issues, Methods and Process*. Maidenhead: Open University Press.



- Mayo, E. (1949) *The Social Problems of an Industrial Civilisation*. London: Routledge.
- McLeod, J. (2001) *Qualitative Research in Counselling and Psychotherapy*. London: Sage.
- McLeod, J. (1999) *Practitioner Research in Counselling*. London: Sage.
- McLeod, J. (1994) *Doing counselling Research*. London: Sage.
- McMahon, G., Palmer, S. and Wilding, L. (2005) *Essential Skills for Setting up a Counselling and Psychotherapy Practice*. London: Routledge.
- McQueen, P. and McQueen, H. (2010) *Key Concepts in Philosophy*. Basingstoke: Palgrave Macmillan.
- Merleau-Ponty, M. (2013) *Phenomenology of Perception*. London: Routledge.
- Meyer, B. and Pilkonis, P. A. (2002) 'Attachment style'. in Norcross, J.C., *Psychotherapy Relationships that Work: Therapist Contributions and Responsiveness to Patients*. New York: Oxford University Press.
- Miles, M. B. and Huberman, A.M. (1994) *Qualitative Data Analysis*. Sage: Newbury Park, CA.
- Miller, M. J. (1991) 'Counsellors with disabilities: A comment on the special feature'. *Journal of Counselling and Development*, 70, 347–349.
- Mind (2009) *The Regulation of Psychotherapy and Counselling*. Available at: [http://www.mind.org.uk/assets/0000/6322/counsellors\\_and\\_psychotherapists\\_regulation.pdf](http://www.mind.org.uk/assets/0000/6322/counsellors_and_psychotherapists_regulation.pdf) (Accessed 10/05/13)
- Mohr, D. C. (1995) 'Negative outcomes in psychotherapy – a critical review'. *Clinical Psychology: Science and Practice*, 2 (1) 1-27.
- Moran, D. (2000) *Introduction to Phenomenology*. London: Routledge.
- Morrell, P. (2013) *Some Notes on the Sociology of Professions*. Available at: <http://www.homeoint.org/morrell/misc/professions.htm> (accessed 20/04/13).
- Morrison, J. K. (1979) 'A consumer-orientated approach to psychotherapy'. *Psychotherapy: Theory, Research and Practice*, 16 381-384.
- Morse, J. M. (1994) *Critical Issues in Qualitative Research Methods*. London: Sage.
- Munro, E (2009) 'On finding a therapist'. *Therapy Today*, 20, 1.
- Murphy, M. J., Faulkner, R. A. and Behrens, C. (2004) 'The effect of therapist-client trial similarity on client satisfaction and therapist and therapist evaluation of treatment'. *Contemporary Family Therapy*, 26, (3): 279-92.

National Counselling Society (2015) *Membership Level Criteria*. Available at <http://www.nationalcounsellingsociety.org/join/criteria/levels/> (accessed 14/02/15)

National Health Service England (2013) *Valuing Mental Health Equally with Physical Health or "Parity of Esteem"* Available at: <http://www.england.nhs.uk/ourwork/qual-clin-lead/pe/> (accessed 21/01/15)

Norcross, J. C. (2002) *Psychotherapy Relationships that Work: Therapist Contributions and Responsiveness to Patients*. New York: Oxford University Press.

Norcross, J. C., Bike, D. H., and Evans, K. L. (2009) 'The therapist's therapist: A replication and extension 20 years later'. *Psychotherapy Theory Research, Practice, Training*, 46(1),32-41.

Norcross, J. C., Strausser, D. J. and Faltus, F.J. (1988) 'The therapist's therapist'. *American Journal of Psychotherapy*, 42(1), 53-66.

Noy C. (2008) 'Sampling knowledge: the hermeneutics of snowball sampling in qualitative research'. *International Journal of Research Methodology*, 11 (4), pp327-44.

Oliver, P. (2003) *The Students Guide to Research Ethics*. Maidenhead: Open University Press.

Oppenheim, A. N. (1992) *Questionnaire Design, Interviewing and Attitude Measurement*. London: Pinter.

Orlinsky, D. E., Ronnestad, M.H. and Willutzki, U. (2004) 'Fifty years of psychotherapy process-outcome research: continuity and change'. In Lambert, M.J. (ed.) *Bergin and Garfield's Handbook of Psychotherapy and Behaviour Change*. Chicago: Wiley.

Orlinsky, D. E., Grawe, K. and Parks, B. (1994) 'Process and outcome in psychotherapy'. In Bergin, A.E. and Garfield, S.L. (ed) *Handbook of Psychotherapy and Behaviour Change* (5<sup>th</sup> ed), Chicago: Wiley.

Owen-Pugh, V. and Jewson, N. (2015) 'Post qualification paths to expertise'. *Therapy Today*, 26 (1) 28-31, Lutterworth: BACP.

Pearson, M. R. and Balsara, C. (2016) 'Therapists experience of alliance formation in short-term counselling'. *European Journal of Counselling and Psychotherapy*, 18,1,75-92.

Peterson, M (2009) *An Introduction to Decision Theory*. Cambridge: Cambridge University Press.

Pink, S. (2007) *Doing Visual Ethnography*. London: Sage.

Popper, K. (2011) *the Open Society and Its Enemies*. London Routledge.

Prochaska, J. O. and DiClemente, C. C. (1983) 'Stages and processes of self change in smoking. Towards an integrative model of change'. *Journal of Consulting and Clinical Psychology*, 5, 390-395.

