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Doctoral Thesis:
Constructing the Processes Involved in Ending Therapy with Clients

Rosie Noyce
Doctorate in Clinical Psychology
Division of Health Research
Lancaster University

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Thesis Abstract

Understanding the processes involved in therapy are crucial to maximising its benefits. This doctoral thesis explores two aspects of therapy which are crucial to the beginning and ending phases of therapy i.e. the formation of the therapeutic relationship and the experience of ending therapy. It is hoped that this contribution to the research base will provide clinicians with practical recommendations based on empirical evidence and prompt future research to investigate these topics further.

The first section of this thesis describes a metasynthesis of qualitative studies exploring the formation of the therapeutic relationship from the client's perspective. Findings highlight clients' initial assessment of therapist characteristics to see whether they fit with their perceived needs. Displays of openness and respect from the therapist were found to facilitate the formation of the relationship and allow for a deep connection between client and therapist to be established.

The second section of this thesis presents a grounded theory study focusing on therapists' experiences of ending therapy with clients. The theory explains the processes that play a significant role in the ending experience (therapist context, therapeutic approach, level of connectedness, level of investment and therapist's perceived responsibility) and how they impact on different types of therapy endings. Elements of the therapy were found to continue beyond the final session as therapists described learning from each ending experience which served to influence their future work with clients.

The third section of this thesis comprises personal reflections on the process of engaging in the thesis project. Specifically, this critical appraisal explores the difficulties experienced by the author in positioning herself within a consistent ontological and

epistemological stance. The reflections offered in this section follow the developmental journey made by the author as a result of engaging in this project.

Declaration

This thesis records work undertaken for the Doctorate in Clinical Psychology at Lancaster University's Division of Health Research from January 2012 to July 2014.

The work presented here is the author's own, except where due reference is made. The work has not been submitted for the award of a higher degree elsewhere.

Name:

Signature:

Date:

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Thank you to all the participants who gave up their time to take part in this project. It was an honour to share your experiences with you. I owe a tremendous amount to my thesis supervisor, Dr Jane Simpson, who guided me through the thesis process. Your support has been invaluable and will not be forgotten. I would also like to thank Dr Craig Murray for facilitating this work through his vast knowledge and experience of grounded theory methodology and his kind words. Finally, to those who have walked with me on this journey, you know who you are and I love you very much.

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Section One: Literature Review

The Experience of Forming a Therapeutic Relationship from the Client's

Perspective: A Metasynthesis

Rosie Noyce

Doctorate in Clinical Psychology

Division of Health Research

Lancaster University

All correspondence should be addressed to:

Rosie Noyce
Clinical Psychology
Division of Health Research
Furness College
Lancaster University
Lancaster
LA1 4YG

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Abstract

Research has shown that the therapeutic relationship is a crucial part of the therapy process. This review aimed to synthesise qualitative research exploring the client's perspective of forming a therapeutic relationship. Noblit and Hare's meta-ethnographic approach was used to guide the synthesis of 13 studies, allowing for translation of concepts between studies of different theoretical perspectives. Four themes were subsequently developed: 1) assessing client-therapist match, 2) facilitating openness, 3) connecting on a deeper level and 4) empowerment through respect.

Findings demonstrated that clients create a hierarchy of desired therapist characteristics which they use to assess how well the therapist and their approach will meet their needs. The formation of the therapeutic relationship is facilitated by an openness from both the therapist and client and helps to develop a deeper level of connection where the client can be fundamentally known. Conversely, displays of disrespectful or disempowering behaviour generate barriers in the formation of a therapeutic relationship.

Recommendations for clinical practice include creating space at the beginning of therapy to allow for the formation of the relationship and constructing imaginative ways to engage clients in therapy. The practicalities of clients' requests for greater therapist disclosure are discussed in line with clinical practice guidelines.

Keywords: therapeutic relationship, alliance, qualitative research, metasynthesis, empowerment, therapist self-disclosure

Highlights

- The therapeutic relationship is a fundamental aspect of therapy process.
- Qualitative studies exploring the formation of the therapeutic relationship were synthesised.
- Clients develop a hierarchy of therapist characteristics to assess their level of 'match'.
- Clients requested more disclosure from therapists to facilitate openness in the relationship.
- Therapists are encouraged to create space at the start of therapy for the relationship to form.

The experience of forming a therapeutic relationship from the client's perspective:

A metasynthesis

The therapeutic relationship has long been the focus of significant attention within the psychodynamic approach to therapy from both theorists (Freud, 1912/1966; Sterba, 1929; Zetzel, 1956) and researchers (Hartley & Strupp, 1982; Horvath & Greenberg, 1985; Horwitz, 1974), and continues to be considered predominantly from this perspective. Indeed, the initial concept of a working relationship between client and therapist tends to be attributed to Freud (Gaston, 1990; Horvath, 2006). He questioned what caused the analysand – the person being analysed – to remain in therapy despite the difficulty of exploring repressed material and proposed that one crucial aspect was the therapeutic relationship (Freud, 1940/1966).

Outside of the psychodynamic arena, other prominent figures have also recognised the importance of the therapeutic relationship. For example, Carl Rogers, a founder of humanistic approaches to psychotherapy, argued that “significant positive personality change does not occur except in a relationship” (Rogers, 1957, p. 241). This insight was a fundamental aspect of Rogers' client-centred therapy which has become a dominant approach in modern-day psychotherapy practice (Cooper, Watson, & Hölldampf, 2010; Gelso & Carter, 1985).

More recently, empirical support for these claims has emerged through consistent findings from reviews of quantitative research (Horvath, Del Re, Flückiger, & Symonds, 2011; Horvath & Symonds, 1991; Shirk & Karver, 2003). These studies have demonstrated the modest yet reliable association between the quality of the therapeutic relationship and positive outcomes in therapy and, as a result, it has been argued that “the alliance may be therapeutic in and of itself” (Martin, Garske, & Davis, 2000, p. 446).

What is the Therapeutic Relationship?

Despite such theoretical and empirical interest, the term ‘therapeutic relationship’ continues to describe a vague concept which is hard to define in terms which suit all practitioners of psychological therapy (for a historical review and further discussion, see Horvath & Bedi, 2002). Indeed, studies investigating the therapeutic relationship have explored constructs as diverse as emotional engagement (Sexton, Hembre, & Kvarme, 1996), therapeutic bond (Mallinckrodt & Nelson, 1991), attachment (Eames & Roth, 2000), empathy (Greenberg, Elliott, Watson, & Bohart, 2001), personality congruence (Taber, Leibert, & Agaskar, 2011) and collaboration (Hatcher & Barends, 1996). Terminology is also diverse; one meta-analytic review on this topic included studies which identified the relationship construct as either a working alliance, a helping alliance, a therapeutic alliance, a working relationship, or just an alliance (Tryon, Blackwell, & Hammel, 2007).

The struggle to provide a fully encompassing definition for the therapeutic relationship has been compounded by the use of multiple research instruments designed to measure this construct, each containing a slightly different nuance on the therapeutic process. For example, one meta-analysis cited over 30 different alliance measures, not including different versions of the same instrument (Horvath et al., 2011). This confusion at both a terminological and construct level has led to suggestions that most of the research on the therapeutic alliance may be fundamentally flawed. Indeed, Dunn and Bentall (2007) have questioned whether researchers are aware of the potential measurement errors and confounding factors in researching this topic, leaving one with “the unsettling thought that the thousands of investigations of mediational mechanisms in the psychological and other literatures are of unknown and questionable value” (p. 4743).

In an effort to address this problem, attempts have been made to define the therapeutic relationship and the following broad definition was adopted by the American Psychological

Association's (APA's) Presidential Task Force for evidence-based psychotherapy relationships: "The relationship is the feelings and attitudes that therapist and client have toward one another, and the manner in which these are expressed" (Norcross & Lambert, 2011, p. 5). The Task Force proposed that the therapeutic alliance is one component of the relationship and listed other, more specific, elements such as empathy, goal consensus, collaboration, positive regard, and congruence. Horvath and Bedi (2002) also regarded the therapeutic alliance as a subsection of the relationship alongside still-active components of past relationships. Therefore it seems that the relationship is an over-arching construct, while the alliance is viewed as "a basic ingredient of the therapeutic relationship" (Horwitz, 1974, p. 250).

It has also been proposed that the alliance itself can be broken down into different components. Luborsky (1976) suggested that the therapeutic alliance developed in two stages: Type 1 alliance refers to the client's belief that the therapist can provide the required help; Type 2 alliance relates to the client's experience of working with the therapist to achieve the goals of therapy. Alternatively, Bordin (1979) proposed that the therapeutic working alliance can be separated out into three components: an agreement on goals, an assignment of tasks and the development of bonds. Bordin's theoretical distinction between goals, tasks and bonds has been subsequently adopted by many researchers interested in exploring the alliance in more detail (Bethea, Acosta, & Haller, 2008; Hatcher & Barends, 2006; Taber et al., 2011).

One of the most significant contributions of the work by Luborsky (1976) and Bordin (1979) was the emphasis on active collaboration within the relationship. This is now understood to be a pivotal factor and most theoretical descriptions of the therapeutic alliance encompass the following themes: a) the collaborative nature of the relationship, b) the

affective bond between patient and therapist, and c) their ability to agree on the goals and tasks within therapy (Martin et al., 2000).

Research on the Therapeutic Relationship

Despite the construct and terminological challenges noted above, significant progress has been made on researching the therapeutic relationship, most of which has taken the form of quantitative empirical research. One of the first of these studies was the extensive Psychotherapy Research Study into the processes and outcomes of psychoanalysis and psychotherapy (Horwitz, 1974). It involved in-depth analysis of data from two client groups (analytically oriented psychotherapy and psychoanalysis) over three time periods (start of therapy, termination, and two year follow-up). The authors found no marked difference in outcome between the treatment modes. There were, however, significant findings in relation to the therapeutic alliance, demonstrating that “the therapeutic alliance is not only a prerequisite for therapeutic work, but often may be the main vehicle of change” (Horwitz, 1974, p. 254-255).

The second key piece of research took the form of a meta-analytic review investigating the association between working alliance and outcome (Horvath & Symonds, 1991). This study provided the first significant empirical evidence regarding the power of the therapeutic relationship. Despite incorporating studies containing different measures of therapeutic alliance, different therapeutic approaches (e.g. dynamic, cognitive, gestalt, etc.) and varying lengths of therapy, a good working alliance was found to be the most predictive measure of a positive outcome in therapy (Horvath & Symonds, 1991). This review extended the findings of Horwitz (1974) to include newer therapeutic approaches which do not place a significant emphasis on the relational aspects of therapy (e.g. cognitive therapy) and became a cornerstone study in the understanding of therapeutic processes. Many more studies, and additional meta-analyses, have since replicated and added to these findings (Hewitt & Coffey,

2005; Horvath et al., 2011; Martin et al., 2000), leading to an understanding among researchers that the therapeutic relationship is a central aspect of the healing process in therapy (Horvath & Bedi, 2002).

It is worth noting here that, despite the evident power of the therapeutic relationship, it is not the only aspect which contributes to a positive outcome in therapy. Therapist technique continues to play a significant role in positive therapy outcomes (e.g. Barber et al., 2006). In fact, rather than being viewed as two distinct entities, it has been argued that “the value of a treatment method is inextricably bound to the relational context in which it is applied” (Norcross & Lambert, 2011, p. 5). Nevertheless, attempts are continually being made to separate these two aspects and explore their individual contribution to the therapy process.

The Present Study

In more recent years, qualitative research into the therapeutic relationship has developed, allowing for a more in-depth understanding of the construct. Specifically, studies have focused on how the therapeutic relationship develops and is experienced by both the therapist and client (Altman, 2008; Shattell, Starr, & Thomas, 2007; Spiers & Wood, 2010). Understanding the client’s experience of forming a therapeutic relationship in particular is fundamental for identifying ways to engage clients in therapy (Eyrich-Garg, 2008) and hopefully therefore reduce drop-out rates.

The research base on the client’s perspective of forming a therapeutic relationship is now at a stage where it would benefit from a review and integration into one coherent report. Similar to a meta-analysis, metasynthesis is a method of bringing together the findings from multiple studies in order to inform clinical practice and provide direction for future research. However, more than just simply combining previous findings, metasynthesis involves adding an additional layer of interpretation to “produce a new and integrative interpretation of

findings that is more substantial than those resulting from individual investigations” (Finfgeld, 2003, p. 894). In order to aid the technique of synthesising qualitative data, numerous approaches for conducting a metasynthesis have been outlined (see Thorne, Jensen, Kearney, Noblit, & Sandelowski, 2004).

One of the more well-known and often-used frameworks in health research (Bondas & Hall, 2007) is the meta-ethnographic approach developed by Noblit and Hare (1988). Emphasising the importance of using interpretive explanations to guide qualitative synthesis, they propose seven phases through which the synthesis develops, providing researchers with a clear and structured procedure to follow. Despite their original focus on ethnographic research, this process has been used to synthesise research from different theoretical perspectives (Downe, 2008) as it provides a method for translating concepts between studies. For these reasons it was decided that this was the most appropriate framework to guide the current review.

Consequently, this review aimed to synthesise the findings of systematically-searched qualitative studies exploring the formation of the therapeutic relationship from the client’s perspective. It was hoped that this methodology would give voice to clients’ experiences and provide direction for future research and clinical practice. The review question for this study was: How does the client perceive and experience the formation of the therapeutic relationship?

Method

Procedure

Comprehensive literature search. A literature search was conducted in May 2014 using the following databases: Academic Search Complete, AMED (The Allied and Complementary Medicine Database), CINAHL, EMBASE, Medline, IBSS (International Bibliography of the Social Sciences), PsycInfo, Web of Science. The databases were selected

to cover medical, health and social science research. Keywords, used in combination and with the appropriate wildcard symbols, were: alliance formation, therapeutic alliance, therapeutic relationship, engag*, client perspective, client experience. Where possible, related terms were sought using each database's search engine thesaurus. There were no date restrictions employed in this search as it is a relatively new field of research. The initial search resulted in 1,828 articles whose titles and abstracts were scanned for relevance using the inclusion criteria listed in Table 1. Further potential studies were identified by searching the reference lists of any relevant articles. The search process (as depicted in Figure 1) was subsequently verified by a subject librarian.

The metasynthesis focused on studies exploring the formation of a relationship with a professional acting in the role of a therapist or counsellor, from the perspective of the client. All studies included in the metasynthesis used an interview format to obtain the majority of the data, providing direct quotations from participants which were used to anchor the interpretations within raw data. Only qualitative research studies employing either a named content-based qualitative method or using thematic coding in the analysis were included. The studies in this metasynthesis used a range of methodologies (e.g. grounded theory, narrative analysis), however they all appeared to be grounded in an interpretivist/constructivist understanding. Case studies were not included.

Given the difficulties described previously regarding terminology, if it was unclear from the title and abstract whether the study met the inclusion criteria, then the full paper was accessed and checked. Although time-consuming, it was considered necessary for this section of the search to be conducted manually to avoid missing relevant papers. For example, one study explored strategies for engaging adolescent females in a therapeutic relationship (Eyrich-Garg, 2008). The professionals in this study were social workers and therefore could have met exclusion criteria. However, because they were providing one-to-

one counselling and home-based family therapy, and were therefore acting in the role of a therapist or counsellor, this study was included in the metasynthesis. Conversely, another study described an exploration of mental health service recipients' experience of the therapeutic relationship (Shattell et al., 2007). However, on closer inspection the study did not distinguish between relationships with different professionals including psychiatric/mental health nurses, psychiatrists and psychologists. Therefore it was not clear which of these relationships were 'therapeutic' in nature (i.e. between a therapist and a client) as opposed to a relationship with a mental health professional in a non-therapy role. The study was excluded on this basis.

This thorough search of the research literature produced 13 qualitative studies exploring the formation of the therapeutic relationship from the client's perspective. These studies have been highlighted in the reference section using an asterisk. Tables 2 and 3 detail the demographic and methodological details of each of these studies, respectively. Two of the studies were conducted by the same research team but did not use the same participants (Fitzpatrick, 2014 – personal communication).

Synthesising the studies. The procedure was guided by Noblit and Hare's seven-step meta-ethnographic approach (1988). This involved identifying a topic area (phase 1), conducting a literature review to decide which studies were relevant (phase 2) and reading each study thoroughly to gain an understanding of their context (phase 3). Key themes and concepts from each study were identified to determine how the studies were related (phase 4) and a common language used to allow the translation of concepts between studies (phase 5). The studies were then compared using these translations, allowing an additional layer of synthesis to develop across the studies (phase 6). Finally the synthesis was presented in the current report (phase 7).

Quality and Rigour

Debate about the quality and methodological rigour applied to qualitative research is ongoing (Barbour, 2001; Yardley, 2000). This naturally affects the trustworthiness of metasyntheses, as including poor quality studies can raise doubts about whether the findings are truly representative of the phenomenon under investigation. In an effort to address this problem, quality checklists have been developed as a way of assessing – albeit crudely – the quality of individual studies.

One such quality checklist is the Critical Appraisal Skills Programme (CASP, 2010) tool which allows researchers to assess studies according to ten quality criteria, such as ‘Is there a clear statement of findings?’ Duggleby and colleagues (2010) adapted the CASP tool to rate each study as either weak (1 point), moderate (2 points) or strong (3 points) on each of the eight main domains (excluding the two initial screening questions). This method produces a maximum score of 24 which can be used to compare studies quickly and efficiently.

It is acknowledged that the use of quality checklists is contentious and researchers have been cautioned against “reducing qualitative research to a list of technical procedures” (Barbour, 2001, p. 1117). Nevertheless, it was deemed necessary to provide some assessment of the quality of individual studies in this metasyntesis and therefore the CASP tool was employed (see Table 4 for ratings). In response to the inherent subjectivity of this exercise, it was decided that no studies would be excluded on the basis of quality alone, in line with previous arguments that “studies might be mislabelled but still be useful for synthesis purpose” (Bondas & Hall, 2007, p. 117). Instead, the ratings were used to provide contextual information for the metasyntesis.

Findings

This literature review aimed to synthesise qualitative research on clients' experiences of forming a therapeutic relationship. The metasynthesis produced 178 individual codes which were organised into four themes: 1) assessing client-therapist match, 2) facilitating openness, 3) connecting on a deeper level and 4) empowerment through respect (see Table 5). Figure 2 visually depicts how the initial themes from each of the studies were translated into the four overall themes developed using the metasynthesis approach. The overall themes are separated out here for ease of understanding, however in reality they overlap both conceptually and temporally. Each theme is described in more detail below using quotes from the original participants.

Theme 1: Assessing Client-Therapist Match

This theme arose in all studies included in the metasynthesis. Clients described evaluating the therapist and the therapy approach from the beginning, assessing how well they thought the therapy would meet their needs. Clients considered a number of different factors when initiating therapy; for some, how well they matched on personal characteristics with their therapist was considered extremely important, while others emphasised their desire to find successful techniques (i.e. matching on therapeutic approach). Individual preferences were influenced by previous experiences of therapy, the importance of each factor in the client's life (e.g. the salience of a Black identity) and how relevant it was to their therapeutic needs.

Personal characteristics. The majority of clients voiced a preference for matching on personal characteristics with their therapist. Some of the characteristics on which clients assessed their level of matching were gender, socioeconomic status, religious beliefs, race/ethnicity or cultural background, and overall life experiences. These clients felt that therapists who shared similar backgrounds or life experiences to them were more likely to

have an implicit understanding of their difficulties and would therefore be more effective as a therapist. One client expressed the significance of this in the formation of his therapeutic relationship:

I guess no matter what the race, you know, I know you been involved [past drug user], you know, you have a first hand knowledge and that's you know, that was real comfortable for me because I wasn't just talking to somebody who got it from a book [*sic*] (Ward, 2005, p. 478).

Thus, therapists without similar experiences were often considered to lack a fundamental understanding of their clients' world. For example, foreign-born therapists were viewed by some as lacking cultural knowledge or sensitivity. One Black client explained her reasons for wanting a Black therapist in the following way: "I think we could have gotten to some critical issues quicker than me having to talk about it with someone White. Someone of your own cultural background would understand it better" (Chang & Yoon, 2011, p. 576). Indeed, some therapists were accused of only having a 'textbook knowledge' of race, rather than subjective experience. This resulted in a barrier to establishing a therapeutic relationship, with some clients stating that they would avoid raising the topic of racial/cultural issues for fear of being misunderstood.

For a small number of clients, the opposite appeared to be true; thus matching in certain ways with their therapist was actually seen to impede therapeutic progress. For example, one Black gay male client commented that "a Black female [therapist] would have been out of the question primarily because most of the time they are church-going females and it would have been difficult for me. I have sexuality issues that I'm dealing with" (Chang & Yoon, 2001, p. 577). This client, and others in this category, appeared to be making assumptions about the therapist (e.g. attitude to homosexuality) based on certain characteristics (e.g. race) which meant they did not feel that particular therapist could meet

their needs adequately. In this way, clients almost seemed to be developing a hierarchy of desired therapist characteristics based on their own idiosyncratic needs. This strategy allowed them to assess the ‘goodness of fit’ dependent on which characteristics were more important to them at that time.

For some, having a therapist who did not have a similar background to them was valued because they provided an alternative perspective. Several clients described holding positive stereotypes of particular groups and therefore having a therapist from that group aided the formation of the therapeutic relationship. In one example, a Black male client described the first impressions of his female therapist as “the little, Jewish grandmother. A broad, considerate person... she’s going to give you some soup to soothe your pain and aches” (Chang & Yoon, 2011, p. 575). Thus, in this scenario, a ‘mismatch’ was viewed as facilitative to the formation of a therapeutic relationship.

Finally, some clients stated that they found any comparison between them and their therapist to be unhelpful or inconsequential. One Hispanic client explained that:

If I go in to see a [non-Hispanic] psychiatrist, and I’m having problems with a relationship, I don’t understand how, like, them giving me advice is going to be any different than a Hispanic person telling me the exact same thing (Chang & Yoon, 2001, p. 575).

Rather than the desire to share an ideology or experience, these clients tended to prioritise the technical ability of the therapist in implementing effective interventions.

Professional ability. Most clients expressed an overall desire to receive practical strategies from their therapist to help with their particular difficulties. Contrasted with those who wanted to match with their therapist on personal characteristics, some clients prioritised finding a therapist who could execute a therapeutic approach which fitted for them. If unsuccessful, clients reported feeling like they were “a little bit like ... a square peg trying to

be pushed into a round hole” (Barnes et al., 2013, p. 362). In this way, these clients were looking for a ‘match’ with the therapeutic process, rather than their therapist *per se*. Thus, one client stated “I think it’s important to know what works for you. I knew certain things that didn’t really sit well with me and you just move on from that and maybe change or see someone else” (Gibson & Cartwright, 2013, p. 346). The benefits of gaining insight into their situation and behaviour meant that the therapy could be viewed as helpful even in the absence of a strong therapeutic relationship.

Additionally, many clients described their desire for a therapist to have good clinical knowledge about their particular experiences, such as domestic violence, trauma or racial oppression. As one African-American client explained,

First of all, you know, I have to look at some of your [counsellor] training. Cause you want some experience in this. Sometimes you don’t even have a chance to ask these questions, you know, how many people of colour have you worked with? (Ward, 2005, p. 477).

In this way, a therapist who was considered ‘experienced’ seemed desirable. Indeed, some clients commented that a young or less experienced therapist created a barrier to establishing a therapeutic relationship as they were assumed to be less effective at working through problems that arose in therapy.

In summary, this theme details how clients judge the suitability of the therapist and/or the therapy itself in helping them with their difficulties. This process starts from the very beginning of therapy and significantly contributes to the formation of the therapeutic relationship.