Proctor, B. (1988) *Supervision a Working Alliance* (videotape training manual). St Leonards on Sea, East Sussex: Alexia Publications.

Proctor, G. (2002) *The Dynamics of Power in Counselling and Psychotherapy: Ethics, Politics and Practice*. Ross on Wye: PCCS Books.

Professional Standards Agency (2013) *Standards for Accredited Registers*. Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/standards/standards-for-accredited-registers.pdf?sfvrsn=4> Accessed 17/02/17

Psychotherapy and Counselling Federation of Australia. (2017). *Definition of Counselling and Psychotherapy.*, Available at <http://www.pacfa.org.au/resources/cid/41/parent/0/t/resources/l/layout> (accessed 12/02/17)

Psychotherapy and Counselling Federation of Australia (2008) *Best Practice Self-Regulation Model for Psychotherapy and Counselling in Australia: Final Report*. Melbourne: State of Victoria Department of Human Services.

Punch, K. F. (2006) *Developing Effective Research Proposals*. London: Sage.

Reinharz, S. (1992) *Feminist Methods in Social Research*. New York: Oxford University Press.

Remley, T. P., Bacchini, E. and Krieg, P. (2010) 'Counseling in Italy'. *Journal of Counseling and Development*, Winter 2010, Vol 88, 28-32.

Robson, C. (2002) *Real World Research: A Resource for Social Scientists and Practitioner Researchers*. Massachusetts: Blackwell.

Rolfe, G. (2006) 'Validity, trustworthiness and rigour: quality and the idea of qualitative research'. *Journal of advanced Nursing*. 53(3), 304-310.

Ronnestad, M. H. and Skovholt, T. M. (2003) 'The Journey of Counsellor and Therapist: Research Findings & Perspectives on Professional Development'. *Journal of Career Development*, 30(1), 5-44.

Rose, G. (2004) 'Everyone's cuddled up and it looks really nice: an emotional geography of some mums and their family photographs'. *Social & Cultural Geography*, 5:549-64.

Roth, A. and Fonagy, P. (2005) *What Works for Whom: A Critical Review of Psychotherapy Research*. New York: The Guildford press.

Royal College of General Practitioners (2016) *GP Training Curriculum*. Available at <http://www.rcgp.org.uk/training-exams/gp-curriculum-overview/online-curriculum.aspx> (accessed 19/10/16)

Royal College of Psychiatry, (2013) *Whole-person care: from rhetoric to reality. Achieving parity between mental and physical health*. Available at <http://www.rcpsych.ac.uk/pdf/OP88.pdf> (accessed 20/01/15)

Rubino, G., Barker, C., R., Roth, T. and Fearon, P. (2000) 'Therapist empathy and depth of interpretation in response to potential alliance ruptures: The role of therapist and patient attachment styles'. *Psychotherapy Research*, 10, 408-420.

Sandlewski, M. and Barroso, J. (2002) 'Reading qualitative studies'. *International Journal of Qualitative Methods*. 1 (1) article 5 <http://www.ualberta.ca/~ijgm/> (accessed 18/03/15)

Schwartz, J. A., Chapman, G. B., Brewer, N. T., & Bergus, G.B. (2004) 'The effects of accountability on bias in physician decision making: Going from bad to worse'. *Psychonomic Bulletin & Review*, 11, 173-178.

Semlyen, J., King, M., Varney, J. and Hagger-Johnson, G. (2016) 'Sexual orientation and symptoms of common mental disorder or low wellbeing: combined meta-analysis of 12 UK population health surveys'. *BMC Psychiatry*. Available at: <http://search.proquest.com.ezproxy.brighton.ac.uk/docview/1797892550?pq-origsite=summon&accountid=9727> (accessed 14/02/17)

Shaw, A. (2014) 'More than meets the eye: a consideration of the influence of a counsellor's visual impairment upon his therapeutic relationships'. *British Journal of Guidance & Counselling*, 42, 3, 297-308.

Sherriff, N., Gugglberger, L., Hall, C., and Scholes, J. (2014) 'From start to finish: Practical and ethical considerations in the use of focus groups to evaluate sexual health service interventions for young people'. *American Psychological Association*, 14, 96-104.

Silverman, D. (2006) *Interpreting Qualitative Data (3<sup>rd</sup> Edition)*. London: Sage.

Simon, H. A. (1960) *The New Science of Management Decision*. New Jersey: Prentice Hall.

Slife, B. D. (2004) 'Theoretical challenges to therapy practice and research: the constraints of naturalism'. In Lambert, M. J. (ed.) *Bergin and Garfield's Handbook of Psychotherapy and Behavioural Change*. Chicago: John Wiley and Sons, 44-83.

Sloman, S. A. (1996) 'The empirical case for two systems of reasoning'. *Psychological Bulletin*, 119, 3-22.

Snyder, C. R., Michael, S. T. and Cheavens, J. (1999). "The empirical case for the common factors in therapy: Quantitative findings". In Hubble, M. and Duncan, B.(ed.) *The heart and soul of change: What works in therapy*. 179–200. Washington, DC: American Psychological Association.

Soble, A. (1978) 'Deception in social science research: Is informed consent possible?' *Hastings Centre Report*, 40-46.

Spalter, D. (2013) *How clients choose their psychotherapist: Influences on selecting and staying with a therapist*, For the award of Doctorate in Counselling Psychology and Psychotherapy by Professional Studies, Middlesex University and Metanoia Institute.