Theme 2: Facilitating Openness

This theme was raised to varying degrees in 12 of the 13 studies included in the metasynthesis (all except study 11). Clients emphasised the importance of being allowed

time to form a trusting relationship with their therapist where they felt safe and comfortable discussing sensitive issues. In order to build trust, clients described the need for openness and honesty between the therapist and client, without which it was difficult for clients to disclose personal information.

Some clients felt their therapist had a natural ability to respond to their wishes, demonstrating their ability to be open and receptive to their client's needs. For example, one client explained that they were "looking at diagrams... and I thought, 'Well I can do this at home... I want you to come over my shoulder'... and there was the chair, she came over" (Fitzpatrick, Janzen, Chamodraka, Gamberg, & Blake, 2009, p. 659). This intuitiveness on behalf of the therapist was considered by clients to be significant in the formation of the therapeutic relationship.

Other clients reported that their therapist shared something meaningful with them in therapy, which served to enhance the therapeutic relationship. For example, one client reported that his therapist "said his wife left him and basically opened up to me so I felt that to show him respect I would pay attention and open up to him as well" (Brown et al., 2014, p. 199). Indeed, some clients reported specifically wanting to know information about their therapist, seeing disclosure as a two-way process: "You tell me a little about yourself, and I'll tell you a little about myself" (Eyrich-Garg, 2008, p. 379). Clients felt this strategy helped them to assess whether their therapist was authentic and trustworthy. This request for therapist self-disclosure related to both professional credentials and more personal information e.g. whether the therapist had children. This relates to *Theme 1: Assessing client-therapist match* whereby clients wanted to know about their therapist's background in order to judge their ability to help. For example, one client described how her therapist

Told me about his childhood and all the stupid things he did in his childhood and all that kind of stuff, and things he goes through and things he does to help himself as

well and says how it works for him. So he gives me an idea like ‘Oh, maybe I could try that and it would help’ (Gibson & Cartwright, 2013, p. 345).

As clients developed a level of trust in their therapist, their confidence in the therapeutic process increased. A client’s belief that their therapist could help them seemed to aid the formation of the therapeutic relationship.

Moreover, clients reported that in order to form a trusting relationship they also needed to be open with their therapists. That is, they needed to be willing to disclose sensitive information but also to be open to suggestions about how to deal with their difficulties. One study (Fitzpatrick, Janzen, Chamodraka, & Park, 2006) labelled this process ‘productive and receptive openness’ and explained how it was circular in nature: as each party started to trust and open up to each other, the relationship developed further, increasing the level of self-disclosure and so forth. This process was exemplified by a client who described that his therapist:

...asked me questions, which I might have felt they haven’t got anything to do with what I’m talking about, but I’m willing to say, ‘Okay, I’ll go there’ [receptive], and I went there... and after talking about it I realised, ‘Yeah, there was a good reason for us to talk about that thing’ [productive] (Fitzpatrick et al., 2006, p. 491).

The theme of *Facilitating Openness* is encapsulated by this reciprocal trusting, displayed by both client and therapist, which seemed to spiral and develop as each person became more open to the enriching relationship.

Theme 3: Connecting on a Deeper Level

This theme was evident in all studies included in the metasynthesis, and describes the process by which clients and therapists start to form a deeper level of connection within the therapeutic relationship. This theme describes some clients’ experiences of feeling truly understood by their therapist and fundamentally known; a concept which involved

completely opening up to the therapist in a way that made the client vulnerable. If this submission was met with non-judgemental acceptance from the therapist, it allowed the pair to move towards a deeper understanding of the client as a whole. Thus, one client said about her therapist:

I think she knew there was more to what I was saying than I was actually admitting or she could read between the lines and she gave it back to me and I was like ‘O Jesus you really know me, ahh, did I really want that? Well you know me now so here, have the rest! (Roddy, 2013, p. 57).

In this way, clients described their desire to have an empathic therapist; one who was able to view the situation from the client’s perspective. Some clients felt this was facilitated by a good client-therapist match in terms of personal characteristics (see *Theme 1: Assessing client-therapist match*). Others reported that their therapist had taken a holistic approach and explored all aspects of their difficulties thoroughly. However it was achieved, clients who felt listened to and understood reported that this enhanced the formation of a therapeutic relationship. Conversely, clients who did not feel heard regarded this as a lack of respect which damaged the therapeutic relationship (see *Theme 4: Empowerment through respect*).

Indeed, clients particularly appreciated occasions when their therapist showed an interest in them or demonstrated that they cared: “She gave me feedback about how she viewed me... she said, ‘You know what you did was something great, it was important’. It showed she cares and understands what’s happening here” (Fitzpatrick et al., 2006, p. 491). Some clients reported feeling special within their relationship with their therapist. This depth of connection highlights the uniqueness of the therapeutic relationship, with many clients reporting that they had not had the experience of being fully known before. It seems that an emotional connection was important for clients to believe their therapists were able to understand them. However, one client emphasised the need for a parallel process of

continued professional detachment as she highlighted the risk of feeling too close to her therapist: “It was just difficult after a while to share certain things with my social worker at school because we had that emotional attachment” (Brown, Holloway, Akakpo, & Aalsma, 2014, p. 197).

The essence of this theme is in the depth of understanding between the therapist and client, which appeared to be facilitated for most by a strong emotional connection. Feeling unique and properly heard were factors which positively impacted on the formation of the therapeutic relationship.

Theme 4: Empowerment through Respect

This theme was present to some degree in all studies included in this metasynthesis, however it was particularly prevalent for adolescent client populations or those from minority ethnic groups. Clients in these studies commented that therapists who actively worked at reducing the power differential in therapy and establishing a level of mutual respect significantly aided the formation of a therapeutic relationship. One adolescent said of her therapist: “Usually when you go to adults they talk down to you. ‘Oh you’re just a kid.’ She talks to me like I’m an adult – that really helps me” (Hollidge, 2013, p. 282).

Fostering an egalitarian relationship. Many clients seemed to value the concept of an egalitarian relationship with their therapist, where both parties were viewed as equals. Some clients described how this helped form the therapeutic relationship by aiding client disclosure, and was therefore potentially seen as another ‘match’ between therapist and client (see *Theme 1: Assessing client-therapist match*). Clients described the importance of therapists being flexible and/or available, adopting a client-centred approach and allowing the client to pace the therapeutic process themselves. One client described how her therapist encouraged her to take time to regain trust in their relationship, following a distressing dream:

She said that if what you need is for me to regain your trust that is what I'll do. So for a short time I didn't share with her ... she didn't push me and waited til I was ready. I eventually knew she wasn't that person in my dream and I trusted her again (Hollidge, 2013, p. 282).

This aspect of maintaining safety in the therapeutic relationship connects with *Theme 2: Facilitating openness*. If therapists were perceived to be following their own agenda or delved into the client's past too quickly, clients reported that they were less likely to disclose personal information.

Some therapists had apparently explained to their clients about their rights and responsibilities at the start of therapy, including such things as confidentiality clauses, allowing them access to information which served to empower them. As a result, one client described feeling confident that her private information would not be shared outside of the therapeutic setting: "He kept everything confidential. My dad would always try to take him out for lunch and ask him to tell him stuff and he wouldn't. That was a huge thing" (Everall & Paulson, 2002, p. 82). This relates to *Theme 2: Facilitating openness* where clients expressed the desire for their therapist to be open and honest with them.

Examples where this did not happen included therapists conducting assessments without explaining their purpose, resulting in clients feeling stupid, angry and disempowered. These clients recommended that therapists explain the overall process of therapy including what they are doing and why. Some clients highlighted note-taking as a practice which they found to be particularly anxiety-provoking and disempowering. They requested that clinicians could "ask my permission to take notes" or "just show me what you're writing" (Eyrich-Garg, 2008, p. 379), regarding this display of openness as a sign of respect.

One client commented that if they had known they were entitled to leave at any point, they would not have continued attending a therapy which they considered to be unhelpful: "I

didn't know that I could say, after one session or two sessions or even ten sessions... I think I need to see someone else because I'm not making any connection with you" (McGregor, Thomas, & Read, 2006, p. 44). In this way, clients highlighted the importance of agency in the therapeutic process and described the significance of making the initial decision to attend therapy. Clients who reported pressure to attend therapy tended to find it harder to establish a therapeutic relationship.

A sense of empowerment seemed to propel clients towards taking positive action to foster their own well-being. Some clients described actively engaging with the therapeutic process to develop idiosyncratic techniques in collaboration with their therapist. In one study, adolescent clients described feeling like their therapists had benefitted from the therapeutic encounter in terms of enjoying their company and also learning "how to do counselling" (Gibson & Cartwright, 2013, p. 345), further enhancing the client's own feeling of empowerment. There was a sense among these clients of taking control of their emotional well-being, contrasting markedly with other clients who seemed to passively follow the advice of their therapist who they viewed as an 'expert'.

Demonstrating acceptance. A few clients reported initially feeling fearful about being judged by the therapist or being 'analysed' and this fear became a reality for some who felt attacked or, alternatively, dismissed by their therapist. One adolescent client described her experience where "the first thing [counsellor] opens her mouth with is 'Why did you do that? You shouldn't do that'" (Eyrich-Garg, 2008, p. 381). This approach left the client feeling vulnerable and created a significant barrier to the formation of a therapeutic relationship.

Conversely, therapists who demonstrated acceptance and validated their clients' experiences were able to establish a respectful relationship in therapy. For example, one adolescent said that her psychiatrist "would just sit there and listen... just letting me say it

however I wanted to say, that was a big comfort... It is really good to have someone listening to you who isn't judging you" (Everall & Paulson, 2002, p. 82). Therapists who were able to demonstrate respect by fostering an egalitarian relationship and displaying a non-judgemental attitude significantly impacted on the formation of a positive therapeutic relationship.

Discussion

Through translating and synthesising the findings of 13 qualitative studies, this review has been able to explore a broad range of client experiences in forming a therapeutic relationship with their therapist or counsellor. Applying Noblit and Hare's (1988) meta-ethnographic approach enabled studies from different theoretical perspectives to be compared, allowing for synthesis across research methodologies. Consequently, an additional layer of interpretation was developed across the studies.

One of the key findings from this metasynthesis was the complex assessment of the therapists' personal and professional ability to fit with the client. The meta-ethnographic approach extended the findings from each individual study by demonstrating that clients created an idiosyncratic hierarchy of therapist characteristics which were of varying importance to them, depending on their own individual needs. The concept of 'matching' for many clients involved the therapist having experienced similar difficulties to the client and as such assumed to possess a greater level of implicit knowledge. If the therapist did not appear to understand the client's experiences or was perceived as inadequate in some way, the client's confidence in the therapist's ability was reduced. Luborsky's (1976) definition of Type 1 alliance highlights the client's belief that the therapist will be able to provide the required help as an essential part of forming the therapeutic alliance.

A belief that the therapist had the ability to fundamentally understand their experiences paved the way for clients to connect with their therapist on a deeper level. How

this was achieved relates to a further important finding made possible by the metasynthesis approach; the requests from clients for therapists to disclose both professional and personal information to demonstrate honesty and openness. This was evident in a number of studies across the dataset indicating a shared concern for clients despite their many differences in presenting problems, therapeutic settings and types of therapy. Therapist self-disclosure has been found to have a positive effect on clients as research shows they tended to view their therapist as warmer, had a stronger liking for them, and were willing to disclose more in therapy (Henretty & Levitt, 2010). The findings from this review further previous research as clients described feeling that their relationship with their therapist was more open and connected on a deeper level if the therapist used self-disclosure techniques.

This raises an ethical dilemma for therapists about whether to self-disclose and to what extent. Clinical psychology training courses generally follow the ethical guidelines of the British Psychological Society (BPS) and the Health and Care Professions Council (HCPC) which recommend that therapists honestly and accurately disclose professional information, such as whether they are registered practitioners with the HCPC, so the client can make an informed decision to engage in therapy with that individual (BPS, 2009). However, none of the guidelines seem to comment specifically on the disclosure of personal information. Instead, this appears to be influenced by the psychological approach used by individual therapists, with traditional psychoanalysts arguing for a total absence of self-disclosure while humanist therapists advocate the cautious use of self-disclosure in therapy (Henretty & Levitt, 2010).

Bordin acknowledged how therapist self-disclosure can influence the therapeutic relationship when he described “the bond developed when a therapist shares his or her feelings with a patient, in order to provide a model, or to provide feedback on the patient’s impact on others” (1979, p. 254). In the current review, clients described how a sense of

reciprocal responding between them and their therapist helped form the therapeutic relationship, extending Bordin's (1979) point to incorporate disclosure from both sides. This involved a joint openness which allowed the therapist to adapt their approach to meet the needs of the client, and the client to be receptive to suggestions of new strategies.

This sense of connecting and working together appears to reflect the collaboration emphasised by both Luborsky (1976) and Bordin (1979) in their separate conceptualisations of the working alliance. Many of the adolescents in particular within this review advocated for an egalitarian relationship with their therapist, where they felt as though they were working together on an equal level. Despite some authors arguing for the inappropriateness of this stance (Eyrich-Garg, 2008), it likely reflects these clients' wider experience of feeling powerless during a phase in their lives where they are striving to become more autonomous (Oetzel & Scherer, 2003). This sense of powerlessness and the emphasis on mutual respect were also apparent in the studies involving clients from a racial or ethnic minority background.

Finally, one further important finding of this metasynthesis was that some clients described benefitting from therapy despite the lack of a strong therapeutic relationship. This finding supports previous suggestions that a good therapeutic relationship aids therapeutic work by creating an optimal environment to instigate change; however a poorer relationship does not mean that progress cannot be made with the implementation of appropriate and useful psychological techniques (Barber et al., 2006).

Clinical Implications

Given the understandable desire of many of the clients in this review to feel safe with their therapist before discussing their difficulties, it seems crucial that a trusting relationship is given time and space to form. Some of the clients suggested this took place over the first six sessions. For therapists who work in services offering brief psychological interventions,

this may seem impractical. However, the findings from this review suggest that increasing the time at the beginning of therapy dedicated to establishing a relationship may allow for increased client productivity later on.

Acknowledging clients' descriptions of unhelpful practices within the primary studies may also encourage clinicians to adapt their approach. For example, one adolescent described not being aware that her personal disclosures would be discussed with her parents (Everall & Paulson, 2002). Being very clear on the limits of confidentiality from the beginning is likely to buffer the effects of these perceived 'breaches' and allow the therapeutic relationship to form nonetheless. Furthermore, some of the clients highlighted note-taking as a barrier to the formation of the therapeutic relationship. As note-taking is often more prevalent at the beginning of therapy, when the client is unknown to the therapist and much factual information is required (e.g. past history, genogram, etc.), this could easily impact on the newly-forming relationship. Therefore, clinicians may like to consider alternative ways of gaining this information without the client feeling unheard. Clinicians could offer to audio-record these sessions (with the appropriate consent) instead of writing notes. In addition, participating in collaborative activities such as asking young clients to help draw their own genogram within the therapy session (Carr, 2006) can help with engagement and could act as a template for more collaborative work with other client populations.

Significantly, some of the clients in this review emphasised the importance of therapist self-disclosure in order for them to ascertain how well they 'matched' with their therapist. Providing potential clients with an appropriately considered information sheet about the therapist prior to initiating therapy could hasten that decision-making process. Taking this philosophy one step further, providing information sheets on multiple therapists could allow potential clients to choose a therapist whom they feel would best meet their

needs. In a context where resources are limited, this may enable better allocation of therapist time by reducing the number of clients who drop out of therapy. It could also help to facilitate the formation of a therapeutic relationship as the client is likely to feel respected, empowered and supported by the service, all factors which clients in this review emphasised as important.

Limitations and Recommendations for Future Research

As this is the first attempt known to the author at synthesising qualitative research exploring the client's experience of forming a therapeutic relationship, it is hoped that the findings from this review can be used to further develop an understanding of therapeutic processes. A few suggestions of how this may be done have been listed below.

Initially, the literature review was intended to focus specifically on the formation of the therapeutic relationship; however, in reality it was very difficult to separate out articles concentrating on the formation of the relationship as opposed to the therapeutic relationship overall. The factors which play a role in the different stages of the relationship may be diverse and therefore it would be helpful to investigate this in future research.

In a similar way, it was originally intended for the review to include studies involving only voluntary therapeutic relationships, not ones which are mandated such as in forensic settings. However, it was not always clear in the studies whether the clients were voluntarily engaging in therapy, and some adolescent clients reported feeling pressurised into therapy by their parents or school, questioning the 'voluntary' nature of their attendance. As a result, this review did not distinguish between voluntary and mandatory therapeutic settings. However, future empirical research would benefit from attempting to extricate these different types of therapy.

In searching for relevant published data for this review, it became clear that studies had been conducted across a wide age range of participants, from 11 – 61 years old.

However, there were no studies exploring the formation of the therapeutic relationship with children younger than 11. Children are increasingly being used in qualitative research studies and recommendations on how to adapt interviews for children have been published (Clark, 2011). With this in mind, attempts should be made to identify the salient aspects of forming a therapeutic relationship for children, and how these compare to older clients.

Finally, this developing area of qualitative research requires more carefully-designed research studies to enhance our understanding of the formation of the therapeutic relationship by teasing out different client preferences. For example, identifying which clients prefer to match on racial/ethnic backgrounds with their therapist would be beneficial. Moreover, findings from this metasynthesis suggest that some clients are looking to connect with their therapist during the therapeutic process whereas others would prefer to focus on developing concrete strategies. Future research might help to distinguish between the clients that fall into each of these categories. Focusing research in either of these areas may help services allocate clients to the most appropriate therapy or therapist at the earliest opportunity.

Rating the quality of research. Rating each of the studies using a quality measure raised some interesting observations that could inform future research. Two (Brown et al., 2014; Hollidge, 2013) of the three lowest scoring studies were published in relatively short reports compared with the other studies, implying they may have been restricted on the amount of information they could present. This reflects concerns by researchers that it is the quality of the research report that is being judged, not the quality of the research undertaken (Murray & Forshaw, 2013), and therefore highlights the risks of excluding studies on quality ratings alone. However, it is worth acknowledging that length of report did not correlate neatly with the quality ratings and other authors managed to score higher with shorter articles (Roddy, 2013).

One particularly interesting observation was that the highest-scoring study (Chang & Yoon, 2011) dedicated the largest proportion of its report to the method section compared with all other studies included in the metasynthesis. This suggests that allowing space for a more detailed description of how the study took place provides researchers with a platform to demonstrate the trustworthiness of their findings. It was also interesting to note that the lowest scoring domain in the CASP across the studies was that of 'reflexivity'. This indicates that researchers tend not to place as much significance on exploring how their personal background may impact on the study compared with, for example, detailing how the data were analysed. The value of providing this information for the reader is perhaps underestimated. However, deciding what level of personal detail to include in the report can be difficult, and potentially exposing, and may account for the number of studies that avoided this topic all together.

Conclusion

Understanding clients' experiences of forming a working relationship with their therapist or counsellor is fundamental to improving therapeutic practice. The aim of this metasynthesis was to collate research findings on the formation of the therapeutic relationship from the perspective of clients and, additionally, to synthesise those findings using a higher level of interpretation to generate a more holistic understanding. The metasynthesis produced four over-arching themes: assessing client-therapist match, facilitating openness, connecting on a deeper level, and empowerment through respect.

Using the metasynthesis approach, it was possible to discern that clients appeared to create a hierarchy of therapist characteristics, the importance of which were assessed based on the client's perception of their own needs. In this way clients could rapidly ascertain whether the therapist and their approach fit with their own idea of what they needed. Additionally, a strong theme across many of the studies was a request by clients that their

therapist shared both professional and personal information with them. The implications of this have been explored within the constraints of current professional practice guidelines. It is hoped that this review will provide clinicians with tools to inform their therapeutic practice and encourage researchers to continue exploring this crucial area of investigation.

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Table 1

Inclusion and Exclusion Criteria for Metasynthesis

| Inclusion criteria | Exclusion criteria |
|---|--|
| Qualitative research (or mixed methods) using a content-based approach to guide analysis with a significant enough component to allow for synthesis | Quantitative research or very little qualitative data analysis |
| The majority of data collected using an interview format (either individual or group), possibly supplemented by other written text | Data collected via observation or through methods where it was unclear how much the client perspective had been obtained |
| More than one participant in the study, resulting in themes being developed across the data | Case studies |
| Client perspective/experience (or dyadic) with enough individual data to allow analysis | Therapist or observer perspective only |
| Significant findings regarding alliance formation/engagement in therapy | Lack of findings regarding alliance formation/engagement in therapy |
| Focus on a working relationship with professional acting as a therapist or counsellor | Focus on relationships with other health professionals or service providers not in a counselling role |
| Current (at the time of participation in the study) or previous engagement in individual or group therapy focusing on a mental health difficulty | Engagement in alternative support mechanisms, such as domestic violence support groups |
| Evidence of direct quotations | Paraphrasing or lack of substantial or clear quotations |
| Written in English | Published in a language other than English |
| Published in a peer-reviewed journal | 'Grey' literature |

Table 2

Demographic Characteristics of the Participants from Each Study Included in the Metasynthesis

| Study number | Authors | Sample | Age of participants | Occupation | Ethnicity | Location of study |
|--------------|---|--|---|---|---|---|
| 1 | Barnes, Sherlock, Thomas, Kessler, Kuyken, Owen-Smith, Lewis, Wiles & Turner (2013) | 26 adult former clients (16 females) | Mean age = 47 years, SD = 9.7 | 13 paid employment, 6 not in employment, 7 not employed due to ill health | All White British | Glasgow, Bristol and Exeter trial sites, UK |
| 2 | Brown, Holloway, Akakpo & Aalsma (2014) | 19 youth clients (7 females, 12 males) | Age range = 11-17 years (median age = 16 years for females; 15.5 years for males) | Not stated | Females = 3 Black, 4 White Males = 7 Black, 4 White, 1 Hispanic | USA |
| 3 | Chang & Yoon (2011) | 23 adult, ethnic minority, former clients (13 females, 10 males) | Age range = 19-55 years (average age = 33.7 years) | Not stated | 5 Asian American, 9 African American, 5 Hispanic American, 4 multiracial / multiethnic | New York City, USA |
| 4 | Everall & Paulson (2002) | 18 adolescents (15 females, 3 males) | Mean age = 16.3 years | Not stated | 16 Caucasian, 1 Aboriginal, 1 East Indian | Alberta, Canada |
| 5 | Eyrich-Garg (2008) | 5 adolescent females staying at an emergency shelter | Age range = 13-17 years | Not stated | 2 Caucasian, 2 African-American, 1 Biracial | Midwestern United States |
| 6 | Fitzpatrick, Janzen, Chamodraka, Gamberg & Blake (2009) | 15 currently depressed adult clients (12 females, 3 males) | Age range = 20-61 years (mean age = 27.2 years, SD = 11.18) | Students | 8 Caucasian, 2 Canadian, 1 Persian / Iranian, 1 Armenian, 1 South-East Asian, 1 Chinese / Mauritian (1 unknown) | Eastern, Canada |

| Study number | Authors | Sample | Age of participants | Occupation | Ethnicity | Location of study |
|--------------|--|--|--|----------------------|---|-------------------------------------|
| 7 | Fitzpatrick, Janzen, Chamodraka, & Park (2006) | 20 adult current clients (16 females, 4 males) | Age range = 20-54 years (mean age = 28.26 years, SD = 9.287) | Students | 11 Canadian, 4 European, 3 Biracial, 1 Asian, 1 Caribbean | Canada |
| 8 | Gibson & Cartwright (2013) | 22 young, former clients (15 females, 7 males) | Age range = 16-18 years | High school students | 11 New Zealanders of European Ancestry, 6 Immigrants from English-speaking countries, 5 Maori and / or Pacifica | New Zealand |
| 9 | Hollidge (2013) | 42 adolescent, current clients (33 females, 9 males) | Age range = 14-18 years (mean age = 16.3, SD = 1.6) | High school students | 16 European American, 16 African American, 7 Hispanic, 2 Asian, 1 Native American | Midwestern United States |
| 10 | Marich (2012) | 10 adult, female, former clients | Age range = 27-52 years (mean age = 41.7 years) | Not stated | 4 African-American (Black), 5 Caucasian, 1 mixed European / Iranian | Midwestern United States of America |
| 11 | McGregor, Thomas & Read (2006) | 20 adult women, former clients | Age range = 26-57 years (mean age = 40.5 years) | Not stated | 13 New Zealand Europeans, 6 Maori, 1 Samoan | New Zealand |
| 12 | Roddy (2013) | 4 female former clients | Age range = 30-50 years | Not stated | All White British | North of England, UK |
| 13 | Ward (2005) | 13 adult current clients (8 females, 5 males) | Age range = 26-53 years (average age = 39.9 years) | Not stated | All African American | Midwestern United States of America |

Note. All information in this table has been taken from the available information in the primary source material. SD = standard deviation.

Table 3

Methodological Characteristics of the Qualitative Studies Included in the Metasynthesis

| Study number | Authors | Method of data collection | Aim of study | Research design | Method of data analysis | Length of therapy and therapeutic approach | Therapist information |
|--------------|---|------------------------------------|--|--|---|--|--|
| 1 | Barnes, Sherlock, Thomas, Kessler, Kuyken, Owen-Smith, Lewis, Wiles & Turner (2013) | Individual face-to-face interviews | To explore experiences of depression and CBT, the therapist, and reasons from completing or withdrawing from treatment | Mixed methods – participants who met criteria for depression were randomised to treatment with CBT and antidepressant medication (intervention arm), and were then invited to participate in an in-depth interview | Qualitative data analysis involving the development of themes from transcript data, informed by the Framework approach | 12-18 one hour sessions of individual CBT | CBT therapists representative of those working in National Health Service (NHS) psychological services |
| 2 | Brown, Holloway, Akakpo & Aalsma (2014) | Individual face-to-face interviews | To understand how previously detained youth experienced therapeutic alliances | Data obtained from a larger qualitative study exploring youth and parents' experiences of connecting with mental health care following detention | Qualitative data analysis using a grounded theory approach | Not stated | Not stated |
| 3 | Chang & Yoon (2011) | Individual face-to-face interviews | To clarify the connotative meaning of race and its perceived impact on the therapeutic relationship | Phenomenological qualitative research study – participants were recruited from a larger dataset on the basis of their perceived racial difference with their therapist | Data were analysed using the consensual qualitative research approach (CQR) with the aid of qualitative software package Atlas.ti | Varying length of therapy, categorised as less than 6 months, 6-11 months, and at least 1 year | All therapists were White. The majority of the participants saw female therapists |

| Study number | Authors | Method of data collection | Aim of study | Research design | Method of data analysis | Length of therapy and therapeutic approach | Therapist information |
|--------------|---|------------------------------------|--|---|--|---|--|
| 4 | Everall & Paulson (2002) | Individual face-to-face interviews | To explore what adolescents considered to be important in therapy relationship formation and maintenance | Qualitative research study derived from a larger study on factors in counselling that helped participants overcome their difficulties | Qualitative data analysis involving the development of themes from transcript data, using a combination of methods | Participants had received a variety of individual, group and family counselling. They were unable to account for the specific number of sessions they attended or identify the theoretical orientation of their therapist | All therapists were either psychologists, psychiatrists or counsellors |
| 5 | Eyrich-Garg (2008) | One focus group of 5 participants | To explore ways to engage and build a positive therapeutic alliance | A small, exploratory study to obtain qualitative data | Data was analysed qualitatively using an inductive approach | Weekly, one-to-one counselling for up to four weeks | All counsellors were social workers employed in a counselling role |
| 6 | Fitzpatrick, Janzen, Chamodraka, Gamberg & Blake (2009) | Individual face-to-face interviews | To elaborate how depressed clients understand the development of the therapeutic alliance | Qualitative methodology | Data were analysed using the consensual qualitative research approach (CQR) | Therapeutic orientation identified by therapists as a mixture of humanistic, cognitive-behavioural, psychodynamic, feminist, and narrative | All therapists were Caucasian (7 females, 3 males) and experienced counsellors in university counselling centres |

| Study number | Authors | Method of data collection | Aim of study | Research design | Method of data analysis | Length of therapy and therapeutic approach | Therapist information |
|--------------|---|------------------------------------|--|--|---|---|--|
| 7 | Fitzpatrick, Janzen, Chamodraka & Park (2006) | Individual face-to-face interviews | To investigate how clients understand critical incidents in alliance development in early therapy sessions | Qualitative methodology | Data were analysed using the consensual qualitative research approach (CQR) | Offered up to 15 sessions of personal counselling on undergraduate program | Therapists were master's-degree students in counselling psychology (13 females, 3 males) |
| 8 | Gibson & Cartwright (2013) | Individual face-to-face interviews | To explore young clients' retrospective narratives of their experience of counselling | Narrative approach used to obtain qualitative data | Data were analysed using narrative analysis | Varying lengths of therapy categorised as fewer than five sessions, five to 19 sessions, and over 20 sessions. Counsellors trained in a range of models (humanistic, cognitive- behavioural and narrative approaches) | All therapists were school counsellors |
| 9 | Hollidge (2013) | Individual face-to-face interviews | To present what adolescents' experienced as helpful in engaging them in psychotherapy | Qualitative methodology | Data were analysed by following a grounded theory framework | Varying lengths of therapy categorised as less than six months, six months to a year, one to two years, and more than two years; all psychotherapies were individual | Therapists were licensed clinical social workers in a counselling role |

| Study number | Authors | Method of data collection | Aim of study | Research design | Method of data analysis | Length of therapy and therapeutic approach | Therapist information |
|--------------|--------------------------------|------------------------------------|--|--|---|--|---|
| 10 | Marich (2012) | Individual face-to-face interviews | To explore the use of EMDR with women in addiction continuing care | Phenomenological (qualitative) approach | Data were analysed using Giorgi's descriptive phenomenological psychological method | All participants had worked with a primary counsellor, several different group counsellors, case managers and an EMDR therapist | All therapists were trained in EMDR technique |
| 11 | McGregor, Thomas & Read (2006) | Individual face-to-face interviews | To explore helpful/ unhelpful therapy experiences of women who had experienced childhood sexual abuse | Mixed methods – a large sample of participants responded to a postal survey from which 20 participants were selected for interview | Data were analysed using a grounded theory approach | Length of therapy varied significantly from between 11-20 hours, up to 501+ hours | Not stated |
| 12 | Roddy (2013) | Individual face-to-face interviews | To explore the perceptions of former clients regarding their counselling to identify a preliminary client-preferred domestic violence counselling approach | Qualitative pilot study within a constructivist philosophical framework | Data were analysed separately using an adapted grounded theory and narrative approach | All participants received counselling for women who had suffered domestic violence. Counsellors were qualified in person-centred, psychodynamic or integrative counselling (including cognitive behavioural therapy) | Not stated |

| Study number | Authors | Method of data collection | Aim of study | Research design | Method of data analysis | Length of therapy and therapeutic approach | Therapist information |
|--------------|-------------|------------------------------------|---|--|--|---|--|
| 13 | Ward (2005) | Individual face-to-face interviews | To examine the subjective experiences of African American clients at a community mental health centre | Qualitative grounded theory methodology within constructivist paradigm | Data analysis procedures were guided by grounded theory methodology and dimensional analysis | Clients underwent a wide range of different therapies, including individual, couples and group therapy; treatment for substance abuse; and interventions for families | 8 of the participants reported they had a female counsellor, 5 reported they had a male counsellor |

Note. All information in this table has been taken from the available information in the primary source material. CBT = cognitive behaviour therapy; EMDR = eye movement desensitisation and reprocessing.

Table 4

Appraisal of Study Quality using Critical Appraisal of Study Programme (CASP) Tool

| Study | Authors | Research design | Sampling | Data collection | Reflexivity | Ethical issues | Data analysis | Findings | Value of research | Total score |
|-------|---|-----------------|----------|-----------------|-------------|----------------|---------------|----------|-------------------|-------------|
| 1 | Barnes, Sherlock, Thomas, Kessler, Kuyken, Owen-Smith, Lewis, Wiles & Turner (2013) | 1 | 2 | 2 | 1 | 2 | 2 | 2 | 2 | 14 |
| 2 | Brown, Holloway, Akakpo & Aalsma (2014) | 2 | 2 | 2 | 1 | 2 | 1 | 2 | 1 | 13 |
| 3 | Chang & Yoon (2011) | 3 | 2 | 2 | 3 | 2 | 3 | 2 | 3 | 20 |
| 4 | Everall & Paulson (2002) | 1 | 2 | 1 | 2 | 2 | 2 | 2 | 2 | 14 |
| 5 | Eyrich-Garg (2008) | 2 | 1 | 2 | 1 | 2 | 1 | 2 | 3 | 14 |
| 6 | Fitzpatrick, Janzen, Chamodraka, Gamberg & Blake (2009) | 2 | 1 | 2 | 2 | 2 | 3 | 2 | 2 | 16 |
| 7 | Fitzpatrick, Janzen, Chamodraka & Park (2006) | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 16 |
| 8 | Gibson & Cartwright (2013) | 2 | 3 | 2 | 2 | 2 | 2 | 2 | 2 | 17 |
| 9 | Hollidge (2013) | 1 | 2 | 2 | 1 | 2 | 1 | 2 | 2 | 13 |
| 10 | Marich (2012) | 2 | 2 | 2 | 2 | 2 | 3 | 2 | 2 | 17 |
| 11 | McGregor, Thomas & Read (2006) | 2 | 2 | 1 | 2 | 1 | 2 | 2 | 1 | 13 |
| 12 | Roddy (2013) | 3 | 2 | 2 | 1 | 2 | 2 | 2 | 2 | 16 |
| 13 | Ward (2005) | 2 | 2 | 2 | 2 | 1 | 3 | 3 | 3 | 18 |

Table 5

The Creation of Four Main Themes from Individual Study Codes

| Theme 1: Assessing Client-Therapist Match | Theme 2: Facilitating Openness | Theme 3: Connecting on a Deeper Level | Theme 4: Empowerment through Respect |
|--|--|---|--|
| <p>Barnes et al (2013)</p> <ul style="list-style-type: none"> - CBT seen as helpful despite difficult relationship - impact of CBT on problem - feeling like not giving right answer - age/perceived experience of therapist is a barrier <p>Brown et al (2014)</p> <ul style="list-style-type: none"> - therapist been through what client has <p>Chang & Yoon (2011)</p> <ul style="list-style-type: none"> - match as a facilitator to therapy - better understanding of key experiences - appreciated uniqueness of individual experience - could offer insider's perspective of client's difficulties - ability to work through differences that arose | <p>Barnes et al (2013)</p> <ul style="list-style-type: none"> - feeling uncomfortable <p>Brown et al (2014)</p> <ul style="list-style-type: none"> - being 'straight up' - therapist self-disclosure indicates authenticity - build trust to confide in therapist - sense of safety - rapport - feeling comfortable - sense of humour - sense of credibility <p>Chang & Yoon (2011)</p> <ul style="list-style-type: none"> - easier to discuss sensitive issues | <p>Barnes et al (2013)</p> <ul style="list-style-type: none"> - relating to therapist - not being listened to, not understood <p>Brown et al (2014)</p> <ul style="list-style-type: none"> - too much emotional attachment, too close - connecting emotionally to build trust - empathy - deeply caring and understanding - seeing situation from client's perspective <p>Everall & Paulson (2002)</p> <ul style="list-style-type: none"> - uniqueness of therapeutic relationship - feeling listened to/heard <p>Eyrich-Garg (2008)</p> <ul style="list-style-type: none"> - not feeling listened to | <p>Barnes et al (2013)</p> <ul style="list-style-type: none"> - fear of being analysed <p>Brown et al (2014)</p> <ul style="list-style-type: none"> - client-directed care and sequencing - perceived level of self-governance - staying in here and now, following client - therapist putting own agenda first <p>Chang & Yoon (2011)</p> <ul style="list-style-type: none"> - dismissive of experiences of racial oppression <p>Everall & Paulson (2002)</p> <ul style="list-style-type: none"> - egalitarian relationship (trust and respect) - discussing/explaining context of therapy - non-judging <p>Eyrich-Garg (2008)</p> <ul style="list-style-type: none"> - labels and offensive descriptions - respect, egalitarian relationship |

| Theme 1: Assessing Client-Therapist Match | Theme 2: Facilitating Openness | Theme 3: Connecting on a Deeper Level | Theme 4: Empowerment through Respect |
|--|--|---|---|
| <ul style="list-style-type: none"> - need to match on experiences, issues and concerns, not race - more knowledgeable about issues of oppression - mismatch as a barrier to therapy - culturally incompatible communication style - therapists only have 'textbook' knowledge of race - lack of understanding/relating if foreign born therapist - could not understand fundamental experiences of client - not raising racial/cultural issues for fear of not being understood - lack of cultural knowledge or sensitivity - mismatch as facilitator to therapy - easier to discuss issues with white therapist - recognised other demographic similarities - developed positive transference based on positive stereotype | <p>Everall & Paulson (2002)</p> <ul style="list-style-type: none"> - therapist openness and impartiality - therapist is authentic, open, sincerely cared - feeling safe - therapeutic environment <p>Eyrich-Garg (2008)</p> <ul style="list-style-type: none"> - curiosity about credentials and basic demographics <p>Fitzpatrick et al (2009)</p> <ul style="list-style-type: none"> - increased client openness - client is open with therapist - feeling comfortable - increased positive expectations - therapist met client's unexpressed needs <p>Fitzpatrick et al (2006)</p> <ul style="list-style-type: none"> - client contributing bidirectional openness | <p>Fitzpatrick et al (2009)</p> <ul style="list-style-type: none"> - therapist understands - therapist provided emotional support - therapist cares - therapist demonstrated interest - feeling understood - therapist really listens <p>Fitzpatrick et al (2006)</p> <ul style="list-style-type: none"> - therapist encouraged client to take space <p>Gibson & Cartwright (2013)</p> <ul style="list-style-type: none"> - not being heard (e.g. writing notes) <p>Hollidge (2013)</p> <ul style="list-style-type: none"> - therapist conveying verbal support - expressing emotions - made to feel special/unique - being heard/listened to - therapist demonstrates empathy, builds trust | <ul style="list-style-type: none"> - anxiety and curiosity - not explaining process/measures - being judged/feeling attacked <p>Fitzpatrick et al (2009)</p> <ul style="list-style-type: none"> - increased self-assurance, decreased anxiety - client works actively - therapist did not judge <p>Fitzpatrick et al (2006)</p> <ul style="list-style-type: none"> - increased client productivity - belief that I can do this myself - belief that I'm important - belief that I am ok - acceptance and validation <p>Gibson & Cartwright (2013)</p> <ul style="list-style-type: none"> - counsellor obtaining benefits from clients - taking control, agentic - the initial decision: it's my choice |

| Theme 1: Assessing Client-Therapist Match | Theme 2: Facilitating Openness | Theme 3: Connecting on a Deeper Level | Theme 4: Empowerment through Respect |
|--|---|---|--|
| <ul style="list-style-type: none"> - match as a barrier to therapy - personal issues conflicting with in-group behaviour - match having minimal impact - mismatch having minimal impact - therapist characteristics/skills seen as more important - racial, ethnic and cultural differences seen as secondary to presenting problem - comparisons between therapist and client are unhelpful - more important to provide practical strategies and interventions <p>Everall & Paulson (2002)</p> <ul style="list-style-type: none"> - therapist characteristics <p>Fitzpatrick et al (2009)</p> <ul style="list-style-type: none"> - therapist communicated understanding - comparing therapy process to previous one - comparing therapist to previous one - therapist helped client think/act in a new way | <ul style="list-style-type: none"> - client contributing receptive openness - client contributing productive openness - comfort and safety - trust/confidence in therapist - trust/confidence in process - increase in positive emotion/positive expectation - belief that therapist can help me - increase in disclosure/ openness - therapist shared something meaningful - therapist responded to client wish <p>Hollidge (2013)</p> <ul style="list-style-type: none"> - therapist being honest and trustworthy - sense of safety - therapist being warm - therapist portraying unique non-verbal communications | <p>Marich (2012)</p> <ul style="list-style-type: none"> - connecting with therapist <p>McGregor et al (2006)</p> <ul style="list-style-type: none"> - holistic approach and thoroughness - experiences of rapport and being heard - feeling listened to, respected and understood <p>Roddy (2013)</p> <ul style="list-style-type: none"> - showing understanding, reading between the lines (empathy) | <ul style="list-style-type: none"> - egalitarian relationship regarding self-disclosure - pressure to attend counselling <p>Hollidge (2013)</p> <ul style="list-style-type: none"> - therapist being flexible - therapist being easy to understand - therapist being available - egalitarian relationship - non-judgemental stance <p>Marich (2012)</p> <ul style="list-style-type: none"> - empowering <p>McGregor et al (2006)</p> <ul style="list-style-type: none"> - client feeling in control; empowering - experiences of equality in the relationship - encouraging equal and collaborative relationship - doing what they are told to by 'expert' - being given information about the process of therapy - knowing rights and responsibilities |

| Theme 1: Assessing Client-Therapist Match | Theme 2: Facilitating Openness | Theme 3: Connecting on a Deeper Level | Theme 4: Empowerment through Respect |
|---|--|---------------------------------------|---|
| - client gains new understanding | Marich (2012) | | - feeling validated and accepted |
| - therapist is skilled | - safety | | Roddy (2013) |
| Fitzpatrick et al (2006) | - feeling in capable hands with therapist | | - recognising problems in beginning |
| - now I know what to do (strategies) | - intuitive/natural | | - make own decision to engage with services |
| - therapist helped client think in a new way | Roddy (2013) | | - consistent, non-judgemental |
| - therapist gave tools/assignments | - gaining trust: the importance of understanding | | |
| Gibson & Cartwright (2013) | - started to build trust over time | | |
| - make judgements about suitability | Ward (2005) | | |
| - evaluating the counsellor | - monitoring and managing disclosure | | |
| - professional qualities not important | - assessing safety in therapy | | |
| Hollidge (2013) | - concerns about court involvement (confidentiality) | | |
| - therapist personal qualities | - sense of trust and emotional comfort | | |
| - helped to solve problems | - counsellor's responsiveness | | |
| - therapist being knowledgeable/having confidence | | | |
| Marich (2012) | | | |
| - role of EMDR therapist | | | |
| - good understanding of trauma | | | |

Theme 1: Assessing Client-Therapist Match Theme 2: Facilitating Openness Theme 3: Connecting on a Deeper Level Theme 4: Empowerment through Respect

McGregor et al (2006)

- effective assessments

Roddy (2013)

- weighing up counsellors (protecting against self-disclosure)
- gaining insight into situation and behaviour
- counsellor sharing knowledge on domestic violence
- understanding domestic violence

Ward (2005)

- assessing counsellor effectiveness
 - perceptions of ideology similarity
 - counsellor's experience (personal and professional)
 - salience of black identity
 - gender match
 - firstly assess race/ethnicity of counsellor
 - religious beliefs
 - assessing client-therapist match
-

Note. Some of the codes could be categorised under multiple themes. Therefore studies which are not included in a category may still be relevant to that category.

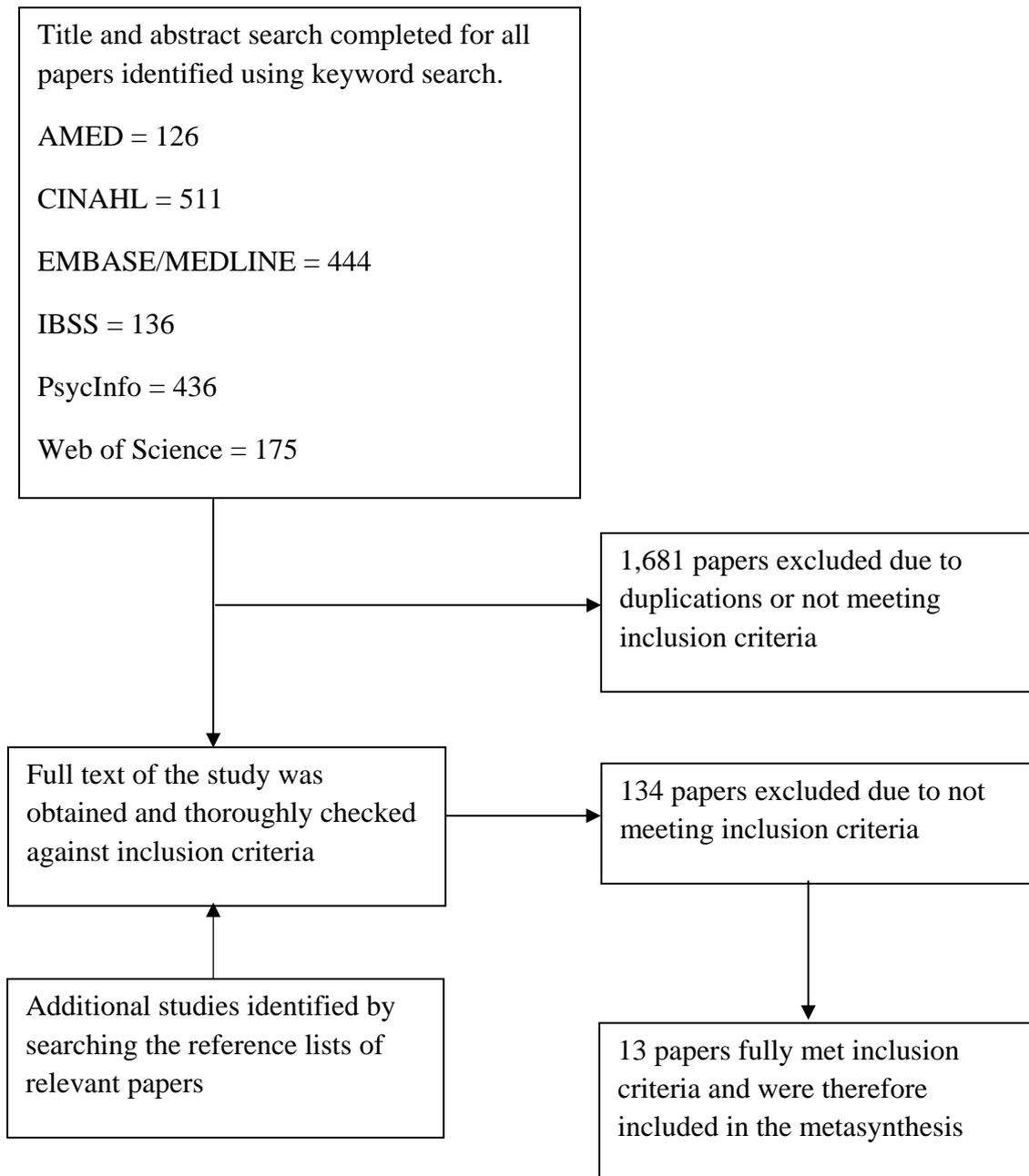


Figure 1. Flow diagram to illustrate the literature searching process.