Starhawk, M, (1987) *Truth or Dare: Encounters of Power, Authority, Mystery*. San Francisco: Harper & Row.

Stein, D. M. and Lambert, M. J. (1995) 'Graduate training in psychotherapy – are therapy outcomes enhanced'. *Journal of Consulting and Clinical Psychotherapy*, 63 (2) 182-96.

Stein J. G (2013:). '*Threat Perception in International Relations*'. In *The Oxford Handbook of Political Psychology*, Huddy, L., Sears, D.O.and Levy J. S. (ed.) Oxford: Oxford University Press: 364–94.

Sue, S. and Lam, A. (2002) 'Cultural and demographical diversity'. In Norcross, J.C. (2002) *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. New York: Oxford University Press.

Swift, J. K., Callahan, J. L. and Vollmer, B. M. (2011) 'Preferences'. *Journal of Clinical Psychology*, 67, 155-165.

Syme, G. (1994) *Counselling in Independent Practice*. Buckingham: Open University Press.

Tagg, J. (1988) *Burden of Representation: Photographies and Histories*. Basingstoke: Macmillan.

Tashakkori, A. and Teddlie, C. H. (2005) 'Mixed methods research tradition'. *Encyclopaedia of Educational Administration*. Thousand Oaks, CA: Sage.

Taylor, G. W., and Ussher, J. M. (2001). 'Making sense of S&M: A discourse analytic account'. *Sexualities*, 4(3), 293-314.

Teasdale, J.D. (1985) 'Psychological treatments for depression – how do they work'. *Behavioural Research and Therapy*, 23 (2):157-65L.

Tetlock, P.E. (2002) 'Social functionalist frameworks for judgement and choice: Intuitive Politicians, theologians and prosecutors'. *Psychological Review*, 109, 451-471.

Tinkler, P. (2013) *Using Photographs in Social and Historical Research*. London: Sage.

Todorov, A., Olivola C. Y., Dotsch, R., and Mende-Siedleck, P. (2015) 'Social Attributions from Faces: Determinants, Consequences, Accuracy, and Functional Significance'. *Annual Review of Psychology* 66(1): 519–45.

Tryon, G. S. (1985) 'The engagement quotient: One index of a basic counseling task'. *Journal of College Student Personnel*, Vol 26(4), Jul 1985, 351-354.

Tuckett, A. G. (2005). 'Applying thematic analysis theory to practice: A researcher's experience'. *Contemporary Nurse*, 19(1-2), 75-87.

Tyrrell, C.L., Dozier, M., Teague, G.B. and Falloot, R. D. (1999) 'Effective treatment relationships for persons with serious psychiatric disorders: the importance of attachment states of mind'. *Journal of Consulting and Clinical Psychology*, 67, 725-733.

United Kingdom Council for Psychotherapy (2015) *Standards, Guidance, Policies*. Available at <https://www.psychotherapy.org.uk/registers-standards/standards-guidance-and-policies/> (accessed 14/03/15)

United Kingdom Council for Psychotherapy (2014) *Memorandum of understanding on conversion therapy in the UK*. Available at <http://www.psychotherapy.org.uk/news/memorandum-of-understanding> (accessed 16/01/15)

University of Brighton (2013a) *Good Practice in Research Ethics and Governance*. Available at <http://staffcentral.brighton.ac.uk/xpedio/groups/public/documents/staffcentral/doc007528.pdf> (accessed 06/04/13)

University of Brighton (2013b) *Guidance Notes for Faculty Research Ethics Governance Committee*. Available at [http://staffcentral.brighton.ac.uk/ro/ethics\\_govern.shtm](http://staffcentral.brighton.ac.uk/ro/ethics_govern.shtm) (accessed 06/04/13)

University of Brighton (2013c) *Handling Personal Data*. Available at <http://www.brighton.ac.uk/hss/fregc/personaldata.php> (accessed 06/04/13)

Unsafe Spaces (2016) *Monthly Achieves July 2016: Unsafe Spaces Report Discussed in Parliament*. Available at <https://unsafespaces.com/2016/07/> (accessed 24/07/16)

Van Audenhove, C. and Vertommen, H. (2000) 'A Negotiation Approach to Intake and Treatment Choice'. *Journal of Psychotherapy Integration*, 10, 3.

Van Manen, M. (1997) *Researching Lived Experience*. Ontario: Althouse Press.

Vera, E. M., Speight, S. L., Midner, C. and Carlson, H. (1999) 'Client perceptions and evaluations of similarities and differences from their counsellors'. *Journal of Counselling Psychology*, 46, 277-283.

Walker, M., Fang, J., Vetter, T. and Sczesny, S. (2011) 'Universals and cultural differences in forming personality trait judgments from faces'. *Social Psychological and Personality Science* 2(6): 609–17.

Waller, D. and Guthrie, M. (2013) 'The sociology of regulation: The case of psychotherapy and counselling and the experience of the arts therapies'. *British Journal of Guidance and Counselling*, volume 1 (41), 4-13.

Wampold, B. E. (2001) *The Great Psychotherapy Debate: Models, Methods and Findings*. Mahwah, NJ: Erlbaum.