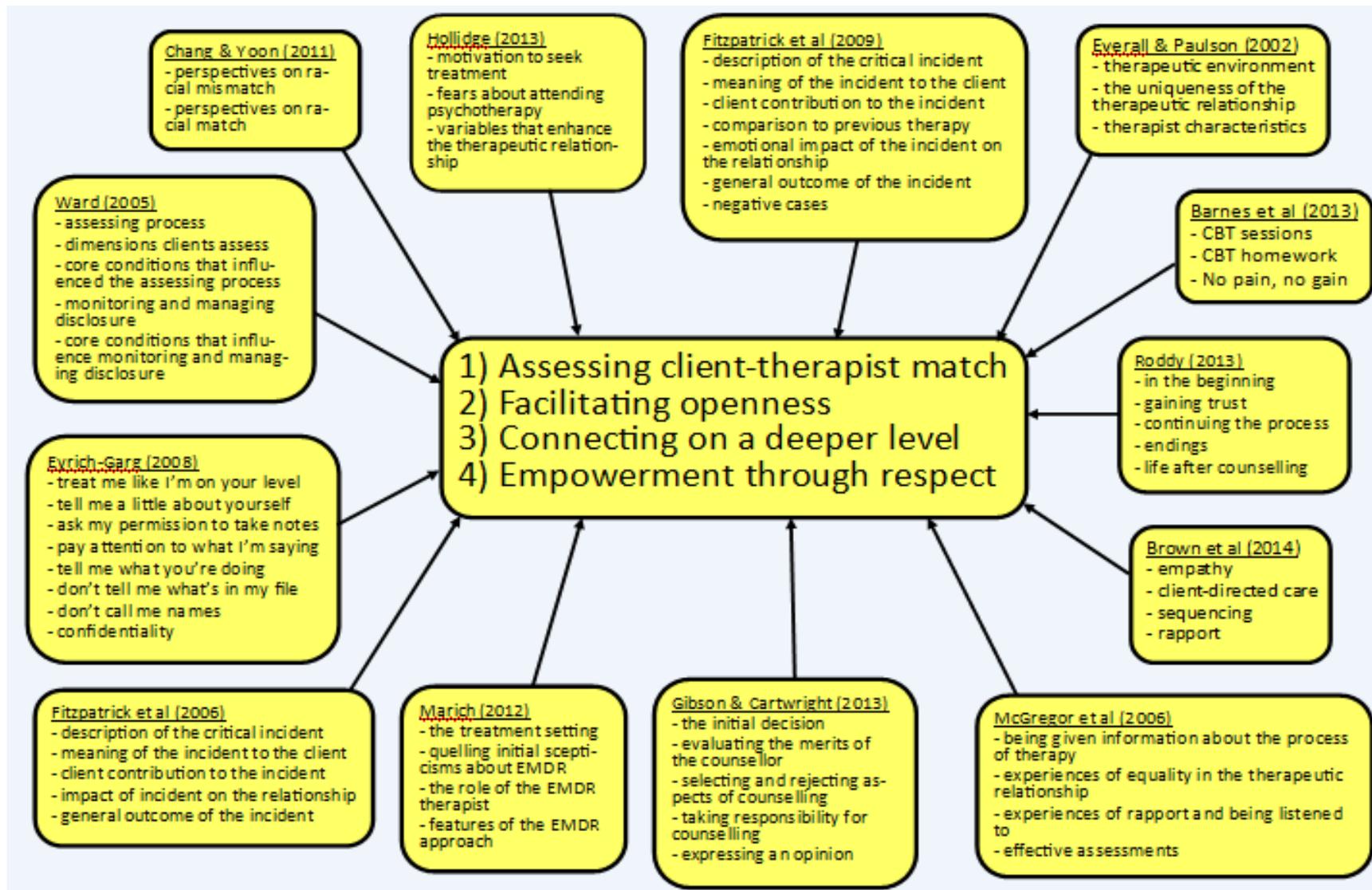


Figure 2. The qualitative synthesis of themes from individual studies included in the metasythesis.

Appendix: Author Guidelines

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CLINICAL PSYCHOLOGY REVIEW

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ISSN: 0272-7358

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Clinical Psychology Review publishes substantive reviews of topics germane to **clinical psychology**.

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Section Two: Research Paper

Constructing the Processes Involved in Ending Therapy with Clients

Rosie Noyce

Doctorate in Clinical Psychology

Division of Health Research

Lancaster University

All correspondence should be addressed to:

Rosie Noyce
Clinical Psychology
Division of Health Research
Furness College
Lancaster University
Lancaster
LA1 4YG

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Abstract

Ending therapy is a fundamental part of the therapy process and can be used as a tool to maximise therapeutic potential. However, there is limited empirical research focusing on this area. The aim of this study was to develop an in-depth understanding of the processes involved in ending therapy from the perspective of the therapist. Semi-structured interviews were conducted with 11 qualified clinical psychologists and data were analysed using a grounded theory methodology.

The findings demonstrate that the ending of therapy is affected by multiple factors including the context in which the therapist is working, the therapeutic approach, the level of connectedness and level of investment in the work. Additionally, the therapist's experience of ending therapy is heavily influenced by their perceived level of responsibility for the ending. The different types of therapy ending identified by participants were separated into four main categories (therapist-initiated, collaborative, client-initiated and externally-driven) and elicited complex emotional reactions from therapists. As a result of the ending experience, therapists described a continuation beyond the end of therapy in the form of learning which influenced their future work with clients.

Suggestions for clinical practice have been made, including a regular peer support group and time for personal reflection to allow for the processing of emotions associated with endings in therapy. The significant levels of self-doubt found in less experienced therapists could be reduced by raising awareness about the importance of therapy endings during training and learning about the processes that influence them.

Keywords: terminating therapy, endings, clinical psychology, therapist, qualitative research, grounded theory

Key Practitioner Message:

- Endings in therapy are a fundamental part of the therapy process and can be used as a clinical tool to maximise therapeutic potential.
- Findings from this study highlight therapist context, therapeutic approach, level of connectedness, level of investment and therapist's perceived responsibility as major factors which influence the therapist's experience of ending therapy.
- Through the process of learning, an element of the therapy continues beyond the ending and influences future work with clients.
- Therapists are encouraged to organise regular peer support groups and protected reflection time to process their experiences of ending therapy with clients and learn from theirs' and others' experiences.
- Raising awareness of the importance of endings in therapy and learning about the factors influencing therapists' experiences early in training could help to reduce the level of self-doubt apparent in less experienced therapists.

Constructing the Processes Involved in Ending Therapy with Clients

The ending of therapy has long been recognised as an important phase in the therapeutic journey (Fortune, 1985; Gelso & Woodhouse, 2002; Maholick & Turner, 1979; Quintana, 1993). In fact, it has been argued that ending therapy is a fundamental part of the therapy process and can be used as a tool to maximise therapeutic gains (Davis, 2008; Frank, 2009). It is therefore crucial to understand the processes involved in ending therapy to enable therapists to make use of what could be considered both a valuable resource and opportunity.

Given the potential power of the ending in therapy, it is surprising that relatively little empirical research has explored this topic. Instead, the focus has predominantly taken the form of theoretical debates (Holmes, 1997; Walsh & Harrigan, 2003) and clinical recommendations based on subjective experiences (Emanuel, 2014; Wittenberg, 1999) which have not been formally analysed using recognised research methods. One of the most influential theorists in this respect has been Freud (1937), who proposed that essentially the task of analysis ended once the best possible psychological condition had been reached. However, he argued that new problems could surface unexpectedly in response to future life events making therapy, in theory, interminable. Other theorists have since continued this discussion (Novick, 1997; Powell, 1994; Sirois, 2011) and subsequently most of the interest in this topic has come from a psychodynamic framework (Fragkiadaki & Strauss, 2011; Roe, Dekel, Harel, Fennig & Fennig, 2006; Willock, 2007).

Conceptualising Endings in Therapy

From a theoretical perspective, ending therapy tends to be viewed as “a phenomenon of considerable complexity” (O’Donohue & Cucciare, 2008, p. xviii). Indeed, multiple theorists have attempted to conceptualise what is meant by the ending in therapy (Baum, 2007; Goodyear, 1981; Quintana, 1993) but currently no single definition is universally

accepted. There are, however, many similarities between models that have been used to conceptualise the process of ending therapy.

One example of a typical framework for understanding therapy endings has been provided by Wittenberg (1999) who separated different types of endings into three main categories: the natural ending, where therapy comes to a natural end in order for the client to continue their psychological growth alone; impasse or disruption due to internal reasons, which can involve either the client or therapist deciding to stop therapy; and finally, the premature ending (also known as a forced ending) which is dictated by external factors such as either party moving away or experiencing significant illness. The potential for multiple types of endings within each of these categories makes it clear that the process of ending therapy is complex and multifaceted (Hardy & Woodhouse, 2008).

Empirical Research on Endings in Therapy

Empirical research focusing specifically on the ending of therapy is limited. One reason for needing to gain a better understanding of this topic lies in the significant impact it could have on funding and resource allocation; a factor which is particularly relevant for state-funded schemes. Using the UK as an example, it has been estimated that half of all endings in primary care counselling services are unplanned, client-led decisions to end therapy (Connell, Grant, & Mullin, 2006). Not only does this potentially result in reduced treatment efficacy (and possibly, therefore, a return to treatment later on), it also has significant cost implications for services due to missed appointments (Lucock et al., 2003) and prevents future clients from having access to earlier treatment because of long waiting lists (April & Nicholas, 1997).

Furthermore, clinician productivity may be affected as research suggests that unplanned endings initiated by the client (i.e. client dropout) impact significantly on the therapist. Powerful negative emotions have been reported as a result of having a client

unexpectedly terminate therapy, including shock, disappointment, anger and intense sadness (Baum, 2007; Wilson & Sperlinger, 2004). Similar negative emotions were found in student therapists who experienced forced terminations as a result of their placement ending, resulting in sadness, regret, frustration and uncertainty about their own professional capabilities, as well as worry, anxiety and guilt in relation to their clients (Baum, 2006). Taken together, these findings suggest that intense negative reactions could be a response to the therapist's loss of control over the ending. Indeed, Baum (2007) identified 'therapist control over the ending' as one factor which related to therapists' experiences of positive self-feelings about the ending.

Other research has shown that therapists' responses to client non-attendance are heavily influenced by their sense of perceived legal, moral and personal responsibilities (Tweed & Salter, 2000). Thus, anxiety seemed to develop in response to the legal responsibilities held by therapists in this particular study, who were required to account for how their time had been spent. Feelings of self-blame occurred in response to a perceived failure in the therapists' moral responsibility to help alleviate psychological distress. Moreover, therapists who attributed client non-attendance to a personal failure to engage the client in therapy resulted in feelings of both self-blame and anxiety. Despite these therapists having little or no control over the ending, this did not seem to reduce their perception of responsibility (evidenced by the feelings of self-blame they reported). Therefore, the research in this area suggests that it may be the perceived level of responsibility that induces the negative emotional response to a loss of control over the therapy ending.

Another factor which has been shown to influence the therapist's experience of ending therapy is the therapeutic relationship (Baum, 2007). Researchers from a study investigating how therapy endings are negotiated proposed that the development and maintenance of the relationship may influence the shared decision to end therapy (Råbu,

Binder & Haavind, 2013). In another study, intensely bonded relationships between psychoanalytic and psychodynamic therapists and their clients were found to result in so-called 'proper endings' while unsettled relationships led to erratic endings (Fragkiadaki & Strauss, 2011). Of note, participants in this study reported feeling like the therapy process is never truly finished as they continued to feel an ongoing connection with their clients post-therapy. Studies such as these provide a rich understanding of how the therapeutic relationship influences the ending of therapy, including how an element of the relationship can be seen to be ongoing following termination.

Overall, the findings from these studies provide much-needed evidence of the processes involved in ending therapy from the perspective of the therapist. However, the majority of studies have either focused on therapists from a particular therapeutic framework (e.g. psychoanalytic and psychodynamic therapists; Fragkiadaki & Strauss, 2011) or concentrated on a specific type of ending (e.g. client non-attendance; Tweed & Salter, 2000), somewhat limiting the findings. Research exploring how different processes impact on different types of endings across different theoretical approaches is necessary to understand this phenomenon in greater detail.

Rationale for This Study

Research studies which have addressed the topic of endings in therapy have primarily focused on client-initiated endings, leaving the other types of ending poorly understood. From the studies described above, some factors (such as control over the ending, perceived responsibility for the ending and the strength of the therapeutic relationship) have been identified that appear to contribute to the process of ending therapy. However, the role that these factors play in different types of therapy ending needs to be explored in more detail so that clinicians can optimise the use of endings as a therapeutic tool. Clinical psychologists have been used in previous research which enabled the researchers to capitalise on a

professional group that work in a variety of settings using a range of therapeutic approaches (Tweed & Salter, 2000) and were therefore identified as an appropriate participant pool for this study.

The need for a richer understanding of the processes involved in ending therapy necessitates a qualitative approach to allow participants space to develop and consolidate their own thoughts (Krahn & Putnam, 2003). Grounded theory methodology offers the ability to engage in simultaneous data collection and analysis so that gaps in understanding can be identified and additional data collection focused using theoretical sampling techniques (Charmaz & Henwood, 2008). Moreover, grounded theory engages a constant comparison between different levels of analysis to ensure the theory is grounded in empirical evidence, yet is able to relate to well-founded theories of basic social processes. Techniques such as illustrative modelling allow for a visual depiction of how the central elements of the theory fit together (Birks & Mills, 2011) and can be used to supplement the more detailed verbal explanation. Thus, the features of grounded theory provide robust techniques for developing an understanding of the processes involved in ending therapy and therefore it was considered the most suitable methodology for this study.

Method

Ethics approval was obtained from the Research Ethics Committee at the researcher's host academic institution and approval received from ten Research and Development Trusts across the North-West of England, enabling access to a large participant pool. All relevant documentation has been included in this report (see Section Four: Ethics Section).

Design

This study adopted a qualitative, exploratory design using semi-structured interviews to explore the processes involved in ending therapy with clients from the perspective of clinical psychologists. Grounded theory methodology was specifically chosen due to the lack

of empirical research on this topic as it offers a method of constructing a theory around social phenomena which is 'grounded' in the data obtained (Creswell, 2007; Tweed & Charmaz, 2012). Although the initial aim was to develop a grounded theory, this proved not to be achievable within the constraints of the study. However grounded theory methodology was used to provide a robust exploration of the processes involved in therapy endings that might contribute towards the development of a theory.

Since its initial conception by Glaser and Strauss (1967), grounded theory has developed into a number of approaches based in differing epistemological paradigms. The social constructionist stance argues that subjective experiences and values influence the entire research process. Therefore, knowledge is viewed as constructed through the interaction between the researcher and participants rather than being seen as an objective truth devoid of context (Willig, 2012). This study was conducted predominantly from a social constructionist stance in line with the author's belief system and has therefore been heavily influenced by the work of Charmaz (2006, 2008).

Participants

The study took place in the North West of England. Out of 619 qualified clinical psychologists who were emailed information about the study, 28 expressed an interest in taking part. Specific sampling procedures were employed in line with grounded theory methodology which resulted in 11 participants being interviewed. One person was interviewed twice because she raised new information towards the end of the first interview and it was considered important to explore this in more depth. Therefore, 12 interviews were conducted overall.

Of the people who expressed an interest and were not interviewed, two were offered an interview but withdrew within a month of opting in; one moved out of the area and the other commenced maternity leave. The researcher maintained brief email contact throughout

the study with the remaining 15 individuals comprising the rest of the participant pool, and informed and thanked them when the study came to an end. Table 1 contains demographic information, using pseudonyms to protect the participants' identity.

Procedure

Data collection. Clinical psychologists were informed of the study via email, through a contact list held for research purposes by the researcher's host academic institution. Potential participants were asked to contact the researcher directly to express their interest in taking part. They were informed that an expression of interest did not mean they would necessarily be interviewed, as theoretical sampling techniques would be employed (Charmaz, 2006). Participant selection was initially led by the limited information volunteered by participants when contacting the researcher, such as their gender, the environment in which they worked (e.g. community, inpatient settings, etc.) and the types of clients they tended to see (e.g. children, older adults, etc.). Several participants were able to be selected based on their job title which reflected differing levels of experience (e.g. Consultant Clinical Psychologist). Initially, selection was based on attempts to sample from a wide variety of backgrounds.

As simultaneous data collection and analysis progressed, participants were identified who might be able to fill any gaps in the data. For example, a therapist who worked in a service offering time-limited cognitive-behavioural therapy (CBT) was selected for interview to explore endings in time-limited therapies in more detail, following participants' differentiations between these and open-ended therapies. Furthermore, one therapist from a physical health setting remarked on her experience of client deaths and therefore a participant from a similar setting was selected to explore this uncommon experience in more detail.

At the start of the interview, participants were asked to sign a consent form following an explanation of the study and an opportunity to have any questions answered. A topic

guide was used to initiate and re-focus the discussion, comprising open questions such as ‘how important do you think endings are in therapy?’ and ‘can you tell me about a time when a therapy ending did not go as well as you had hoped?’ The researcher facilitated discussion by summarising what had been said in order to encourage participants to elaborate further. Field notes written after each interview captured observations and subsequent reflections and helped to identify gaps in the data. At the end of the study, participants were emailed a short summary of findings (see Appendix 2-1).

Data analysis. Interviews took place between October 2012 and April 2013. All interviews were conducted by the researcher and their duration ranged from 53 to 96 minutes. Audio-recordings of the interviews were transcribed verbatim, anonymised, and then subjected to detailed analysis using grounded theory methodology (Charmaz, 2008; Strauss & Corbin, 1998). In this study, audio-recordings were re-played after each interview to identify potential themes to explore in subsequent interviews and in-depth analysis took place after each ‘wave’ of data collection (i.e. a cluster of interviews conducted within a short time-frame). This enabled immersion in a large amount of data at one time, allowing rapid familiarisation with the data analysis techniques specific to grounded theory.

The first wave of data collection consisted of eight interviews. Each transcript was subjected to line-by-line coding (Charmaz, 2008) and then the codes were further developed into focused codes (see Table 2 for a definition of grounded theory terms). Charmaz (2006) recommends using gerunds (i.e. action words such as ‘describing’ rather than ‘description’) when developing codes to help detect processes in the data. Focused codes were sorted into different conceptual categories and constant comparison between the different levels of data analysis (data, codes, categories and concepts) helped ensure the analysis was ‘data-driven’. Throughout this process, ideas and narratives were captured in the form of memos and

multiple diagrams were sketched to help develop the analysis and identify any areas for further exploration.

Following this detailed analysis, four more interviews were conducted (second wave) to develop the conceptual categories and the relationships between them. For example, interview 10 provided more information on the experience of ending therapy as a result of client death and added an alternative perspective on how client-initiated endings could be experienced as positive by the therapist. In a similar way, the role of self-doubt was examined in greater detail during interview 11, adding valuable information about the role of supervision and learning. It was recognised at this point, however, that the newly-obtained data were not significantly altering the core features and relationships between categories that had already been developed and the author concluded that the analysis had reached a stage of theoretical sufficiency¹ (Dey, 1999). Wider empirical evidence and theories of basic social processes were consulted to further enhance the data analysis process.

Credibility of Research

It has been argued that reflexivity is beneficial to qualitative research as it allows the author to reflect on their position within the research (Finlay, 2002; Watt, 2007). Thus, the author was employed as a trainee clinical psychologist within the National Health Service (NHS) in the UK both before and throughout the research project. Experiencing unexpected endings with clients during this time highlighted the importance of having a structured end to therapy. Based on these experiences, it was anticipated that abrupt endings would be a more difficult experience for participants compared with endings which were planned with the client.

¹ Accordingly to Dey, theoretical sufficiency refers to “the stage at which categories seem to cope adequately with new data without requiring continual extensions and modifications” (1999, p. 117). He argued that this is a more practical aim for grounded theory research compared with Glaser and Strauss’ (1967) concept of ‘saturation’.

In order to judge the credibility of the research findings, previous authors have encouraged transparency when describing the methodological process of qualitative research (Hiles, 2008; Meyrick, 2006). To this end, the procedure for data collection and analysis has been described in detail above. In addition, an audit trail of transcripts, coding and different stages of the evolving theory were created and sample extracts have been appended to this paper (see Appendices 2-2 and 2-3). To ensure accuracy of the data, interviews were audio-recorded to gain a detailed and precise account of the conversation. In addition, participants' words were used where possible when creating codes so that the resulting conceptual categories were grounded in their understanding. The author's interpretation of this was checked with participants during their interviews and a reflective journal used to highlight any assumptions and observe how the author's understanding changed over time. The process of data analysis was shaped throughout by frequent supervision sessions, with particular guidance around developing the different layers of analysis.

Findings

The aim of this study was to develop an understanding of the processes involved in ending therapy with clients. This was achieved through the identification of key processes by participants and the development of an explanation of their relationship to the ending of therapy. *In sum, the way each ending was experienced by the therapist was influenced by factors such as the context in which the therapist was working (including their own background), the therapeutic approach, their level of connectedness to the client and their level of investment in the therapy process. The therapist's perceived sense of responsibility for the ending was also critical to their experience and the learning gained from each experience of ending therapy influenced therapists' future work with clients.*

The findings have been unpacked and presented below along with an illustrative model to facilitate this explanation (see Figure 1). Additional quotes to support the analysis have been selected and are presented in Appendix 2-4.

Endings in Context

All participants in this study acknowledged that the context in which they worked impacted on their experiences of ending therapy with clients. This included both their professional and personal context. For example, some participants drew attention to the way that personal experiences of endings (e.g. relationships ending, family member dying) affected their experiences of ending in a professional role: “how I manage endings out of work life is very much, the development of that informs the way I feel about endings [at work]” (Elijah). Similarly, participants felt that their clients’ past experiences of endings played a significant role in therapy, highlighting concerns that “you don’t want to start a relationship that’s just going to end abruptly and you’re not going to get to say goodbye, ‘cos you’re just going to echo all the other experiences that they’ve had” (Alesha). Furthermore, therapists’ personal style affected their experience of ending therapy with clients as this influenced the therapeutic approach they adopted.

In terms of professional context, the therapists’ level of experience appeared to play a significant role in their endings with clients. Participants described experiencing more self-doubt when they were less experienced, wondering “why did I not predict a bit more of that and I wonder if I could have made it a bit easier for him?” (Jenny). This concept is explored in more detail below as it directly relates to the type of ending experienced by the therapist.

Additionally, the environment in which participants worked strongly influenced the therapeutic approach and the therapist’s level of investment, contributing to the experience of ending therapy. For example, some participants worked within a service that adopted a time-limited approach because of the high demand for therapy: “you have to know when to give up

and you probably have to give up sooner than you would if you had more time and money” (Sue). Others were contracted to work within certain models (e.g. CBT) which dictated the approach that could be taken.

Therapeutic Approach

Even if participants had the freedom to choose a therapeutic approach, many preferred to work within a particular model, some of which by nature resulted in time-limited therapy (e.g. cognitive analytic therapy). This meant that therapist and client had a clear idea from the start of therapy when the ending would take place, enabling them to prepare for it in advance. Even for therapies which do not specify a certain number of sessions (e.g. psychodynamic psychotherapies), some participants decided to adopt a time-limited approach because of the direct impact on the therapy ending. This was often conceptualised within an existential framework, as Sue explained: “what defines all our relationships in our lives is our existential reality and that is about ending, it is about – we’re all going to die and every relationship we’re in will end for that reason if nothing else”.

Other therapists chose to take a more open-ended approach, explaining that they could not predict how long the therapy would last. For these participants, there was an initial focus on engagement and trying to formulate the client’s difficulties. The issue of ending was then raised much later in therapy. Some participants felt it made sense to apply a time-limit to ‘goal-focused’ therapies which aimed to develop practical strategies to achieve change, but not the more ‘process-driven’ therapies which were viewed more as a journey and tended to work at a deeper level using the therapeutic relationship. The overall approach to therapy was heavily determined by what the therapist considered would suit the client best, taking into account their own personal style.

Level of Connectedness

The approach to therapy adopted by participants had a direct impact on how connected they felt with their clients as “the more emotive the content of the sessions, so the less kind of goal-focused and the more process-focused they are, the harder the ending” (Clare). Some of these experiences were reported to be very powerful. For example, Saskia recalled endings where she had been “on the brink of tears” and Natalie described her experience of abrupt therapy endings as “quite damaging for me actually, so it does make you think about how important the ending of therapy is when you’ve been in a very sort of intense relationship with somebody”.

Feeling a strong connection with clients reflected the ability of these therapists to profoundly empathise with their situation. Clare explained that “I want to feel like they feel, I want... I kind of feel like unless I’m as perplexed about the problem as they are for just even five minutes, I haven’t got it”. A few participants remarked on the desire to delay the ending of therapy if they felt strongly connected to a client, highlighting their internal struggle: “There’s something about her that makes me want to keep trying and makes me find it hard to just do what I should do and time-limit the relationship” (Sue). A lack of connection with the client could still produce a positive ending, for example when clients achieved their goals in CBT, but these types of endings were considered “cut and dried” (Elijah) and resonated less with participants.

Level of Investment

The way the client behaved in therapy influenced the level of therapist investment, such that if a client appeared to be trying hard in therapy, the therapist was likely to be more invested in the work. Sue explained that for some clients, “they haven’t engaged so you haven’t engaged with them”. Most therapists described a tendency to invest more time in the cases where they felt a connection with the client. This was a circular process whereby

increased investment tended to deepen the connection between therapist and client which fuelled further investment by the therapist. However, the level of investment did not always correlate with the level of connectedness and a few therapists described actively working harder with clients with whom they did not feel a strong connection:

If I meet a client and you don't click from the beginning there's almost like 'hmm not really comfortable with this person', I do actually make a, well I don't know if it's a conscious effort now it's probably an unconscious one now, of working harder with that person, that they wouldn't know that you didn't like them (Rachel).

Furthermore, the degree to which participants were able to invest in their work with clients was heavily influenced by their workload. Elijah described times when he thought "there's too much demand for the limited resource that I am, so how can I get people out of the service as quickly as possible?" This reflected other participants' experience whereby those who felt overwhelmed by their workload felt unable to invest as much into their work with each individual client.

Types of Endings

Participants described a number of different types of therapy endings. The findings have been separated into four main categories based on the therapist's perceived level of responsibility for the ending: therapist-initiated, collaborative, client-initiated and externally-driven.

Therapist-initiated. Therapist-initiated endings took place when the therapist decided to finish therapy against the wishes of the client. This usually occurred when the therapist did not feel the therapy was working or if continuing in therapy was expected to result in more problems for the client. For example, Dave described a situation where he was concerned about "building in a dependent relationship so I had to make a decision to say 'the therapy's going to end'". Despite holding a strong conviction that they were acting in their

clients' best interests, therapists' heightened sense of responsibility for this type of ending left them feeling like they were abandoning their clients, resulting in feelings of guilt and a sense that somehow they had failed in their role. This effect was particularly powerful for less experienced therapists.

There was also a sense of relief, as the experience of "working really hard, hardly getting anywhere" (Sue) was draining and eroded self-confidence. The feeling of relief was particularly prominent for therapists who had invested a significant amount of time and energy in the therapy. As for all types of ending, the emotional impact was greater if the therapist felt more connected with the client.

Collaborative. The ideal type of ending for most participants was described as a collaborative decision following positive change occurring within therapy. In the event of this type of ending, therapists described feeling proud of their clients and pleased with their progress. The sense of satisfaction inherent in these types of endings increased with the amount of investment from the therapist. Alongside positive emotions, participants also described a sense of sadness when ending therapy with a client with whom they felt connected. The mixed emotions described by many were summed up by Clare:

I was really proud of her, I was really proud of how far she'd come and how hard she'd worked ... but it was erm, it was a wrench I suppose and I was kind of sad that I wouldn't see her to hear about what had happened.

Elements of these emotions were clearly re-experienced on some level within individual interviews, with many of the participants smiling and becoming animated or alternatively tearful when describing their experiences.

Occasionally participants described situations where both therapist and client agreed to end therapy because of a lack of progress. The difference between this and the therapist-initiated ending was that in this situation the client agreed with the decision to end. This type

of ending tended to result in therapists feeling sad and frustrated that they were not able to promote change in the client, “because presumably we are motivated for many conscious and subconscious reasons to believe there’s been a shift or a change, that we’ve made a difference” (Ruth). Thus, the lack of progress triggered feelings of self-doubt, the extent of which was mediated by the therapist’s level of experience.

Similar to the therapist-initiated endings, some participants described experiencing a feeling of relief at this type of ending because their efforts to create change in the client and their situation had been ineffectual. The sense of letting their client down was similar to the experience of feeling like they had failed their client, differing only by the degree to which the therapist took responsibility for the decision to end therapy. This experience was mediated by the level of connection felt with the client.

Client-initiated endings. The most common client-initiated endings were ones where the client did not return to therapy. This resulted in an unexpected ending, leaving therapists confused about what had happened. This type of ending was apparently more likely to happen at the beginning of therapy, before there had been a chance to develop a therapeutic relationship or invest heavily in the work. On these occasions, therapists described feeling frustrated that the opportunity to have a planned ending had been lost, leaving the work incomplete. The fact that the therapist was unaware of the client’s decision to end therapy meant it was “harder to know at what point has the ending actually happened?” (Dave). Predominantly, though, therapists described feeling relieved in this situation as it provided them with “a free hour” (Sue) and it meant they could focus on the next client on the waiting list: “I’ll be perfectly honest, it’s a relief to kind of end and kind of think ‘well that’s one off my list’” (Saskia).

Participants reported that uncommonly a client would unexpectedly drop out of therapy after a significant number of sessions. This was a more difficult experience and

participants described “trying to figure out what the hell happened and why you didn’t see it coming” (Sue). This resulted in a period of reflection in an attempt to understand the ending, along with self-doubt about their professional abilities. As found in other types of endings, this was a more powerful reaction for less experienced therapists and those who felt strongly connected to the client or had invested significantly into the work. A client suicide elicited a similar response, however sadness and self-doubt were the dominant emotions in response to this type of ending and Rachel described ultimately being left “with a sense of failure”.

It was also possible to have a client-initiated ending as a result of positive change. Some participants expressed a desire for their clients to initiate the ending to demonstrate their move towards autonomy: “it’s got to get to the point where you just, you don’t need me anymore, you don’t want to be here” (Ruth). For others, a client’s decision to end therapy surprised them and elicited feelings of sadness. These two different reactions seemed to depend on whether the therapist agreed with the decision to end therapy. In some situations therapists were informed of their client’s decision in advance. This resulted in a less difficult ending as it provided the opportunity for therapists to prepare for it.

Externally-driven. Sometimes the responsibility for ending lay outside the control of both therapist and client. Forced endings like this were often a result of service demands or therapists leaving their jobs. Some of the participants worked in services where they were only allowed to offer a set number of sessions, following which the client had to be discharged. Others described the requirement to engage in separate phases of therapy to allow more clients access to the service. Helen described her experience of clients being unexpectedly moved between wards, acknowledging that “it can be quite frustrating when you know your experience is about how important it is to have an ending and then that’s kind of interrupted in some way or by something beyond your control”. These types of endings tended to result in clients being left with unresolved issues.

Thus, it was common in this type of ending for participants to feel like they were abandoning their clients: “with some families I feel worries about what’s going to happen to them and if they’re going to ge-, and if people are going to really understand what they need” (Clare). This was exacerbated if the therapist did not feel another service would be able to meet the client’s needs adequately. Where therapists did not feel a strong connection with the client or the therapy did not seem to be having the desired effect, participants felt relieved at no longer having to work with the client and that they were not responsible for that decision. Infrequently, participants had the experience of a client death (non-suicide related), bringing about an abrupt and uncontrollable end to the therapy. These participants described experiencing shock, immense sadness and a sense of self-doubt as they were left wondering “was something left undone?” (Rachel).

Continuing Beyond the Ending

The pressure to “have a throughput of cases” (Clare) meant many participants quickly moved on to new clients once therapy had ended. However, there were many ways in which the work and the relationship were extended beyond the final session. In a very real sense, some participants maintained direct or indirect contact with ex-clients and received infrequent updates on their progress. Dave described that one family “just like telling me what’s going on, so there’s sort of an ending that is never quite ended”. In most situations, though, what endured beyond the end of therapy was less tangible.

Participants often chose to stagger the final sessions to help the client get used to the idea of being without therapy. Many also offered a ‘safety net’, where clients could return to the service directly within six months of the ending. This overall “easing off of therapy” (Rachel) extended both the therapy and the relationship in ways that made the ending unclear:

I’ve got a client at the moment who when I took her on, no I’ve finished with her, I’ve finished with her a couple of months back, no I haven’t I’ve still got one, you see

that's how tenuous it is I don't feel like I'm still in a relationship with this woman (Sue).

Nearly all therapists described writing a letter following the end of therapy to inform clients that they had been discharged from the service. For those who had engaged in more relational therapies, a therapeutic letter was often written which required a greater investment than the standard summary of therapy and reflected participants' views that the type of ending should "fit like a glove" (Elijah) with the therapeutic approach. However, some therapists described being more likely to write a therapeutic letter to clients with whom they felt more connected.

The letter provided clients with a memento of therapy; something to keep that they could refer to in the future to "charge themselves up again" (Elijah). Thus, it was hoped that the therapeutic journey could continue without the physical presence of the therapist through the learning that clients had gained: "if you're a good enough springboard, they'll get a pretty good jump out of it and then they can carry that on themselves" (Sue). Therapists also held residual memories of the therapy as they too internalised aspects of the client in the form of learning. Dave reported that one client had taught him "about overcoming difficulty or pain" and others described how they continued to learn from clients after therapy had ended: "sometimes in supervision I will take somebody that I've finished with" (Jenny). Dave was noticeable in that he ritually scheduled time alone following the final session with a client to reflect on the entire process of therapy. His decision to do this was based on a belief that "the work was too important to just dismiss".

Each experience of ending therapy with a client added to the therapist's overall experience of endings and shaped the context in which they worked: "the very next person you see, you've got that learning to take straight in" (Dave). This influenced both the therapeutic approach and the level of investment in work with future clients. As more client

endings were experienced over time, the more experienced (in a professional sense) therapists became, allowing them to make sense of each ending in light of their previous experiences.

Discussion

The findings from this study show the processes involved in ending therapy with clients and how they relate to different types of therapy endings. The use of grounded theory methodology enabled each of the processes to be identified and explored in detail, producing key elements which could contribute to a theory of how clinical psychologists experience the end of therapy with clients. This study is unique as it examined different types of therapy endings from the perspective of therapists working within different therapeutic settings and approaches. The empirical evidence provided by this study therefore offers a significant contribution to the existing knowledge base on therapy endings, highlighting in particular the major roles played by the therapeutic relationship, feelings of professional self-doubt and the therapist's perceived level of responsibility for the ending.

The therapeutic relationship is considered crucial in the therapeutic process as it supplies the vehicle through which change occurs (Cooper, 2004; Horwitz, 1974). This study provides evidence to suggest it is also an important factor in how the therapy ending is experienced. Feeling more connected to a client resulted in a stronger emotional response from the therapist at the end of therapy. This indicates the development of an emotional bond between therapist and client, echoing work by Bordin (1979) on the therapeutic alliance. Some participants reported that they were at risk of delaying the ending of therapy if they felt strongly connected to a client. Others had maintained contact with clients after the end of therapy or asked colleagues who were still working with them for regular updates, highlighting some of the ethical issues generated by therapy endings. There is some evidence to suggest that therapist attachment style is likely to influence the end of therapy (for a review

of the available literature, see Rutishauser and Rovers, 2010), however it was not possible to explore its role in the current study.

Participants reported that there was little opportunity to process the intense emotions associated with therapy endings and repeated experiences of this kind could have a detrimental effect on therapists' emotional well-being and interaction with future clients. For example, it has been argued that failing to process negative emotions can contribute to dysfunctional behaviour such as the inappropriate expression of emotions that are out of context or proportion, general feelings of irritability and an inability to concentrate on the task at hand (Rachman, 1980). Additionally, new research shows that repeated exposure to emotional events results in a desensitization bias which could impact on therapists' ability to empathise with their clients' experiences of ending therapy (Campbell, O'Brien, Van Boven, Schwarz & Ubel, 2014).

One aspect of therapists' emotional response to endings which played a particularly significant role was their sense of self-doubt. Indeed, therapists who were less experienced reported heightened levels of professional self-doubt when ending therapy with clients. This supports findings from previous research with social work students (Baum, 2006) and evidences a similar trend in the clinical psychology profession. Participants in this study highlighted the limited exposure for students and trainees to different types of endings due to their placement requirements determining the end point of therapy. This produced an unanticipated and steep learning curve for many post-qualification.

A further finding of this study was the powerful influence of therapists' sense of responsibility for the ending, which impacted on the type of ending that was experienced and the therapist's emotional response. Endings where the therapist had little or no control (such as client-initiated and externally-driven endings) generated feelings of sadness, self-doubt and worry. This finding has been demonstrated in previous research (Baum, 2006, 2007) and

contributes to the evidence showing that a perceived lack of control over one's environment is detrimental to psychological well-being (Michie, 2002; Seligman, 1975). However, this study extended previous findings in that this reaction appeared to be mediated by therapists' sense of responsibility. Thus, participants reported experiencing positive emotions (e.g. relief) despite their lack of control over the ending because they did not feel responsible for the decision to end therapy. Conversely, when participants felt a greater sense of responsibility for the ending, they reported a more negative emotional response (e.g. feeling like they had failed in their role).

Recommendations for Clinical Practice

A striking finding of this study was the sheer intensity of the work that therapists were undertaking. In fact, participants' reports were found to echo the three main elements that comprise burnout, defined as "overwhelming exhaustion; feelings of frustration, anger and cynicism; and a sense of ineffectiveness and failure" (Maslach & Goldberg, 1998, p. 63). Therefore, adaptations to clinical practice are essential for the continued well-being and efficiency of the clinical psychology profession.

In response to the study findings, clinicians are urged to create opportunities for processing the emotions associated with ending therapy. Where possible, planning and preparing for the ending with clients is strongly recommended. Early explanations to clients about the importance of having a planned ending and promoting an open and honest environment where they can raise concerns could potentially reduce the number of abrupt client-initiated endings. Additionally, allocating time for personal reflection immediately after ending therapy with a client should be encouraged. This technique was employed by a participant in this study and reflects work by Bateman and colleagues on *mentalising* (Allen, Fonagy & Bateman, 2008). Therapists may also find it helpful to explore how their own personal and professional experiences of endings could influence the process in therapy.

Previous authors have recommended the use of personal therapy for therapists (Tweed & Salter, 2000) and this recommendation is echoed here to help ensure the ending is of maximum benefit to the client.

Establishing a good support network is also likely to foster resilience and protect against burnout (Dyrbye et al., 2010). Participants in this study highlighted the usefulness of the interview process for consolidating their experiences and reflections on ending therapy, implying this need had not been met previously. Therefore, allocating time during clinical supervision or, moreover, establishing regular peer support groups to discuss experiences of ending therapy would be beneficial. A group would provide an opportunity to learn more about endings in therapy from others' experiences, informing future clinical practice. Peer support groups for newly qualified professionals in particular have been recommended previously (Deeley, Donoghue & Taylor, 1998) and could be used to foster confidence-building by highlighting examples of 'good' or ideal endings.

Other strategies to reduce the powerful sense of self-doubt reported by less experienced therapists could involve conceptualising the process of therapy (including the ending) as a shared responsibility between the therapist and client. Participants who adopted this view did not appear to experience as much self-doubt as those who claimed more responsibility for the ending. Additionally, many participants described learning to accept the notion of 'good enough' therapy as they became more experienced which served to counter their sense of abandoning or letting down their clients. Finally, raising awareness during training of the different types of therapy endings and the processes influencing them could help to smooth the transition from trainee to qualified practitioner. Increasing therapists' understanding of the ending process early in their career may serve to reduce their sense of self-doubt and provide tools to manage endings in a therapeutic way.

Limitations and Recommendations for Future Research

Purist grounded theory studies demand more time and resources than were available for this project; hence some of the techniques were adapted, such as engaging in waves of data collection and analysis. Upon initiation of data collection it became apparent that the scope of the project was too wide and therefore it was not possible to fulfil the aim of producing a substantive grounded theory. With this in mind, the current findings are presented as key elements that could contribute to a theory of endings. Future research may wish to focus on each of these elements in more detail (for example the role of therapist self-doubt) thereby contributing additional knowledge to an overall theory of endings in therapy. Engaging in a thorough literature review of the topic area prior to initiating the project would also have been helpful to develop an understanding of previous research findings and use them alongside data generated in the current study to guide theoretical sampling procedures.

In an attempt to sample a group of professionals who could offer insights from different theoretical perspectives, this study specifically recruited clinical psychologists. Despite significant overlap, it is important to distinguish between different professions due to their specific training programmes and professional cultures, potentially leading to alternative understandings of therapy endings. Therefore it would be beneficial for future research to explore endings in other professional groups and identify both specific and generic concepts.

One potential limitation of this study was the researcher's role as a trainee clinical psychologist. This may have introduced a conflict for interviewees, who were all qualified clinical psychologists, between honestly exploring their emotional reactions to endings and aspiring to maintain a level of professionalism in front of a less experienced colleague. Indeed, one participant reflected on this dynamic in interview and wondered how her responses may be viewed by the interviewer. Thus, future research would benefit from attempts to access experiences that may not be seen as socially desirable, such as using

separate individuals to interview and analyse data or engaging in telephone or computer-mediated interviews (for a discussion of the advantages and disadvantages of different types of interview technique, see Opdenakker, 2006).

Finally, this study was only able to focus on one perspective: that of the therapist. Research has shown that client-therapist dyads do not necessarily share the same experiences of ending therapy (Hunsley, Aubry, Verstervelt, & Vito, 1999; Westmacott, Hunsley, Best, Rumstein-McKean, & Schindler, 2010) and therefore future research involving clients is crucial. Following on from this study, a grounded theory approach aiming to explore the processes involved in ending therapy from a client's perspective would enable a richer understanding of therapy endings to be developed.

Conclusion

Despite its significance, the ending phase of therapy has received limited interest as a focus for research. The aim of this study was to develop a deeper understanding of the processes involved in ending therapy with clients. Using grounded theory methodology, elements which could contribute to a theory of therapy endings from the perspective of qualified clinical psychologists were identified and their relationships explored.

The findings highlight the complex nature of therapy endings, showing how they are influenced by the therapeutic approach, the level of connectedness between the therapist and client, and the investment of the therapist. Descriptions of different types of endings produced four categories based on the therapist's perceived level of responsibility: therapist-initiated, collaborative, client-initiated and externally-driven. The analysis presented in this paper explains how each process contributes to the different types of ending and the experience of the therapist. Finally, the role of learning was explored and how it impacts on future experiences of ending therapy.

This study provides a unique contribution to the understanding of endings in therapy. It is hoped that it will influence how therapists think about endings, promoting more awareness of how their actions and decisions throughout therapy will impact on the ending phase. Recommendations for clinical practice include the initiation of a peer support group and protected reflection time following the ending of therapy, as well as an appeal for training courses to focus adequate attention on the topic of endings in therapy. In addition, it is hoped that this study will spark renewed interest in researchers to further the empirical evidence available to clinicians, thereby encouraging the application of evidence-based practice.

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Table 1

Demographic Characteristics of Participants

| Pseudonym | Gender | Service context / client group | Main therapeutic approaches |
|----------------------|--------|---------------------------------------|---|
| Sue | Female | Adult Secondary Care | Psychodynamic and CBT |
| Alesha | Female | Looked After Children | CBT, DBT and interpersonal |
| Elijah | Male | Child and Adolescent Mental Health | CBT and systemic |
| Saskia | Female | Children and Adolescent Mental Health | CBT, solution-focused, narrative, interpersonal |
| Clare | Female | Child Learning Disabilities | Systemic, solution-focused, narrative |
| Natalie | Female | Adult Learning Disabilities | Psychodynamic and systemic |
| Rachel (Interview 1) | Female | Adult Physical Health | Cognitive approaches and mindfulness |
| Rachel (Interview 2) | Female | Adult Physical Health | Cognitive approaches and mindfulness |
| Helen | Female | Adult Forensic | CAT |
| Ruth | Female | Adult Physical Health | ACT |
| Jenny | Female | Adult Primary Care | CBT |
| Dave | Male | Adult Secondary Care | Psychodynamic and CBT |

Note. CBT = cognitive behaviour therapy; DBT = dialectical behaviour therapy; CAT = cognitive analytic therapy; ACT = acceptance and commitment therapy

Table 2

Terminology Associated with Grounded Theory Studies

| Grounded theory term | Definition relevant to this study |
|----------------------|---|
| Data | All the material produced as a direct result of interviews e.g. audio-recordings, transcripts, codes, memos, illustrative models, etc. |
| Initial code | Captures a segment of data e.g. words, a sentence, an idea, etc. |
| Focused code | Derived through initial-coding, focused codes explain a larger segment of data e.g. a concept, a paragraph, etc. |
| Category | Focused codes which cluster together to create an overriding, more abstract concept |
| Concept | The most significant categories are chosen to represent the main concepts of the theory |
| Memo | A narrative explaining each category and how they relate to other categories in the theory |
| Substantive theory | A theoretical interpretation or explanation of a specified phenomenon |
| Illustrative model | A visual representation of the main concepts in a substantive theory and how they relate together. Models are used to support the presentation of a theory but are not explanatory on their own |

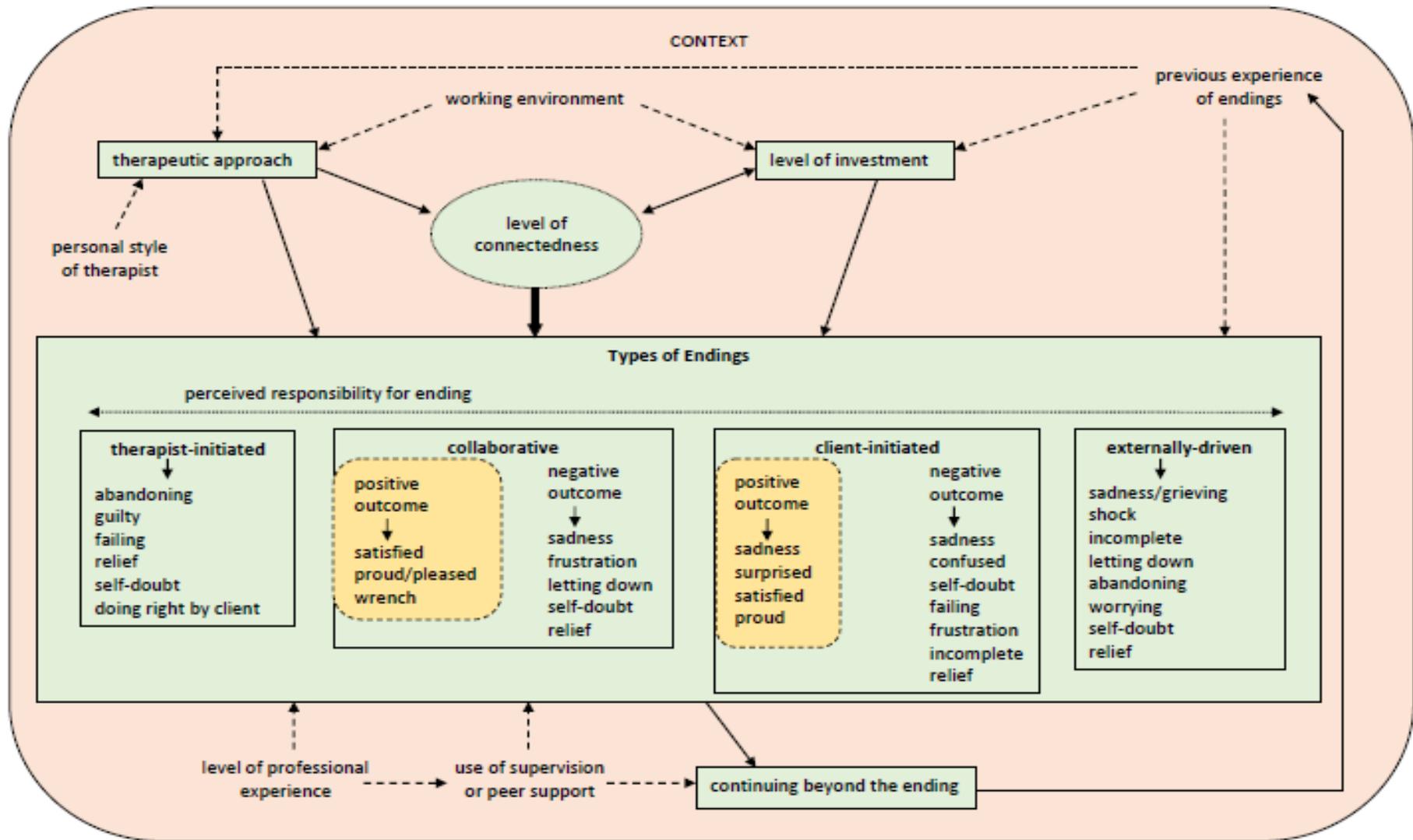
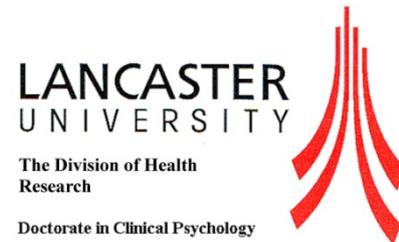


Figure 1. Illustrative model of the processes involved in ending therapy with clients.