Warnecke, T. (2010) *Working as a Psychotherapist in Europe*, Available at [http://www.psychotherapy:competency.eu/Documents/Working\\_as\\_a\\_psychotherapist\\_in\\_Europe.pdf](http://www.psychotherapy:competency.eu/Documents/Working_as_a_psychotherapist_in_Europe.pdf) (accessed 22/01/15)

Weber, M. (1992) *Economy & Society*. London: University of California Press.

Wheeler, S. and King, D. (2001) *Supervising Counsellors: Issues of Responsibility*. Sage: London.

Wikler, M. (1989) 'The religion of the therapist: Its meaning to Orthodox Jewish Clients', *Hillside Journal of Clinical Psychiatry*. 11, 131-146.

Wiles, R. (2013) *What are Qualitative Research Ethics?* London: Bloomsbury.

Witz, A. (1992) *Professions and Patriarchy*, London: Routledge.

Worthington, E. L. and Sandage, S. J. (2002) 'Religion and Spirituality'. In Norcross, J. C. (2002) *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. New York: Oxford University Press.

Yardley, L. (2000) Dilemmas in Qualitative Health Research. *Psychology and Health*, 15, 215-228.

Zlotnick, C., Elkin, I. and Shea, M. T. (1998) 'Does the gender of a patient or the gender of the therapist affect the treatment of patients with major depression'. *Journal of Consulting and Clinical Psychology*, 66 (4): 655-9.

# Appendices

<a href="#"><u>Appendix 1 – Semi-Structured Interview Questions (Clients)</u></a> .....	184
<a href="#"><u>Appendix 2 – Participant Consent Form</u></a> .....	186
<a href="#"><u>Appendix 3 - Participant Information Sheet</u></a> .....	187
<a href="#"><u>Appendix 4 – Semi-Structured Interview Questions (Professional Bodies)</u></a> .....	189
<a href="#"><u>Appendix 5 - Introduction Letter to Prospective Participants</u></a> .....	191
<a href="#"><u>Appendix 6 – Semi-Structured Interview Questions (Practitioners)</u></a> .....	193
<a href="#"><u>Appendix 7 - Pre Pilot Questionnaire</u></a> .....	195
<a href="#"><u>Appendix 8 – Initial Themes</u></a> .....	197



## Appendix 1 – Semi-Structured Interview Questions (Clients)

1. How did you chose/find the practitioner? (What was the process that informed the choice)
2. What qualities was it about your chosen practitioner that influenced your choice?
3. Had you identified multiple potential practitioners, how would you have made a choice between them? (Which factors were given greater value).
4. In what ways did you establish the practitioner's professional standing?
5. Did you give any consideration to the practitioner's qualifications or prior experience of supporting others presenting with similar difficulties?
6. Had you needed to make a complaint about your practitioner or the service they provided, to whom would you have addressed this?
7. What is your awareness of the regulatory status of the counselling and psychotherapy professions?

8. Are you aware of the existence of any counselling or psychotherapy professional bodies (please name) and the purpose they serve?
  
9. Did you continue with therapy beyond the initial assessment session?
  
10. Can I ask about your own educational attainment and which socio-economic status you feel affiliated with?
  
11. Do you know of anyone else who you feel might have a valuable contribution to make to this study and be willing to take part?
  
12. Would you be interested in seeing the results from this study, once complete?

Appendix 2 - Participant Consent Form



**University of Brighton**

Doctoral College

*What factors influence a client’s choice of counsellor/psychotherapist in a private practice setting?*

- I agree to take part in this research which is to explore the factors influencing a client’s choice of practitioner, when selecting to work with a Psychotherapist or Counsellor in a private practice setting.
- The researcher has explained to my satisfaction the purpose of the study and the possible risks involved.
- I have had the principles and the procedure explained to me and I have also read the information sheet. I understand the principles and procedures fully.
- I understand that I am required to answer questions.
- I consent/do not consent to the interview being audio recorded.
- I understand that the interview will be transcribed by a professional third party, but otherwise, confidential information will only be seen by the researchers and will not be revealed to anyone else. However, In the event that professional malpractice is disclosed to the researchers, the matter would be referred to the academic supervision team and a decision taken as to whether further reporting action is required.
- I understand that I am free to withdraw from the investigation at any time.

Name (please print)

.....

Signed

.....

Date.....

## Appendix 3 - Participant Information Sheet



# University of Brighton

---

## Doctoral College

My name is Julie May and I am a Professional Doctorate student (Counselling and Psychotherapy) attending Brighton University. I am also a counsellor and psychotherapist working in private practice. Thank you for your interest in my study which has the title:

***What factors influence a client's choice of counsellor/psychotherapist in a private practice setting?***

*Private practice is defined by Syme (1994:6) as: "accepting private referrals, counselling clients in one's own time, using one's own premise and charging a fee"*

### **Introduction**

My study aims to explore what factors inform and influence a client's choice of practitioner, when selecting to work with a Psychotherapist or Counsellor in a private practice setting. I am interested to learn how clients make their selection and what they consider to be important things to know in advance. Ultimately, I aim to provide the public with a model to guide them in the process of selecting a practitioner in a private practice setting. I am undertaking this study to gain the award of Professional Doctorate in Counselling and Psychotherapy.

I am asking participants to attend a face to face interview with myself, which should last no longer than 45 minutes. My office is located in central Fareham, close to the main shopping area and I am happy to refund reasonable travel expenses. Alternatively, we can arrange to meet at your home, or at another venue of your choice.