Appendix 2-1: Summary of Findings for Participants

**Constructing the Processes Involved in Ending Therapy with Clients****SUMMARY OF FINDINGS****What was the study about?**

The aim of this study was to develop a deeper understanding of clinical psychologists' experiences of ending therapy with clients. Using a grounded theory approach, individual, semi-structured interviews were used to identify the main processes involved in ending therapy and how they relate to different types of endings.

What did we find?

Findings demonstrated the complex nature of the ending, identifying the role of multiple factors which influenced the ending experience. These included the context in which therapists worked, the therapeutic approach adopted, the level of connectedness between therapist and client, and the amount invested in the work by the therapist. The therapist's perceived responsibility for the ending also had a pivotal impact on how the ending was experienced and different types of ending were categorised to portray this i.e. therapist-initiated, collaborative, client-initiated and externally-driven. Participants reported experiencing a variety of emotional reactions to different types of endings, some of which were particularly intense, however little time was available to process these emotions. Elements of the therapy process appeared to remain with participants after the end of therapy in the form of memories and learning, and served to influence future work with clients.

How is this information helpful to clinicians?

Therapists may be able to work with the ending in therapy to prevent clients from re-experiencing traumatic endings and potentially maximise therapeutic gains. However, the findings from this study suggest that therapists are at risk of burnout as a result of their experiences of ending therapy with clients. Therefore, it is recommended that opportunities to process the emotions associated with ending therapy are created, such as organising peer support groups and engaging in protected reflection time. Peer support groups may be particularly helpful for less experienced therapists who reported a strong sense of self-doubt regarding the endings they experienced. Raising awareness and increasing understanding early on in training about the processes involved in ending therapy with clients may also serve to protect therapists against the significant impact of these experiences.

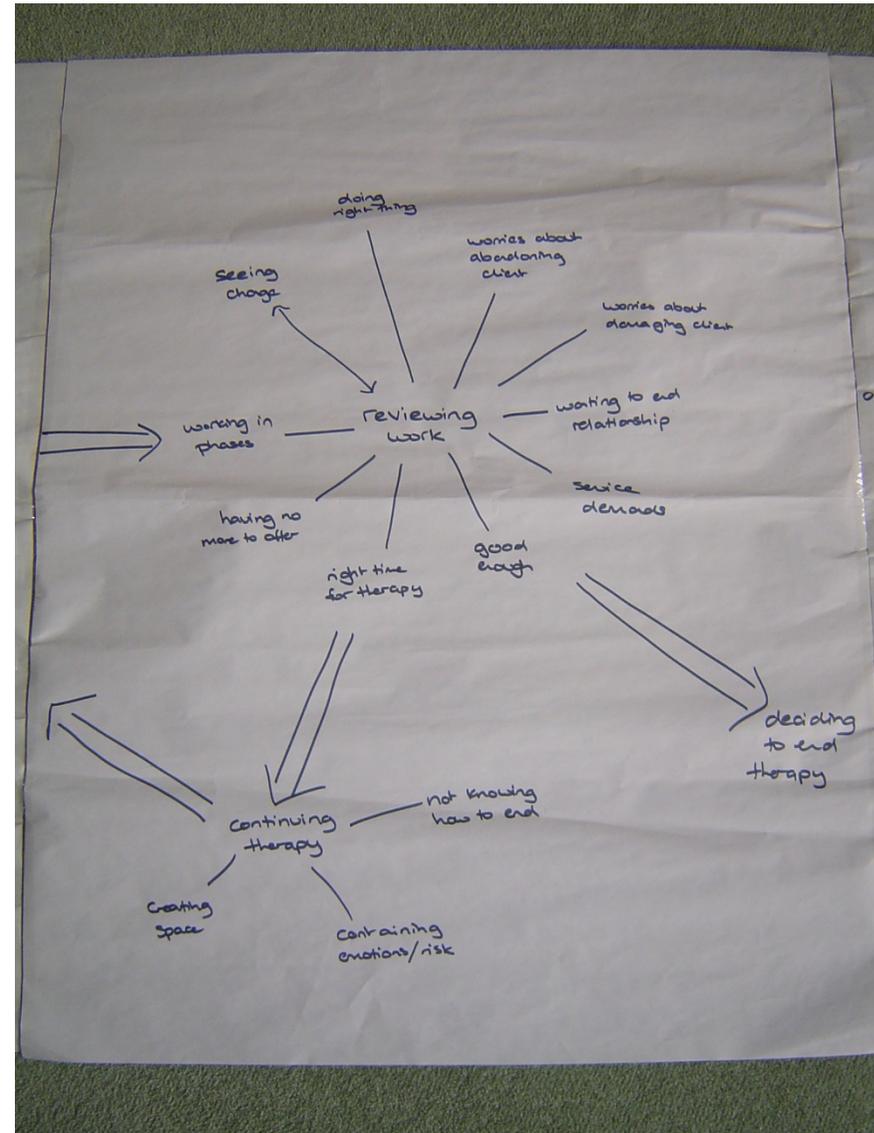
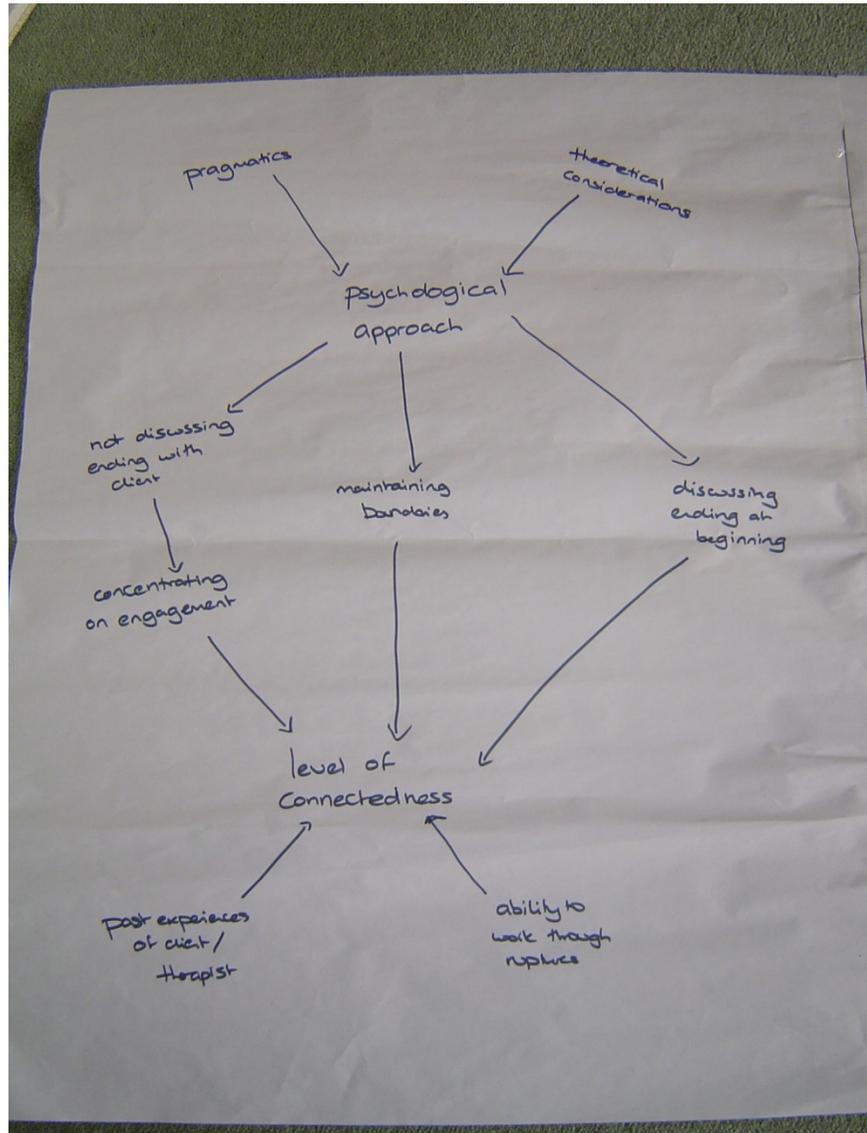
Thank you to all those who took part in this study.

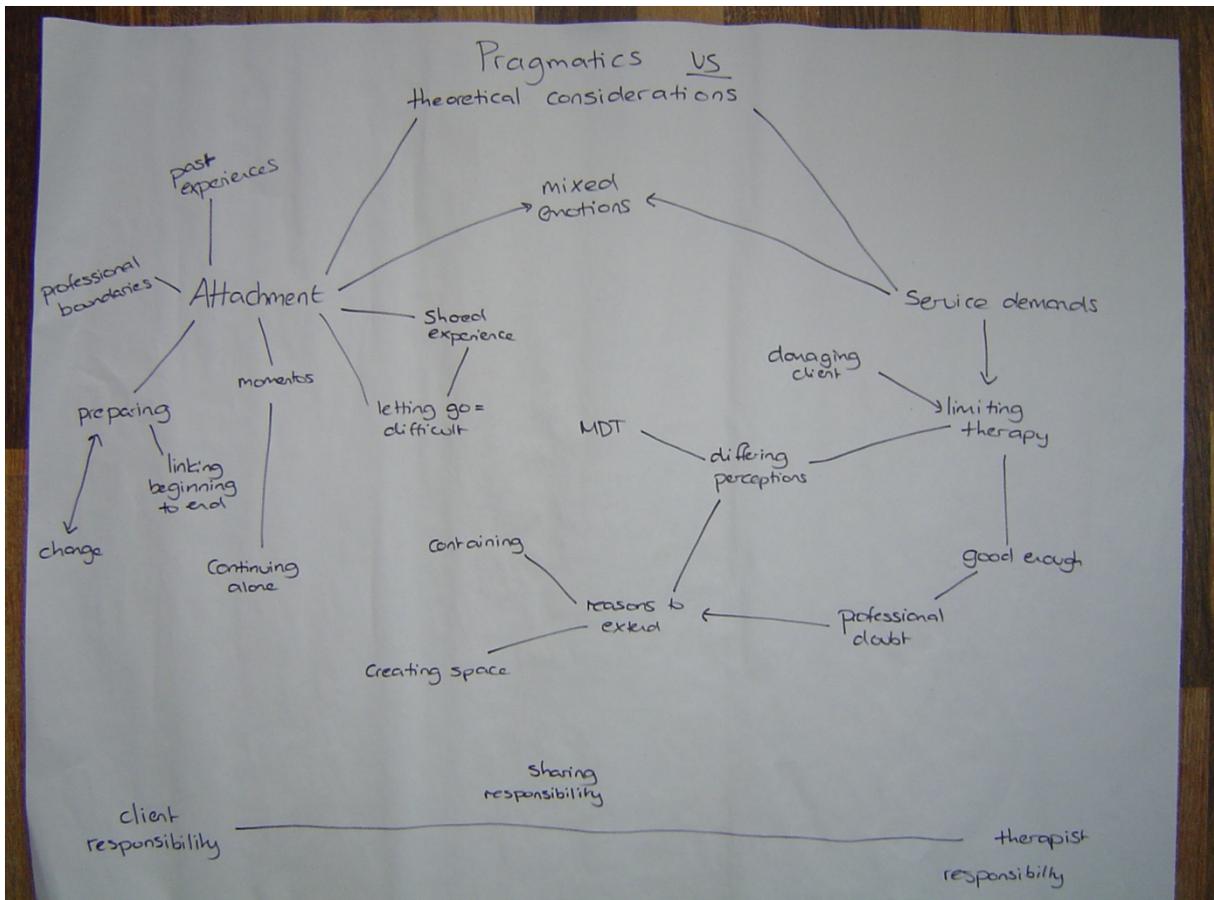
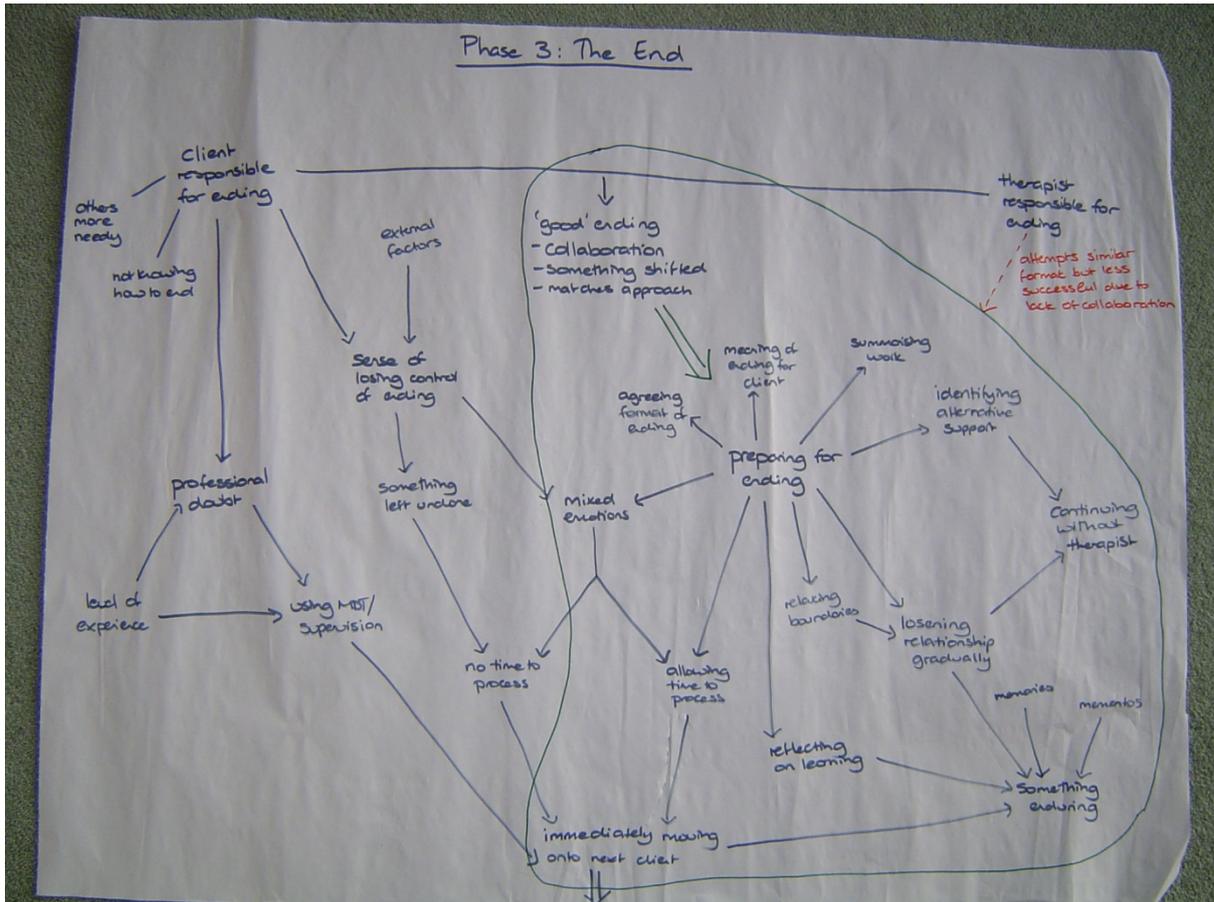
Appendix 2-2: Coding Extract

| | Initial coding | Summary and Focused coding |
|---|---|--|
| <p>Yeah and that’s interesting to think about when it comes to boundaries. And does, I mean do you think there’s something about boundaries impacting on endings or…?</p> <p>I think for that lady there was because there was something about professionalism, there was something about she had come from a professional background and I think that meant a lot to her you know, that erm, about linked to her self esteem, identity and everything but I think even I suppose with other people that when I said earlier on about ‘friendship’, that idea of what friendship is, erm I mean I’ve always been really clear... not that, I was going to say anybody ever has said “do you want to meet for a cup of coffee?”, but that just wouldn’t happen, I think once or twice, or... it has happened that often once or twice I have met someone in a shop or something and each time they’ve approached me and obviously it’s sort of taken me by surprise cos I’ve kind of thought “oh I know them but I can’t figure it out where they’re from” because you see so many patients... and I think on one occasion actually this man started to talk to me about his wife and stuff and I had to really say “look we’re in the middle of Waterstones” you know, very quietly, very very quietly, so nobody could hear and I had an appointment with him the following month anyway so, but that’s interesting isn’t it, what those boundaries are. I suppose in a sense then, it’s really our responsibility isn’t it then, I think maybe to take responsibility for what those boundaries are, that it’s we, well my view is</p> | <p>Boundaries impacting on endings</p> <p>Coming from professional background Meaning a lot to client Linking to self-esteem</p> <p>Clarifying relationship</p> <p>Not crossing obvious boundaries</p> <p>Meeting client in shop</p> <p>Approaching therapist Taking by surprise Difficulties recognising client Seeing many patients Talking about wife Recognising environment is inappropriate Not allowing others to hear Having appointment soon Reflecting on boundaries</p> <p>Taking responsibility for boundaries</p> <p>Guiding clients</p> | <p>Boundaries impacting on endings</p> <p>Clarifying relationship</p> <p>Not crossing ethical boundaries</p> <p>Recognising behaviour is inappropriate</p> <p>Taking responsibility for boundaries</p> |

| | | |
|---|--|--|
| <p>we're the guiding... cos I suppose sometimes clients don't really know do they? They come into touch with doctors all the time and nurses and maybe physio's but they don't come in touch with psychologists and they don't quite know we behave in a way that is in a sense warmer than, that sounds a bit of a generalisation but, cos I'm sure that nurses are very warm but we talk about more personal things and presumably give them a sense that they're understood and so you can see how they would say "oh I like this person, I might keep in touch with this person. They make me feel good about myself or they help me understand things a bit better" and how it might be hard if you've not really got that in your life to not want to let go... but I think, and I suppose that was one of the interesting things about your research about thinking of it as something we as psychologists I feel we think about, you know to be aware of this idea about endings and... I suppose for me it's often about control, I don't mean that about controlling the person, but just about keeping things in their place and having a sense of things and doing your job properly and really abiding by codes of ethics, but maybe because I'm so keen to be doing the right thing maybe sometimes not having that time to reflect on what it feels like around, you know I sometimes don't think 'what does it feel like?', I must do it sometimes of course but not always time to think that. And I suppose even, because then you have to be very honest with yourself don't you to say "I didn't like that person anyway, I'm glad I'm not seeing them anymore" or "that is sad" or... and then acknowledging that actually you're missing them yourself.</p> | <p>Not knowing 'rules' Experiencing medical staff</p> <p>No experience of psychologists Behaving warmer Generalising in professions Talking about personal things</p> <p>Feeling understood Wanting to maintain contact Making me feel good Helping me understand Finding it hard Not wanting to let go Finding research interesting Reflecting on endings Being aware of endings</p> <p>Sense of control Keeping things in place</p> <p>Doing job properly Abiding by ethics codes Eager to do right thing No time to reflect Recognising emotions</p> <p>Being honest Liking person affecting feelings at end Not liking person – relief Acknowledging experiences Missing clients</p> | <p>Clients not knowing 'rules'</p> <p>Talking about personal things</p> <p>Feeling understood</p> <p>Finding it hard to let go</p> <p>Being aware of endings</p> <p>Having sense of control</p> <p>Doing job properly</p> <p>Acknowledging feelings</p> <p>Liking client affecting feelings at end</p> |
|---|--|--|

Appendix 2-3: Evolution of the Data Analysis





Appendix 2-4: Additional Quotations to Support Data Analysis

| Process | Participant | Line in transcript | Quotation |
|----------------------------------|-------------|--------------------|--|
| Context | | | |
| Previous experience of endings | Sue | 170 | I think for a lot of the people we actually work with, a lot of the people have quite profound attachment difficulties which are about ruptured relationships of some kind, relationships that have ended in a difficult way. |
| | Clare | 865 | ...in the grief and loss work that I do and, that has a lot of parallels with my own losses. |
| | Natalie | 459 | In my personal life I have experienced quite a few traumatic abrupt endings which have been horrific and I think because of that personal experience I'm acutely aware of how difficult that can be, how damaging that can be and how it can take a long time to get over that, so that influences how I approach ending as well so you bring your personal stuff into it. |
| | Helen | 105 | ...a lot of that work was with people who'd, you know had terrible experiences of loss and trauma and often my caseload was the people who'd tried to commit suicide, so endings always kind of a big issue there. |
| Personal style of therapist | Elijah | 767 | I certainly think the way I feel inside about an ending would be informed by my personal style and kind of what buttons it presses. |
| Level of professional experience | Rachel | 1033 (interview 1) | I suppose over the years I've adjusted my view of a good ending according to where the person's at so I think initially I probably had higher expectations of endings. |
| | Jenny | 732 | I think I've relaxed as a therapist into the interpersonal stuff which has allowed me to kind of, the interpersonal stuff to kind of, to experience it more rather than me thinking about 'right what techniques shall I use next?', it's given me the freedom to go with feelings so I've definitely started using endings as a much more important... probably <i>the</i> most important or one of the most important bits really. |
| | | 820 | ...the self-doubt or the fact that you think you might have failed somebody, you could have done it better or you didn't see someone long enough, and there's so many judgement calls you make in therapy ... and that's why you remember the difficult ones more as well I guess. |
| Working environment | Sue | 22 | Across the country we've got lengthy waiting lists so in order to manage those we kind of ration what we give people. |
| | Natalie | 318 | Certainly I feel like sometimes the decisions I make are around the fact that there's a p-, feeling like this huge pressure of a waiting list behind me and they aren't the right decisions I think to be making an ending decision around therapy. |

| | | | |
|-------------------------------|--------|-------------------|---|
| | Helen | 131 | I've had to sort of plan how the work would be around what the criminal justice system wants for him. |
| Therapeutic approach | Sue | 98 | ...it's a conversation that begins at the beginning of therapy, it's almost like I'm having that conversation out loud with my clients to help formalise it for me as well as to help formalise it for them, that there is, the clock is ticking on the therapeutic relationship. |
| | Saskia | 707 | If the, more of the approach is about process-stuff and more about transference and interpersonal stuff then yeah, I think the ending's going to be more, it's going to be bigger and more important whereas if the focus is more on perhaps something like CBT of kind of solution-focused stuff or narrative stuff and it's less about the feelings that exist between me and the client then I think that would probably be easier and lend themselves probably better to endings. |
| | Clare | 695 | I suppose in essence when the family come, they don't know when the work is done because they don't really know where they're going to go, I don't know where they're going to go. |
| | Dave | 150 | If I feel like I might just be banging through three months or four months of CBT, it's easy just to finish, it's much more structured and the nature of the relationship, the personal rapport between the two people ... it feels less personal to me. |
| Level of connectedness | Alesha | 588 | I think that was one of the endings that I can remember that I was quite sad that we're not working together anymore cos I liked her. |
| | Clare | 217 | You've got to know them so well generally, you've got to know them to the core of who they are, yeah that's... that's harder to say goodbye to. |
| | Rachel | 770 (interview 2) | I remember having the thought 'oh if I'd met this woman in a different situation she would have been a really nice friend'. |
| | Jenny | 437 | ...with some people, I might give them a second chance or a third chance, that's another thing I need to think about in supervision, what is it I'm doing here? Am I rescuing this person, have they charmed me into wanting to give them a second chance, whereas with somebody else that I don't like for example, would I just discharge them straight away and go 'phew!'? |
| | Dave | 916 | So it's that sense of, just that feeling that you've got about the sessions and about the person and the honesty about it, you know whether you like them, whether you dislike them, whether you can't stand the sight of them or whether you're attracted to them, it's just being honest about the fact that you're sharing space with another human being and that you're going to have feelings towards that person. |

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| Level of investment | Natalie | 752 | There's something about the amount of time I invest in people so if I'm invested so many years of my energy into working with people it's nice to know how they're doing. |
| Types of endings Therapist-initiated | Sue | 190 | I think it's very important to say to my clients "I will leave you. I will absolutely end this relationship, but what I'm going to do is I'm going to make, do everything in my power to let you know about that. There'll be lots of warning. |
| | Clare | 260 | ...sometimes I go into them thinking 'God, this is going to be hard' and so I might dread them and then be glad when they're over and then when I'm finishing the work with them be quite relieved that it's done because it is, it takes it's toll. |
| | Rachel | 213 (interview 2) | ...who ultimately takes responsibility for the ending maybe needs to be the therapist because in actual fact if we as therapists thought actually that we really had done all the work here ... it wouldn't seem ethical to allow the client to say 'well actually I'd rather just stay with you'. |
| | Dave | 224 | It's whether it's her choice, whether it's my choice will dictate how that goes cos it could end very badly if it's me turns round and says 'I think we're done', if she turns round and says 'I don't' and that's where I get into pickle with people cos it's a disagreement about finishing. |
| Collaborative | Natalie | 858 | Therapy's very much about the person bringing their emotions to you isn't it and you containing that and holding that and helping the person with that but <i>ending</i> affects both people in that relationship. |
| | Ruth | 339 | That wasn't a positive ending as in there weren't any positive changes ... but we were agreed that we c-, you know there was no point in them carrying on seeing them on a weekly basis forever more. |
| | Jenny | 562 | Collaboration is important because it's a signal really that, even if the ending isn't what, or the outcome isn't what they wanted, there's an acceptance of both of us. |
| Client-initiated | Sue | 799 | It's lovely when they say it, it's reassuring for me, but also it's giving them the reigns and I <i>think</i> that might be quite powerful because in a way that's a communication which says 'I don't need to tell you anymore'. |
| | Elijah | 454 | ...there's relief in certain cases, but in certain cases it's disappointment or maybe sadness because you could kind of think 'if they would have kept coming, their life would be so different' um and then maybe kind of sadness from that point of view, but then maybe 'did I miss the point, how was I not on the same page as them when they were here?'. |

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| | Helen | 203 | Well people who don't say like, don't turn up for the last session in the community, even though they've engaged quite well, sometimes you don't always get to find out why, but sometimes it's because the ending is painful even when it's planned for and seemingly acknowledged. |
| | Dave | 502 | ...the family stopped attending the last couple of appointments and they just sort of dropped off the radar completely and very much as if they couldn't tolerate the end of the work and chose not to have the ending. |
| Externally-driven | Alesha | 276 | I think that the level that we get involved in at, the difficulties are such that it is threatening the placement so endings aren't particularly within our control, the child's control. |
| | Saskia | 309 | It's reminded me of what a relief it was at times during my training when you came to the end of your six months and you were able to kind of hand it, everything over to somebody else and kind of like wipe the slate clean. |
| Continuing beyond the ending | Sue | 487 | ...to all intents and purposes it's over, but it's not over because they know they can still see you. |
| | Alesha | 243 | It's hard with a lot of cases cos you think well I'll just review in a month and they come back and there's all sorts of other problems and you never kind of, your ending isn't clear then. |
| | Elijah | 272 | I've had endings where the door slams in the face and the gentle endings where the door closes slowly and maybe they're closing the door with you, but this is another type of ending where they know they can reopen it when they need to. |
| | | 328 | Because encapsulated in that letter is all the emotion and the journey and the reflectiveness of the sessions that we've had so if the person can take that away with them then it's the case of, it's almost kind of therapy outside [service]. |
| | Saskia | 129 | You know they're not fixed and they might never be completely fixed and that's not our job to completely fix people I guess, it's to help them on their way but there's a lot of work families need to do themselves. |
| | Ruth | 246 | ...for years now it's been standard procedure to copy patients into all correspondence isn't it, so he will receive a copy of my report and actually, is that then the ending? |
| | Dave | 586 | It wasn't the ending of his journey if you like, it was the start of a new one, it was the ending of the need to have therapy in order to live. |
| | | 895 | ...so there's the ending of the relationship, the ending of the therapy and then there's my personal ending with that piece of work so it gives me that in a way, and that's the learning. |

Appendix 2-5: Author Guidelines

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Reference style . The APA system of citing sources indicates the author's last name and the date, in parentheses, within the text of the paper.

A. A typical citation of an entire work consists of the author's name and the year of publication .

Example: Charlotte and Emily Bronte were polar opposites, not only in their personalities but in their sources of inspiration for writing (Taylor, 1990). Use the last name only in both first and subsequent citations, except when there is more than one author with the same last name. In that case, use the last name and the first initial.

B. If the author is named in the text, only the year is cited .

Example: According to Irene Taylor (1990), the personalities of Charlotte. . .

C. If both the name of the author and the date are used in the text, parenthetical reference is not necessary .

Example: In a 1989 article, Gould explains Darwin's most successful. . .

D. Specific citations of pages or chapters follow the year .

Example: Emily Bronte "expressed increasing hostility for the world of human relationships, whether sexual or social" (Taylor, 1988, p. 11).

E. When the reference is to a work by two authors, cite both names each time the reference appears .

Example: Sexual-selection theory often has been used to explore patters of various insect matings (Alcock & Thornhill, 1983) . . . Alcock and Thornhill (1983) also demonstrate. . .

F. When the reference is to a work by three to five authors, cite all the authors the first time the reference appears. In a subsequent reference, use the first author's last name followed by *et al* . (meaning "and others") .

Example: Patterns of byzantine intrigue have long plagued the internal politics of community college administration in Texas (Douglas *et al* ., 1997)
When the reference is to a work by six or more authors, use only the first author's name followed by *et al* . in the first and all subsequent references. The only exceptions to this rule are when some confusion might result because of similar names or the same author being cited. In that case, cite enough authors so that the distinction is clear.

G. When the reference is to a work by a corporate author, use the name of the organization as the author .

Example: Retired officers retain access to all of the university's educational and recreational facilities (Columbia University, 1987, p. 54).

H. Personal letters, telephone calls, and other material that cannot be retrieved are not listed in References but are cited in the text .

Example: Jesse Moore (telephone conversation, April 17, 1989) confirmed that the ideas. . .

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Examples:

- List two or more works by the same author in order of the date of publication: (Gould, 1987, 1989)
- Differentiate works by the same author and with the same publication date by adding an identifying letter to each date: (Bloom, 1987a, 1987b)
- List works by different authors in alphabetical order by last name, and use semicolons to separate the references: (Gould, 1989; Smith, 1983; Tutwiler, 1989).

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Book

Paloutzian, R. F. (1996). *Invitation to the psychology of religion* (2nd ed.). Boston: Allyn and Bacon.

Book with More than One Author

Natarajan, R., & Chaturvedi, R. (1983). *Geology of the Indian Ocean* . Hartford, CT: University of Hartford Press.

Hesen, J., Carpenter, K., Moriber, H., & Milsop, A. (1983). *Computers in the business world* . Hartford, CT: Capital Press. and so on.

The abbreviation *et al.* is not used in the reference list, regardless of the number of authors, although it can be used in the text citation of material with three to five authors (after the initial citation, when all are listed) and in all parenthetical citations of material with six or more authors.

Web Document on University Program or Department Web Site

Degelman, D., & Harris, M. L. (2000). *APA style essentials* . Retrieved May 18, 2000, from Vanguard University, Department of Psychology Website: http://www.vanguard.edu/faculty/ddegelman/index.cfm?doc_id=796

Stand-alone Web Document (no date)

Nielsen, M. E. (n.d.). *Notable people in psychology of religion* . Retrieved August 3, 2001, from <http://www.psywww.com/psyrelig/psyrelpr.htm>

Journal Article from Database

Hien, D., & Honeyman, T. (2000). A closer look at the drug abuse-maternal aggression link. *Journal of Interpersonal Violence*, 15 , 503-522. Retrieved May 20, 2000, from ProQuest database.

Abstract from Secondary Database

Garrity, K., & Degelman, D. (1990). Effect of server introduction on restaurant tipping. *Journal of Applied Social Psychology*, 20, 168-172. Abstract retrieved July 23, 2001, from PsycINFO database.

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Section Three: Critical Appraisal

Developing an Epistemological Stance through Conducting Research

Rosie Noyce

Doctorate in Clinical Psychology

Division of Health Research

Lancaster University

The aim of the research study was to develop a deeper understanding of the processes involved in ending therapy from the therapist's perspective. A grounded theory approach was adopted which involved conducting semi-structured interviews with 11 theoretically-sampled participants and analysing the data according to grounded theory techniques. The resulting theory explained the influence of multiple factors on the experience of ending therapy, including the context in which the therapist worked, the therapeutic approach that was adopted, the level of connectedness between therapist and client, and the amount the therapist invested in the work. The therapist's perceived level of responsibility over the ending was crucial in how they experienced the ending and therefore the different types of endings were categorised on this basis as therapist-initiated, collaborative, client-initiated and externally-driven. Participants described intense emotional reactions in response to some of their experiences and in particular, professional self-doubt was shown to play a major role in the ending experience. There was also a lasting element to therapy as even after the ending, therapists retained memories and learning from their experiences and used them to influence their work with future clients.

This section provides an opportunity to engage in personal reflection on the experience of conducting the thesis project and as such I will use first person terminology hereafter. My study involved using a qualitative research methodology to develop a theory of how clinical psychologists experience the ending in therapy. Engaging in this research process has offered me numerous opportunities for practical learning experiences, eliciting changes both personally and professionally. Despite having been involved in different (and at times extensive) research projects previously, this experience has felt like a steep learning curve in order to negotiate aspects such as liaising with multiple Research and Development Committees to obtain approval, and picking my way through the often-competing grounded theory methodologies to inform the decisions I made at each step of the way. Additionally, it

has been necessary to conduct this project within the framework of an academic research programme and its associated demands in terms of structure and resources.

Throughout this process, one of the major difficulties I experienced was attempting to position myself in relation to seemingly discrete ontological and epistemological ‘camps’; that is, the understanding of what constitutes reality (ontology) and the knowledge we have about that reality (epistemology). In addition, I was aware that the consequence of adopting a particular position would impact on, and potentially limit, the methodological options available to me. My views and beliefs with regards to these concepts changed over time as a result of engaging in the grounded theory process and becoming more familiar with the relevant philosophical arguments. Thus, I came to realise that exploring epistemological stances was a process rather than a single decision. My developmental journey will be the focus of reflection within this critical appraisal.

Starting Out: ‘What do I do?’

As is often the case when one is introduced to a new methodology, my initial questions when first deciding to use grounded theory were ‘What is it?’ and ‘How do I do it?’ In an attempt to provide some guidance, my supervisors suggested I read Kathy Charmaz’s (2006) book on *Constructing Grounded Theory*.

Almost 50 years after Glaser and Strauss published their seminal grounded theory text (1967), Charmaz (2006) developed an approach to grounded theory based on a social constructionist stance which attempted to challenge the fundamental beliefs of the positivist and post-positivist approaches dominant in early grounded theory literature (Glaser & Strauss, 1967; Strauss & Corbin, 1998). Positivism proposes that in order to truly know something, it has to be stripped back to its essential parts and observed (Willig, 2012). This approach emphasises that there is a ‘real’ truth out there, separate from the perspectives and experiences of individuals (positivist ontology). People who position themselves within a

positivist stance argue that the ‘true’ reality can be accessed and observed by controlling all the extraneous variables (positivist epistemology). Therefore, from this point of view it is important for the researcher to remain objective in order to get closer to the ‘true’ phenomenon they are studying without influencing the findings (Guba & Lincoln, 1994).

Charmaz (2006) claimed that these earlier approaches stripped the data from the social context in which they were developed. In addition, she argued that they ignored the influence of the researcher and the process of interaction between researcher and participants. Instead, Charmaz proposed that “the theory *depends* on the researcher’s view; it does not and cannot stand outside of it” (Charmaz, 2006, p. 130, italics in original). In this way, she viewed the resulting theory as one which was constructed between the researcher and the participants and hence was just one of many possible interpretations of the process being studied. Charmaz’s stance reflects that of social constructionism¹ which proposes that there is no ‘true’ reality to be understood, only the constructions of reality that are made through the social discourse of humans, i.e. language (Willig, 2012). From this perspective, our understanding of processes or knowledge is not discovered (in contrast to positivist beliefs) but constructed between individuals whose experiences and interpretations necessarily impact on the knowledge that is created. Thus, social constructionism has been classed as a relativist approach due to the fact that reality and knowledge are considered to be “not absolutely true, but relative in character” (Alvesson & Sköldberg, 2009, p. 18).

Charmaz’s (2006) approach to grounded theory has been eagerly adopted by many, especially those engaging in doctoral level research (examples include Carroll, Adkins, Foth, Parker, & Jamali, 2008; and Gallichan & Curle, 2008), which may reflect the accessibility of this approach; it is appealing not least because of the easy-to-understand guidelines for engaging in grounded theory research and the obvious enthusiasm encapsulated in her writing

¹ The term *social constructionism* was first developed by Berger and Luckmann (1966) in their seminal text entitled ‘The Social Construction of Reality’.

style. As it was my first experience of using grounded theory, I also decided to use Charmaz's approach and designed my study from this perspective.

However, I was aware that the way in which Charmaz approached grounded theory was different to other, more orthodox, approaches and I was concerned that I did not have a sound understanding of the history and context of grounded theory, including how it was originally intended to be practised. Having gained an understanding of Charmaz's arguments against adopting a positivist stance, I felt it important to gain a sense of where positivism can stand in grounded theory research. In addition to this, my feelings of uncertainty about being able to engage in grounded theory methodology were soothed by the idea that there was a 'right way' to do it. Therefore, once I had submitted my application for ethics approval, I decided to go back to the original text on grounded theory published by Barney Glaser and Anselm Strauss in 1967.

Going Back to the Start: Where it All Began

Around the same time as Glaser and Strauss were preparing to present their *Discovery of Grounded Theory* (1967), the majority of social science researchers were attempting to integrate the human sciences with the so-called 'hard' sciences such as physics and mathematics. They were referred to as 'hard' sciences because of their ability to measure their subject in an exact fashion, applying rigour and accuracy (Guba & Lincoln, 1994). In line with a positivist perspective, researchers in these disciplines believed they could "guarantee certainty in knowledge, with the outputs of science being accurate reflections of reality" (Cruickshank, 2012, p. 72). Social science, however, was considered less of an 'exact' science due to its subject matter e.g., humans (Guba & Lincoln, 1994) and it was therefore much harder for social science research to be recognised by the scientific community.

The language and concepts used by Glaser and Strauss in their seminal text (1967) reflect the positivist paradigm which was dominant at the time and it has been argued that this adoption of positivist terms may have been necessary to attract the attention of the prevailing scientific community (Bryant & Charmaz, 2007). Glaser himself rejects the notion that he proposed a positivist approach to grounded theory and in fact rejects allegiance with any epistemology. However, his insistence that the researcher remains unbiased during data analysis and his unwavering belief that the 'true' concepts will emerge out of the data have led most people, including myself, to view his approach as something akin to positivism (Thornberg, 2012; Willig, 2008).

Engaging in further reading and reflection enabled me to recognise that Glaser's approach to grounded theory seemed to fit better with my fundamental understanding and experience of what constituted scientific research (Glaser, 1998; Glaser and Strauss, 1967). I come from a family of medical professionals and academics and, on reflection, I can see that they hold inherently positivist beliefs. Discussions at home, as well as undergraduate teaching and research experiences focusing mainly on quantitative research, have undoubtedly shaped my understanding. Looking back, I think I developed an 'automatic' approach to conducting research which was predominantly positivist in nature, based on a belief that ideally the researcher should remain objective throughout the research process in order to gain access to 'the real world'.

However, with this project in particular, an objective, positivist approach felt like it would fit less well and therefore be less useful than an interpretive, constructionist approach. The focus of the project was on making sense of the experiences of ending therapy with clients and trying to establish what it meant for the participants; this topic felt very subjective and initiated reflections on my own experience of ending therapy with clients. It was these reflections that ultimately led to my interest in developing the research concept.

After receiving ethics approval and starting to conduct interviews, I began to recognise that my background and experiences would have influenced all stages of this study, from developing the research question, through to the decision about how to present the findings. This became particularly apparent to me during the data collection phase of my study where I realised that, despite attempts to ask open-ended questions and clarify participants' conceptualisation of their experiences, I was necessarily a part of the understanding which was constructed between us. Even though I was initially expecting to adopt a more objective stance during interviews, engaging with the grounded theory literature and supervisory discussions helped me to recognise that the position of a completely unbiased researcher was untenable. In fact, I learnt that the researcher's interpretations can be helpful in shaping the construction of the framework, as long as their underlying assumptions and beliefs are made transparent through reflexivity.

My desire to move away from a more positivist approach was also linked to my own relationship with the concept of power. I felt uneasy about the implication inherent in the positivist stance that the researcher had the ability to look beneath the participants' narratives and their own sense-making to see what was 'really' happening. It appeared to me that this perspective positioned the researcher in the role of the expert, indicating a sense of superiority and power (Finlay, 2002). Despite being in the privileged position of being able to explore the different experiences of my participants and develop a theory of endings in therapy based on these narratives, I certainly did not feel I had a 'more true' understanding of the participants' experiences than the participants themselves. Social constructionism appeared to address this power imbalance and position the researcher and the participants on an equal footing, which seemed to fit better with my own personal beliefs and assumptions.

With reservations about engaging in both 'pure' positivism and 'pure' social constructionism, I was keen to see how others had managed to negotiate these issues in

practice. Therefore I turned to applied research using grounded theory studies to establish whether there was a middle ground or whether, more controversially, two independent stances could be adopted at the same time. Alongside these theoretical aspects, I had practical concerns that whichever approach I adopted would necessarily impact on the way I could conduct the remaining aspects of my study. For example, a positivist approach would argue that the literature review should not be attempted until after the data analysis has been conducted (so that the theory could be shown to be grounded in the data rather than *a priori* assumptions – Glaser, 1998; Glaser & Strauss, 1967). However, a social constructionist approach would argue for the ongoing review of literature to help develop the constructed theory in line with previous knowledge (Thornberg, 2012; Charmaz, 2006).

Sense-Making: Finding a Middle Ground?

Following their initial work together, Glaser and Strauss began to move in different epistemological directions and grounded theory was split into two strands. ‘Glaserian’ grounded theory continued to be recognised as the pure form of grounded theory, using the positivist approach espoused in the *Discovery of Grounded Theory* (1967). Anselm Strauss (with colleague Juliet Corbin) went on to develop a set of practical guidelines for conducting grounded theory (see Strauss & Corbin, 1998) which clearly differed from the approach initially adopted by Glaser and Strauss, and has since been referred to as a *post-positivist* or *critical realist* approach (Creswell, 2013).

Critical realism was developed as an approach in the 1970’s by Roy Bhaskar, in response to the overriding positivist stance of the time (Bhaskar, 1997). It has been proposed as a ‘middle ground’ and a more convincing substitute to both positivism and social constructionism (Alvesson & Sköldbberg, 2009). The critical realist approach argues that there is an objective reality separate from our subjective experience (realist ontology), however individuals who adopt a critical realist stance are sceptical about the accessibility of

that 'truth' as all knowledge is believed to be constructed or interpreted by an individual (relativist epistemology). That is, "a critical realist approach does not assume that the data directly reflect reality (like a mirror image); rather, the data need to be interpreted" (Willig, 2012, p. 13).

Strauss and Corbin's (1998) approach to grounded theory has been previously classified as situated within a post-positivist interpretive framework (Creswell, 2013), which is exemplified by the statements that "only God can tell infallible humans the 'real' nature of reality" and the "human grasp of reality never can be that of God's, but hopefully research moves us increasingly toward a greater understanding of how the world works" (Strauss & Corbin, 1998, p. 4). These quotes appear to evidence the authors' belief that there is a true reality but that humans will never be able to fully understand it. In their endeavour to 'move towards a greater understanding', Strauss and Corbin champion those researchers who are "unafraid to draw on their own experiences when analyzing materials because they realize that these become the foundations for making comparisons and discovering properties and dimensions" (Strauss & Corbin, 1998, p. 5).

At this point in my study I was starting to engage in analysis after the first wave of data collection and I felt that the critical realist approach provided me with a better method for engaging with the data. From this perspective I was able to recognise that the theory being constructed was an interpretation, not a fact, which encouraged me to be more creative with my thoughts. However, viewing the evolving model as a representation of a 'true reality' helped me identify its usefulness and relevance to other therapists, not just those who participated in the study.

Nevertheless, I continued to wonder whether there really was an external reality or not, as this appeared to be the main difference between a social constructionist approach and a critical realist approach. In addition, I continued to hold some beliefs that would be

theoretically situated in more of a positivist framework. For example, with the aid of supervisory discussions I recognised that I was delaying engaging with the literature review, a method espoused by Glaser (1998).

Returning to the literature, it did not seem possible to adopt both stances (Alvesson & Sköldböck, 2009) and Cruickshank (2012) argues that social constructionism and critical realism are contradictory due to their ontological assumptions. In other words, critical realists believe in an objective truth (realist approach), whereas social constructionists believe in a truth that is created based on interpretations (relativist approach). Therefore I felt like I needed to make a decision as to whether I adopted a realist ontological stance or a relativist one.

Developing My Own Approach to Grounded Theory

Maxwell (2012) proposes that in order for individuals to adopt an innovation, “they must see it as helping them to meet a perceived need of theirs, and must also see it as compatible with their other important beliefs and practices” (p. ix). A contradiction appeared here, as my needs did not seem to coincide with my beliefs. In this sense, it felt like my ‘need’ was to be able to conduct a grounded theory study in a way that would be approved by those who were assessing me. On reflection, it seems that I assumed this would involve following a ‘correct/pure’ methodology, a belief which is likely to have been influenced by my predominantly positivist background. However, my fundamental beliefs seemed to be shifting towards a more revolutionary social constructionist stance, that an experience shared by two people would be experienced differently by each, and that there was in fact no ‘true’ experience. Therefore, the knowledge owned by individuals would be constructed and dependent on their previous experiences, rather than a factual ‘truth’ which could be accessed by all.