The interview will be digitally recorded and transcribed by a third party so that the information you provide can be analysed. Please let me know if you prefer not to have the interview recorded. In the unlikely event of you becoming distressed during the interview I will check out if you are able and willing to continue and terminate if requested to do so.

Your identity will be protected and anonymised. I will process and analyse the results of this study using my laptop computer. Data and information, I keep on my laptop will be encrypted and password protected at all times. As a backup, in case of technical failure, I intend to keep a duplicate version on a memory stick, which will be kept securely in my locked work safe, to which only I have access. Data which I have printed or handwritten notes or records, will be stored securely in a locked filing cabinet, which again only I have access to. Once these hardcopies are no longer required, I will shred all documents.

I intend to publish the results of this study within the counselling and psychotherapy Professional Body journals and at conference and also sharing information with the Department of Health and the government agencies involved with the voluntary regulation of the professions. If you would like to see these results, I am happy to forward these to you at the end of my study.

Participation in this study is voluntary and participants may withdraw from the study at any time, without giving a reason. The study is separate from the counselling/therapy undertaken by participants. If professional malpractice is disclosed to the researchers, the matter would be referred to the academic supervision team and a decision taken as to whether further reporting action is required. My proposed research has been reviewed by the University of Brighton's Ethics Committee.

I do not envisage any risk of harm to participants, however any concerns about the nature of my study can be directed to Professor Phil Haynes, Head of School of Applied Social Sciences (01273 643465 [P.Haynes@brighton.ac.uk](mailto:P.Haynes@brighton.ac.uk)) I am happy to answer any questions or provide any additional information and can be contacted by telephone on 01329 827121 or by email at [juliemaycounselling@btconnect.com](mailto:juliemaycounselling@btconnect.com)

## Appendix 4 – Semi-Structured Interview Questions (Professional Bodies)

1. What factors do you feel a member of the public takes into account, when choosing a private practitioner?
2. How do you feel a member of the public would select a private practitioner, from a list of several? Which factors do you feel would be of most importance?
3. How do you feel members of the public establish a private practitioner's professional standing, qualifications, experience, competence to practice and credibility?
4. What risks have you identified relating to the public working with private practitioners?
5. In what ways have you disseminated information about the voluntary register to the Public?
6. What are the future intentions regarding advertising the voluntary register and ensuring the Public is informed?
7. Focusing on the Professional Standard Authority (PSA) voluntary register, how did you assess risk factors associated with the profession? What do you consider the risks to be to clients?

8. What consideration (when accessing risk) was given to practice setting?  
(Prompt if needed, in particular to self-employed lone practitioners) Discuss implication of lack of 'institutional buffer' to the self-employed.
9. How have you assessed the level of public knowledge regarding regulation of the profession and the onus on them to check the validity of the practitioner?  
How have you elicited their views?
10. What are your views on protecting the counsellor/psychotherapist title, so that the unqualified, unregistered practitioners cannot work with the public? Do you believe having an unprotected professional title offers the public sufficient safeguard?
11. What are your views on the lack of minimum qualification standards for entry into the profession and that any person can legitimately practice without any education at all? Do you feel the Quality Assurance Agency (QAA) standards recently published relating to both bachelor/master degree standards are a step in the direction of minimum qualification standards?
12. Do you believe that the PSA voluntary register presents appropriate safeguard to the public?
13. Are you aware of anyone else in the field who you feel might have a valuable contribution to make to this study?
14. Are you carrying out any research into the impact of the introduction of the voluntary register on practitioner and the public?
15. Would you be interested in seeing the results from this study, once complete?

## Appendix 5 - Introduction Letter to Prospective Participants



### **University of Brighton**

---

Doctoral College

My name is Julie May and I am a Professional Doctorate student (Counselling and Psychotherapy) attending Brighton University. I am also a counsellor and psychotherapist working in private practice.

I am carrying out a research study and am looking to recruit people who have chosen to work with private counsellor/psychotherapist to take part. I wonder if this might be of interest to you. The title of my study is:

***What factors influence a client's choice of counsellor/psychotherapist in a private practice setting?***

*Private practice is defined by Syme (1994:6) as: "accepting private referrals, counselling clients in one's own time, using one's own premise and charging a fee"*

The aim of my study is to explore what factors inform and influence a client's choice of practitioner, when selecting to work with a Psychotherapist or Counsellor in a private practice setting. I am interested to learn how clients make their selection and what they consider to be important things to know in advance. Ultimately, I aim to provide the public with a model to guide them in the process of selecting a practitioner in a private practice setting



I am asking participants to attend a face to face interview with myself, which should last no longer than 45 minutes. My office is located in central Fareham, close to the main shopping area and I am happy to refund reasonable travel expenses. Alternatively, we can arrange to meet at your home, or at another venue of your choice.

The interview will be digitally recorded and transcribed by a third party so that the information you provide can be analysed. I intend to publish the results of this study within the counselling and psychotherapy professional body journals and at conference and also sharing information with the Department of Health and the government agencies involved with the voluntary regulation of the professions

Participation in this study is voluntary and participants may withdraw from the study at any time, without giving a reason. My proposed research has been reviewed by the University of Brighton's Ethics Committee.

If you are interested in taking part, I am happy to answer any questions or provide any additional information and can be contacted by telephone on 01329 827121 or by email at [juliemaycounselling@btconnect.com](mailto:juliemaycounselling@btconnect.com)

Thank you for taking the time to read this.

## Appendix 6 – Semi-Structured Interview Questions (Practitioners)

1. How do clients make the choice to work with you? (What is the process/knowledge that informs the clients choice)
2. What practitioner qualities do you think influence a client's choice?
3. Had a client identified multiple potential practitioners, how would do you think they would have made a choice between them?
4. In what ways did you feel a client establishes your professional standing?
5. Have clients given any consideration to your qualifications or prior experience of supporting others presenting with similar difficulties?
6. What level of awareness do you feel clients have regarding making a complaint about a practitioner, the service they provided, or to whom this should be addressed?

7. What level of awareness do clients have about the regulatory status of the counselling and psychotherapy professions?
  
8. Are clients generally aware of the existence of any counselling and psychotherapy professional bodies and the purpose they serve? (Are they able to name any?)
  
9. Do you know of anyone else who you feel might have a valuable contribution to make to this study and be willing to take part?
  
10. Would you be interested in seeing the results from this study, once complete?

## Appendix 7 – Pre-Pilot Questionnaire



**University of Brighton**

---

Doctoral College

My name is Julie May and I am a counsellor/psychotherapist working in private practice. I am also studying on the Professional Doctorate programme at Brighton University, researching how the public choose a practitioner. As part of my study, I have been asked to carry out a short pre-pilot, to find out the views of the general public. The responses I receive will help me shape my study and ensure I capture the information I need to answer my research questions.

Many people turn to the private provision of counselling and psychotherapy after discovering the waiting lists and limitations of the NHS service. Please could you answer the following questions as if you were considering having private counselling/psychotherapy?

1. Where would you look to find someone? (Tick all that apply)
  - Ask a friend/colleague/family member
  - Ask my GP
  - Yellow Pages or other paper directory
  - Google or other online search engine
  - Online directory
  - Other (Please specify)
2. What level of qualifications would you expect a practitioner to have? (Tick all that apply)
  - None
  - Certificate or NVQ 1, 2 or 3
  - Diploma or NVQ 4
  - Bachelor's Degree or NVQ 5
  - Master's Degree or Higher Level
  - Other (Please specify)
3. How would you check a practitioner's qualifications? (Tick all that apply)
  - I wouldn't check. I would take their word
  - Look at the letters after their name
  - Ask the practitioner
  - Ask to see certificates

Look the practitioner up on the internet

Other (Please specify)

4. Would you feel the need to check a practitioner's professional standing?

No

Yes

If Yes, how would you do this?

5. If you had short listed 3 potential practitioners, how would you choose between them? What would influence you to pick one over the other two?

Thank you. All responses will be held in confidence and the data used only to shape my study.

## Appendix 8 – Initial Themes

### Client Results

#### Factors affecting selection

##### Location:

##### Close to Home

Amanda, Dorothy, Elizabeth, Fiona, Grace, Helen, Ivor

##### Would go anywhere to find right person

Betty, Charles

##### Most important factor

Dorothy, Grace, Helen, James

##### Cost

Amanda, Fiona, Helen and Ivor

##### Gender

Betty, Fiona, Grace, Ivor

##### Age

Elizabeth, Fiona, Grace, Ivor, James

##### Speed of availability/immediate help

Amanda, Betty, Charles, Dorothy, Fiona, Helen

##### Religion

Grace

**Desperate state of mind**

Amanda, Charles, Dorothy

**First who met criteria**

Fiona

**Accredited/Regulated/BACP**

Amanda, Betty, Ivor

**Specialism/Experience of working with my issues**

Amanda, Betty, Charles, Grace, Helen, Ivor, James

**Modality**

Betty, Helen, Ivor

**Relationship Qualities:**

**Trustworthy/Non-Judgmental/Safe**

Amanda, Betty, Charles, Grace, Helen, Ivor, James

**Took on Trust/Gut Response/Right Person or Fit for me**

Amanda, Betty Charles, Elizabeth, Fiona, Grace, Helen, Ivor, James

**Working alliance/Rapport**

Amanda, Betty, Charles, Elizabeth, Fiona, Grace, Helen, Ivor, James

**Practice Setting:**

**Professional Group Practice**

Dorothy, Elizabeth, Fiona

**Comfortable/Private/Relaxed**

Elizabeth, Helen, James

**Decision Informed by Previous Therapy Experiences**

Amanda, Betty, Ivor, Helen, James

**Detailed, Specific Search with Criteria**

Betty, Ivor (both also aware of profession limitations with regulation – interesting)

**Recommendation - Who?**

**GP**

Amanda, Ivor, James

**Military Service**

Amanda

**Personal**

Betty

**Therapy Practice Manager**

Charles, Dorothy

**Vicar**

Grace

**Counsellor Friend**

Dorothy

**Insurance Company**

Betty



**Rationale for Recommendation Option:**

**Vulnerable state of mind, desperation, not thinking straight**

Amanda, Charles, Dorothy, Grace, James

**Speed/Need for urgent Help**

Amanda, Betty, Charles, Dorothy

**Lack of own Knowledge/Needed Expert or Trusted Advisor/Faith in Professional Judgement**

Amanda, Charles, Dorothy, Grace, James (is this in the literature, the need for expert where we have no knowledge ourselves)

**Was a good Outcome**

Charles, Dorothy, Grace

**Learnt from my previous experiences and this informed the next choice**

Amanda, Betty, Helen, Ivor, James

**Rationale Against Recommendation:**

**Was not a good Outcome**

Amanda, Ivor, James

**Didn't check the Therapist Out/Trusted the Professionals Judgement**

Amanda, Ivor, James

**I was Vulnerable/Not Thinking rationally**

Amanda, Dorothy, Ivor, James

**GP biased and not Best Placed to Refer**

Amanda, Ivor, James

**Qualifications**

Apart from Betty (they are important), rest were fairly ambivalent

**Wouldn't know what they mean**

Amanda, Elizabeth

**Didn't Check/Didn't Think to Ask**

Charles, Ivor

**Experience is more important**

Fiona, Grace, Helen, Ivor, James

**Not an indicator of a Quality Therapist**

Charles, Ivor

**Clinic would Have Checked**

Elizabeth, Dorothy

**Can you practice without?**

Dorothy

**How do we assess these Factors?**

**Photo**

Elizabeth, Fiona, Ivor

**Words/Profile/Website**

Betty, Elizabeth, Fiona, Helen, Ivor

**1<sup>st</sup> Session (face to face)**

Amanda, Betty, Charles, Dorothy, Fiona, Grace, Helen, Ivor, James

## **Awareness of Regulatory Status**

### **Client Results**

#### **Aware**

Betty (daughter knew) and Ivor (NHS experience)

#### **Not Aware**

Charles, Dorothy, Grace, Helen

#### **Assumed Statutory Regulated**

Amanda, Elizabeth, Helen, James

#### **Aware now but Not at the Time**

Amanda, Fiona (both now undertaking training)

#### **Should be/Its not OK**

Amanda, Fiona, Ivor

### **Professional Standing**

#### **Information Given by Therapist**

Charles, Dorothy, Fiona, Helen

#### **Trusted Recommender to Have Awareness**

Amanda, Charles, Dorothy, Grace

#### **Assumption from Letters After Name**

Elizabeth, Helen

## **Knew What to Look For**

Betty and Ivor

## Client Results

### Professional Body Awareness

#### None

Amanda, Charles, Dorothy, Helen, James

#### Aware they Exist

Betty, Elizabeth, Fiona, Grace, Ivor

#### Should be Compulsory Membership

Amanda (assumed it was)

#### Set the Standards

Elizabeth, Grace

### Where to air complaint?

#### No Knowledge

Amanda, Fiona, Helen

#### Would Internet Search

Charles, Grace, Fiona

#### Practice Manager

Dorothy, Elizabeth

#### GP/GMC

James

#### To professional Body

Betty, Ivor

## Professional Bodies Results

### Choice Factors

#### Modality

#### Important, but unknown to clients

Andrew & Bella

#### Cost

Bella

#### Location

#### Limitation of statutory register

Andrew

#### Need local

Bella

#### Demographics

Bella

#### Qualifications

#### Unclear, public doesn't understand

Bella

#### No consistency of standards/confusion

Andrew

#### Psychotherapy/Counselling Label: Some public awareness



Andrew

**Psychology profession overcame with 7 codified competencies**

Andrew

**Recommendation = Precedence, then online search– could get anyone**

Bella

**First meeting Crucial to connect**

Bella

**Establishing Contact**

Bella

**Professional Standing**

**Multiple designations confuses the public**

Andrew

**Registered/Accredited – Public don't understand**

Bella

**Established by Recommender**

Bella

**Via Website (if it looks professional you are)**

Bella

**Checking therapist employment history gives credibility**

Bella

### Limitations of Voluntary Register

1. No Government will statutory register all professions & Australian alternative – Andrew
2. Inconsistent training standards in private practice – Andrew & Bella
3. Standards in profession vary – Andrew & Bella
4. Newly qualified in private practice is not ok – Bella
5. Complaints are not independent, cost implication for taking legal action against a member, struck off can still work, no power to demand access to data – Andrew
6. Specialism doesn't mean trained or qualified in – Andrew
7. No advertising to public – Andrew
8. BACP/UKCP doing what it can to advise Government & Employers – Bella
9. Anyone can go into private practice – Bella

### Benefits of Voluntary Register

1. Made Prof Bodies get complaint processes in order - Andrew
2. Public can check the register – Andrew & Bella
3. Disseminating to Employers – Bella

### Limitation to Statutory Regulation

1. Does not help the public locate a therapist - Andrew
2. Some do reinvent their title and continue to practice once struck off – Andrew

## Therapist Results

### Choice Factors

#### Counselling Directory/Internet Search/website

Resonate with profile/words – Ann, Brenda, Diane, Ellen, Freya, Georgina, Harriet, Imogen, Joe

Few even look at my website - Freya

#### Photo/Profile

Connecting, identifying, resonating , recognition – Ann, Diane, Georgina

Used to assess good fit/relational hook – Cathy

Good and bad reactions – Cathy

My shop window/First thing they see/My PR – Diane, Imogen Joe

Transpersonal connecting before we meet – Diane, Freya, Georgina

Project own issues with their sense of me/transference – Diane, Ellen, Freya, Georgina, Imogen, Joe

Must be a picture of me (not an object) – Freya

See what I look like in advance –Georgina, Imogen

Warm/Friendly/honest face/informal but not inappropriate – Harriet, Joe

#### Relationship Factors

Rapport – Ann

Calm – Ann, Diane

Comfortable – Ann, Imogen

Equal- Ann

Open/honest/genuine – Brenda, Imogen

Trust – Cathy, Freya

Confidential – Cathy, Diane, Harriet, Joe

Be Heard – Cathy

Feel Good – Cathy

Holding – Diane

Safe – Diane, Freya  
Non-Judgemental – Freya, Harriet  
Taken on Trust – Freya  
Personally Aligned more important than cost/availability – Imogen  
Presence/eye contact/no clock watching – Joe  
Don't patronise, objectify or pathologies or assume - Joe

### **Location**

Georgina, Imogen, Joe  
Some chose close, some distance – Ann, Cathy. Ellen  
Don't Know – Freya  
Convenient/Parking/Bus route - Harriet

### **Recommendation**

Read feedback and reviews – Ann  
Colleagues based on my specialisms/trust in me – Diane, Freya, Georgina, Harriet, Joe  
GPs not best placed to refer/don't understand – Diane - Georgina  
GPs/Psychiatrist/Police – Harriet  
GP if not worked out then self search – Imogen  
Word of Mouth - Imogen

### **Cost**

Ann, Brenda, Freya, Harriet, Imogen  
Expensive can be seen as quality – Harriet  
Concessions/free 1<sup>st</sup> apt – Harriet, Imogen, Joe

### **Matching Availability**

Ann, Imogen

### **Qualifications**

Ann

Counselling Directory do check they are genuine – Ellen  
Guess?/ Never asked – Brenda, Georgina, Harriet, Joe  
Clients don't understand the letters – Diane  
Some ask, most don't, check my ilk and they reassure clients even though they don't know what it means – Ellen  
Down to the therapist to decide what level = competence – Freya  
Not important to clients – Freya  
Some interest/use to check my professional standing – Georgina  
Important to me/ as a trainee/other trainees = informed choice – Georgina, Imogen, Joe  
They are on my website – Harriet, Joe  
Don't guarantee quality – Imogen  
Only important to educated clients - Imogen

### **Experience of their issues/specialisms**

Connecting their issue to therapist experience – Ann, Brenda, Cathy, Diane, Georgina, Harriet, Joe  
Trainees = Informed choice – Imogen  
Some do – Imogen  
I don't need it to work with the client - Imogen

### **Modality**

Not a factor – Brenda

Important to me as a trainee – Georgina, Harriet, Imogen

Relevant to experienced clients – Imogen, Joe

### **Environment**

Comfortable/Homley – Cathy, Joe

Speaks Volumes – Ellen

Accessibility – Imogen

Anon/Private - Joe

### **Being First**

Look at first they connect to that resonates - Ellen

Being highest rank on Counselling Directory helps – Ellen

### **Age**

Matching age – Freya

Judges from photo – Harriet, Imogen, Joe

Some ask - Joe

### **Nationality**

Matching nationality – Freya, Harriet

### **Speed of Response/1<sup>st</sup> Appointment**

Georgina, Harriet, Joe

If not quick can trigger rejection/not good enough – Freya

### **Transpersonal**

I am brought the clients I need/who need me – Freya

## **First Appointment**

See if we can connect – Harriet

More important than photo – Imogen

## **Gender**

Imogen

Joe – some erotic/paternal transference

## **1<sup>st</sup> timers learn**

Naïve, desperate 1<sup>st</sup> time, second and beyond – more informed – Imogen

They don't research – Imogen

## **Disability**

Matching to resonate with clients disability – Joe

Understand their culture/connect/I can sign – Joe

No 3<sup>rd</sup> party interpreter = deskilled therapist/relationship between client and 3<sup>rd</sup> party – Joe

Can leave therapist out – Joe

Confidentiality Especially important to deaf community - Joe

## Therapist Results

### Professional Standing

Some – Ann, Georgina

The therapist has to advise/It is in my contract/on website – Ann, Diane, Ellen, Freya, Harriet, Imogen

My NHS background – Brenda

No – Brenda, Cathy, Diane

It's implicit in my way of being/come across trustworthy – Ellen, Imogen, Joe

Very little awareness – Freya

Some don't care/doesn't matter – Georgina, Harriet, Joe

Not asked – Imogen

### Complaints/Professional Bodies

Its in my contract/on my website – Ann, Ellen, Imogen, Joe

No - Brenda, Cathy, Diane, Freya, Georgina, Harriet, Imogen, Joe

They just withdraw/walk away – Brenda, Georgina

Could internet search – Diane, Ellen, Harriet, Imogen

UKCP/BACP trying, but need to do more – Diane, Freya, Georgina

Its therapists responsibility to educate/inform clients – Diane, Freya, Harriet, Imogen, Joe

Never asked/never comes up – Ellen,

Important to me – Freya

Risks to naïve clients/I am a lone voice – Freya

Only trainees know – Georgina, Harriet

Can say what you like on website - Imogen



## **Regulation**

No – Ann, Brenda, Cathy, Diane, Ellen, Freya, Georgina, Harriet, Imogen, Joe

We should be – Brenda, Diane, Freya, Georgina

Trainees/newly qualified in private practice is not ok – Cathy, Georgina

Accreditation good benchmark but clients don't know to look for it – Diane

Clients vulnerable, confused, distressed and assume – Diane, Ellen, Freya, Georgina

Naïve – Ellen

Client Assumption – Ellen, Georgina, Harriet, Imogen

If therapists genuine they will inform clients, if not clients vulnerable – Ellen

Unequal standards of education leads to working outside competency - Georgina

Concerns me – Freya

Vol register = just a pretty logo/but costs for statutory could mean higher client fees – Freya

Training organisations not realistic about work opportunities/questionable motives - Georgina