Alongside this, I was becoming aware of how my shifting belief system did not necessarily coincide with my day-to-day lived experience. As such, I continued to behave as though there were an objective reality, for practical reasons primarily, mirroring Schwandt's (2007) description that most people behave like "garden-variety empirical realists – that is, we act as if the objects in the world (things, events, structures, people, meanings etc.) exist as independent in some way from our own experience with them" (p. 256). In fact, I would argue that it would be extremely difficult to live in our society, which is based on the fundamental assumption that it is objectively 'real', with the pervasive belief that there is no external reality besides our own constructions. Even if this was possible for me, I struggled to argue against the "notion that our words and life are constrained by a reality not of our own invention" (Putnam, 1994, p. 452).

Despite the seemingly discrete nature of different epistemological positions, I have found it helpful to view them as points on a spectrum. This is a notion often implied in tables or diagrams of approaches, as positivism and social constructionism tend to be placed at either end, indicating that they are polar opposites. Given my experiences of adopting different epistemological assumptions at different moments in time, I understand this to be a dynamic spectrum, where an individual can move at will.

Essentially, despite reflecting on these issues in some depth, I still do not know whether I believe that there is a real, objective reality beyond our own perceptions and interpretations or not. My initial attempts to try and fit into an epistemological approach has led me to recognise that this is not a clear-cut decision. Knorr-Cetina (1999) argues that "by not fixing an ontology from the start – by not committing oneself to the thought that the modern world is populated by rational actors, as in rational choice approaches, or by liberal actors, as in political theory, or by systems, as in systems theory – one can see the configuration of several ontologies side by side and investigate their relationship" (p. 253).

In this way, aligning firmly with one particular paradigm may potentially blind the researcher to alternative perspectives. This could have the detrimental effect of curtailing the full scope of hypotheses or theories, and possibly limiting the acceptance of research by audiences who do not share the same basic assumptions as the researcher.

Despite the practical difficulties of approaching qualitative research without a clear ontological and epistemological position, I have found it to be enlightening and beneficial for the research as a whole. Shifting positions has enabled me to view the research from different perspectives and consider how the constructed theory may have developed differently by taking an alternative approach. Therefore I would recommend researchers to engage with this debate and advance the scope of their research by considering how it may be viewed from the perspective of different paradigms.

Conclusions

Grounded theory itself has undergone multiple transformations since its conception (Glaser & Strauss, 1967). Like grounded theory itself, I have found myself shifting my ontological and epistemological stance as a result of the experiences I have had. With regards to this particular research project, this has been influenced by my supervisors, engaging with both empirical research and theoretical debate, participating in teaching on ontology and epistemology, and over time developing a more familiar relationship with grounded theory methodology. I have also found it particularly enlightening to reflect on these issues in my clinical placements, for example when developing psychological formulations with clients (e.g. are we trying to establish a 'true' understanding of their difficulties or create a 'constructed' understanding through our own meaning-making).

Over the course of this project, I feel I have shifted my positioning from more of a positivist approach to somewhere further along the spectrum, perhaps between social constructionism and critical realism. That is, I do believe in a relativist epistemology, where

the ‘knowledge’ that we hold is created from a shared interpretation. However, I am currently still unsure whether there is a ‘true’ reality beyond our interpretations. Therefore my approach to grounded theory is unlikely to fit neatly into what might be considered a ‘Glaserian’ grounded theory or alternatively a ‘Charmazian’ approach to grounded theory, as the decisions I have made along the way will no doubt reflect the shifts in my understanding. I can understand Glaser’s reluctance to ‘fit into’ a particular paradigm with the associated ontological and epistemological constructs, but I do not agree that “epistemological discussions are of no potential help to the actual doing of research” (Glaser, 2005, p. 2).

Instead, I have found that developing a deeper understanding of these discussions has been one of the most crucial learning points from engaging in grounded theory research. I do not expect that my positioning in this respect has ‘settled’ now, rather that my differing experiences will continue to impact on how I understand reality and knowledge. Having a more detailed understanding of these issues will, I hope, enable me to reflect more along this journey where I hope to develop as a researcher and, more generally, a clinical psychologist.

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Section Four: Ethics Section

Constructing the Processes Involved in Ending Therapy with Clients

Rosie Noyce

Doctorate in Clinical Psychology

Division of Health Research

Lancaster University

Ethics Application

This section documents the researcher's application for ethics approval, and includes all supporting documents. The original letter of approval from the ethics committee has been attached, as well as approval of the proposed amendments. The areas that are highlighted show the amendments to the original application. Additionally, an example approval letter from one of the ten Research and Development Trusts involved in this study has been attached. All identifiers have been removed.

FHMREC Application Form



**Faculty of Health and Medicine Research Ethics Committee
(FHMREC) Lancaster University**

Application for Amendment to Previously Approved Research

Instructions: Please re-submit your original research ethics approval documents with any amendments highlighted in yellow, attaching this form as a cover sheet.

Completed documentation should be submitted as a single PDF by email and in hard copy to:

██████████
 Faculty of Health & Medicine
 A71 Physics Building
 Lancaster University
 LA1 4YD
 ██████████

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| 1. Name of applicant: Rosie Noyce |
| 2. E-mail address and phone number of applicant: ██████████; ██████████ |
| 3. Title of project: Clinical Psychologists' Understandings of Endings in Therapy |
| 4. Project reference number: ██████████ |
| 5. Date of original project approval as indicated on the official approval letter (month/year) 27 th July 2012 |

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| Amendment request |
| <p>6. Please outline the requested amendment(s):</p> <p>a) Since I received approval I realised I needed to gain R&D approval from most trusts before I was allowed to engage in data collection. One of the R&D Trusts, ██████████ have requested that I put their logo on all documents to be used with ██████████ participants.</p> <p>b) Since initiating data collection, one participant has asked me for an anonymised copy of his transcript. I would like to be able to give participants anonymised copies for their own transcripts if requested.</p> <p>c) Participants are requesting to be informed of the findings of the study and therefore I would like to provide them with a short summary at the end of the research process.</p> |
| <p>7. Please explain your reason(s) for requesting the above amendment(s):</p> <p>a) This amendment was requested by ██████████ R&D Trust and therefore is necessary just for those participants who are employed by ██████████</p> <p>b) Participants have commented on how useful they are finding the discussions and in this particular case the participant stated that he would like to take the transcript to supervision to discuss it further. In addition, it seems ethically appropriate to provide participants with a copy of their own words.</p> <p>c) Participants are interested in the research topic and it seems ethically appropriate that they be informed of the findings.</p> |

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Signatures

Applicant: _____ Date: _____

Project Supervisor: _____ Date: _____

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**Faculty of Health and Medicine Research Ethics Committee (FHMREC)
Lancaster University**

Application for Ethical Approval for Research

Instructions

1. Apply to the committee by submitting
 - ✓ The University's Stage 1 Self-Assessment Form (standard form or student form). This is available on the Research Support Office website: <http://www.lancs.ac.uk/depts/research/lancaster/ethics.html>
 - ✓ The completed FHMREC application form
 - ✓ Your full research proposal (background, literature review, methodology/methods, ethical considerations)
 - ✓ All accompanying research materials such as, but not limited to,
 - 1) Advertising materials (posters, e-mails)
 - 2) Letters of invitation to participate
 - 3) Participant information sheets
 - 4) Consent forms
 - 5) Questionnaires, surveys, demographic sheets
 - 6) Interview schedules, interview question guides, focus group scripts
 - 7) Debriefing sheets, resource lists
2. Submit all the materials electronically as a SINGLE email attachment in PDF format. Instructions for creating such a document are available on the FHMREC website (<http://www.lancs.ac.uk/shm/research/ethics/>).
3. Submit one collated and signed paper copy of the full application materials. If the applicant is a student, the paper copy of the application form must be signed by the Academic Supervisor.
4. Committee meeting dates and application submission dates are listed on the research ethics committee website <http://www.lancs.ac.uk/shm/research/ethics>. Applications must be submitted at least 14 days beforehand, to:


 Faculty of Health & Medicine
 A71 Physics Building
 Lancaster University
 LA1 4YD


5. Attend the committee meeting on the day that the application is considered.

| |
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| 1. Title of Project: Clinical Psychologists' Understanding of Endings in Therapy |
| 2. If this is a student project, please indicate what type of project by ticking the relevant box: <input type="checkbox"/> PG Diploma <input type="checkbox"/> Masters dissertation <input type="checkbox"/> MRes <input type="checkbox"/> MSc <input type="checkbox"/> DClinPsy SRP <input type="checkbox"/> PhD Thesis <input type="checkbox"/> D Pall. Care/Pub. Hlth/Org. Hlth & Well Being <input type="checkbox"/> MD <input checked="" type="checkbox"/> DClinPsy Thesis <input type="checkbox"/> Special Study Module (3 rd year medical student) |
| 3. Type of study <input checked="" type="checkbox"/> Involves direct involvement by human subjects |

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Involves existing documents/data only. Contact the Chair of FHMREC before continuing.

| Applicant information |
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| 4. Name of applicant/researcher: Rosie Noyce |
| 5. Appointment/position held by applicant and Division within FHM Trainee Clinical Psychologist, Division of Health Research |
| 6. Contact information for applicant: E-mail: [REDACTED] Telephone: [REDACTED] Address: Clinical Psychology Programme, Division of Health Research, School of Health and Medicine, Whewell Building, Lancaster University, LA1 4YT |
| 7. Project supervisor(s), if different from applicant: Name(s): Dr Stephen Weatherhead E-mail(s): [REDACTED] |
| 8. Appointment held by supervisor(s) and institution(s) where based (if applicable): Lecturer in Research Methods & Clinical Tutor, Doctorate in Clinical Psychology course, Lancaster University |
| 9. Names and appointments of all members of the research team (including degree where applicable) Dr Anna Daiches - Research Supervisor, Clinical Director, Doctorate in Clinical Psychology course, Lancaster University |

| The Project |
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| NOTE: In addition to completing this form you must submit a detailed research protocol and all supporting materials. |
| 10. Summary of research protocol in lay terms (maximum length 150 words). Terminating therapy is a fundamental part of the therapy process, and yet there is very little empirical research investigating this phenomenon. The aims of this project are to explore the meaning of endings in therapy for clinical psychologists, and from this to develop a theory of therapeutic endings which is grounded in the data obtained. Participants will be qualified clinical psychologists based in the North West of England. Individual interviews will be conducted to explore in depth the participants' experiences of endings in therapy, and transcripts will be analysed using grounded theory techniques. The findings from this study will be disseminated to the clinical psychology community to create an awareness and provide an opportunity for reflection on this subject. Furthermore, it is hoped that a general theory of therapeutic endings may enable clinical psychologists to use endings as a therapeutic tool to magnify the progress made during therapy. |

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| <p>11. Anticipated project dates</p> <p>Start date: July 2012 End date: June 2013</p> |
| <p>12. Please describe the sample of participants to be studied (including number, age, gender):</p> <p>All participants will be aged over 18 and will be working as clinical psychologists in the North West of England. Due to the grounded theory methodology being employed, it is difficult to predict the actual number of participants, however it is anticipated that approximately 10-15 participants will be required.</p> |
| <p>13. How will participants be recruited and from where? Be as specific as possible.</p> <p>A staged recruitment procedure will operate as follows:</p> <ol style="list-style-type: none"> 1) Following ethical approval, an email will be sent to all clinical psychologists working in the NHS across the North West by an administration team member, informing them about this research study. A database of these email addresses is held by Lancaster University. A Participant Information sheet will be attached to the email, along with the letter confirming ethical approval. 2) If further participants are required at this stage, an online advert will be placed on the British Psychological Society and/or Division of Clinical Psychology websites. This will include contact details for the researcher. 3) If additional participants are required for methodological / sampling purposes, the principal investigator will attend local clinical psychology network meetings such as special interest groups and examiner workshops, to introduce the study verbally and hand out Participant Information Sheets to individuals who express an interest. <p>Potential participants will be asked to contact the researcher directly to express their interest in taking part in the study. They will be informed that an expression of interest does not mean they will necessarily be interviewed, in case an excess of people would like to take part.</p> <p>Later waves of recruitment will be led by methodology consistent with a Grounded Theory approach. They are likely to be more focused and may mean seeking participants who meet particular demographics. For example, the data gathered may indicate a need to test the emerging theory against data gathered from child psychologists. In this case, I would attend targeted forums such as child psychology special interest groups. If this does prove to be necessary / advantageous, the same material would be used as is contained within the application the committee has had sight of (e.g. Participant information sheet / invitation email). Consequently I am requesting approval for utilising the same materials, but across a range of professional forums, the selection of which will be done in a parsimonious manner.</p> <p>Initially, Research and Development (R&D) approval will not be sought and so interviews will take place outside of NHS properties and normal working hours. If recruitment proves too difficult using this strategy, then R&D approval will be sought through the SPEAR process.</p> |
| <p>14. What procedure is proposed for obtaining consent?</p> <p>Following ethical approval, potential participants will be contacted via email to inform them of the study. A Participant Information sheet will be attached to the email and individuals will be encouraged to contact the researcher with any questions. The information sheet will also be briefly reviewed face-to-face prior to commencing the interview, and participants will be asked to sign a consent form in order to take part.</p> |
| <p>15. What discomfort (including psychological), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks.</p> <p>Participants will need to make time to attend for the interview. No danger or discomfort is anticipated within the context of this study. However, the Chief Investigator has experience of working with individuals who are distressed and would ensure any participants showing signs of</p> |

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| <p>distress would be appropriately debriefed.</p> |
| <p>16. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, details of a lone worker plan).</p> <p>No potential risks for the researcher have been identified. Interviews are expected to take place with health professionals, in an appropriately staffed building. If home visits are necessary, these will be conducted in accordance with [REDACTED] Lone Worker Policy, which details the importance of conducting a dynamic risk assessment during the visit and informing a colleague exactly where you are going and how long you expect to be.</p> |
| <p>17. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.</p> <p>This study is deemed to be exploratory and without direct intervention, and therefore there will be no direct benefits to participants. However, as a result of the study it is hoped that a theory can be developed of how different kinds of endings are understood by clinical psychologists (including 'forced' and unexpected endings). It is expected that this will be shared amongst the community of clinical psychologists and other therapists to raise awareness and provoke reflection on these issues, including how endings may be differently experienced when using different psychological approaches.</p> <p>Given that endings are arguably a fundamental part of therapy, a better understanding of the process could provide clinical psychologists with another tool to use for therapeutic change. By making use of the ending itself as a clinical tool, the process of termination could be tailored to the client to potentially magnify the progress made during therapy.</p> <p>Participants will also be given an anonymised transcript of their interview if requested so that they can reflect further on the discussion.</p> |
| <p>18. Details of any incentives/payments (including out-of-pocket expenses) made to participants:</p> <p>It is expected that interviews will be held in buildings close to where participants work. Participants will be informed that they can claim travel expenses up to £10.</p> |
| <p>19. Briefly describe your data collection and analysis methods, and the rationale for their use</p> <p>Data will be collected in the form of individual interviews, lasting about an hour each. The interviewer will aim to explore clinical psychologists' experiences of therapeutic endings using a semi-structured format. As is considered appropriate for grounded theory techniques (Charmaz, 2008), a topic guide will be used to initiate exploration of the topic and to re-focus discussions, but not to restrict conversation with <i>a priori</i> assumptions.</p> <p>The interviews will elicit qualitative data which will be transcribed verbatim, and then subjected to detailed analysis using a grounded theory approach (Strauss & Corbin, 1998). In this approach, data analysis starts immediately after the first interview, so that subsequent interviews can be adapted to develop the theory further. Following each interview, the audio-recordings will be played back and an anonymous transcript created which accurately reflects the discussion that took place.</p> <p>Each transcript will be analysed and coded in line with grounded theory approaches (Strauss & Corbin, 1998; Charmaz, 2008). Following this, it will be helpful to engage in 'theoretical sampling', where further interviews are conducted focusing on exploring the categories further until 'saturation' has been achieved (Strauss & Corbin, 1998). Given that this project is being submitted as part of a degree programme, it is unlikely that I will be able to continue theoretical sampling until data saturation. Instead, I aim to engage in further data collection to explore concepts in as much depth as possible within the constraints of this project.</p> |
| <p>20. Describe the involvement of users/service users in the design and conduct of your research. If you have not involved users/service users in developing your research</p> |

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Project Supervisor (if applicable):

Date:

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Clinical Psychologists' Understandings of Endings in Therapy

PROTOCOL

Chief Investigator: Rosie Noyce (Trainee Clinical Psychologist, Lancaster University)

Academic Supervisor: Dr Stephen Weatherhead (Clinical Psychologist, Lecturer in Research Methods and Clinical Tutor, Lancaster University)

Research Supervisor: Dr Anna Daiches (Clinical Psychologist, Clinical Director of the Doctorate in Clinical Psychology course, Lancaster University)

Research Aim: to explore clinicians' experiences of endings in therapy and how they make sense of them.

Rationale/Background

Terminating therapy is a fundamental part of the therapy process and one which arguably deserves to be thought about, and discussed with the client, from the very start of therapy (Davis, 2008). However, there is very little literature focusing on endings in therapy, with articles mainly concentrating on psychodynamic psychotherapists' thoughts on the subject, rather than research studies investigating the phenomenon further (Davis, 2008; Salberg, 2010). It is well-known amongst therapists that a 'poor ending' is likely to jeopardise the progress made during therapy (Frank, 2009), but the 'correct' formula for a good ending is less well understood. Can a positive ending be used to magnify the progress made in therapy, and what does a 'good enough ending' look like?

In my own experience of training to be a clinical psychologist, very little attention has been paid in course teaching to therapeutic endings, which has tended to focus more on the formulation and intervention stages of therapy. Practical experience of therapeutic endings on placement has highlighted to me the importance of acknowledging the process and preparing for it with the client. However, supervision sessions have only occasionally focused on this topic, and have tended to concentrate more on the administrative side on terminating therapy (e.g. writing a discharge letter to the referrer). It seems that clinical psychologists would benefit from understanding better the process of ending therapy, so that this could be tailored to the client and potentially used to enhance the therapeutic experience.

In her paper entitled 'Holding and letting go', Lanyado (1999) discusses the similarities in the relationships between therapist and client, and parent and child. She uses Stern's theory (1985) to explain how children need a certain amount of mis-attunement between their parents and themselves to become an independent being. In fact, it has been argued that attuning too closely to your baby deprives the child of developing a sense of agency (Hopkins, 1996). Hopkins (1996) suggests that this situation could be mirrored in the therapist-client relationship. In this sense,

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independence is a quality to be encouraged in the client, with the security of the 'safe base' (Bowlby, 1988) provided by the therapist for the client to return to when necessary (Lanyado, 1999). In line with this, Holmes (1997) argued for an attachment-informed approach to therapy endings, proposing that the attachment styles of therapists and clients could play out in therapy to create different kinds of endings. For example, it maybe that the therapist finds themselves in the 'caregiver role', which is then very difficult to relinquish and could result in a delayed ending to therapy (Lanyado, 1999).

To complicate matters further, there are different types of ending in a therapeutic context (Walsh, 2003), such as those that are pre-defined and sometimes referred to as 'forced' (e.g. when a trainee has to end placement, or where therapy is accessed in a service which takes a prescribed approach to the number of therapy sessions offered), or those that are unexpected by one or both parties (e.g. when a client does not return or a therapist goes on long-term sick leave). Bostic, Shadid & Blotcky (1996) compared client experiences of forced endings to the stages of grief proposed by Kubler-Ross (1967), and they suggested that forced endings provide an opportunity during therapy sessions to work directly with feelings of abandonment, disappointment and loss. The authors proposed a set of nine guidelines to help clinicians manage 'forced terminations', such as when and how to first discuss therapeutic endings with clients, as well as when it is appropriate to accept small gifts from clients and whether to encourage further contact through the use of letters (Bostic *et al.*, 1996).

Alongside the theoretical work, there has been unfortunately very little empirical research into therapeutic endings. However, one study by Murdock, Edwards & Murdock (2010) interviewed therapists regarding their understanding of clients' premature (and unexpected) termination of therapy. They found that therapists employed a "self-serving bias" (Murdock *et al.*, 2010, p. 233) by attributing the cause of premature termination to the client or the environment, rather than to themselves. This was more apparent for male therapists and those who endorsed psychoanalytic approaches.

There is a dearth of published research into the process of terminating therapy, and the literature that there is mainly focuses on the thoughts and theories of psychoanalytic psychotherapists rather than empirical research studies. Research in this field would benefit from increased attention on clinicians' experiences of endings in order to gain a better understanding of how endings could be used to support and enhance the work completed during therapy.

Clinical psychologists would be a prime participant pool for this kind of exploratory study because they are trained to use different therapeutic approaches to adapt to the client's needs. Therefore, recruiting clinical psychologists would allow for endings across therapeutic approaches to be explored, rather than restricting the findings to one domain (e.g. psychodynamic psychotherapy). From this information, a more general 'theory of endings' could be developed.

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Objectives

- To explore the meaning of endings for clinical psychologists
- To develop a theory of endings in therapy from the perspective of clinical psychologists, and to ground this theory in the data obtained from this study

This study is deemed to be exploratory and without direct intervention. However, as a result of the study it is hoped that a theory can be developed of how different kinds of endings are understood by clinical psychologists (including 'forced' and unexpected endings). It is expected that this will be shared amongst the community of clinical psychologists and other therapists to raise awareness and provoke reflection on these issues, including how endings may be differently experienced when using different psychological approaches.

Given that endings are arguably a fundamental part of therapy, a better understanding of the process could provide clinical psychologists with another tool to use for therapeutic change. By making use of the ending itself as a clinical tool, the process of termination could be tailored to the client to potentially magnify the progress made during therapy.

Design

This study will take the form of a cross-sectional, exploratory design, making use of qualitative methodology to explore how clinical psychologists understand endings in therapy. It is expected that the study will last no longer than 12 months in total.

Following a grounded theory methodology (Charmaz, 2008; Strauss & Corbin, 1998), participants will be recruited in waves using purposive sampling to enable exploration of initial data categories further. The latter waves of recruitment could involve returning to the original participants or recruiting new participants depending on what part of the analysis needs further exploration (see Procedure below).

Setting

The study will take place in the North West of England. Clinical psychologists will be recruited from across this area to take part in the study, and interviews will be conducted in a convenient setting for both the interviewer and the participants.

Participants

Participants for this study will be qualified clinical psychologists based in the North West of England. All participants will be aged 18 or above. When using grounded theory methodology, the researcher selects participants who they think will be able to contribute to theory development (Creswell, 2007). It is hoped that participants from a wide variety of therapeutic approaches can be recruited to this study so that different perspectives can be captured. A staged recruitment process will be used in order to access as many participants as possible (see Procedure below).

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Procedure

A staged recruitment procedure will operate as follows:

- 1) Following ethical approval, an email will be sent to all clinical psychologists working in the NHS across the North West by an administration team member, informing them about this research study. A database of these email addresses is held by Lancaster University. A Participant Information sheet will be attached to the email, along with the letter confirming ethical approval.
- 2) If further participants are required at this stage, an online advert will be placed on the British Psychological Society and/or Division of Clinical Psychology websites. This will include contact details for the researcher.
- 3) If additional participants are required for methodological / sampling purposes, the principal investigator will attend local clinical psychology network meetings such as special interest groups and examiner workshops, to introduce the study verbally and hand out Participant Information Sheets to individuals who express an interest.

Potential participants will be asked to contact the researcher directly to express their interest in taking part in the study. They will be informed that an expression of interest does not mean they will necessarily be interviewed, in case an excess of people would like to take part.

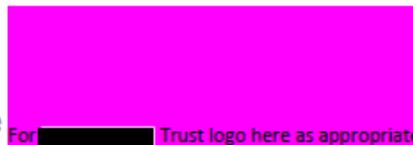
Individual interviews will be arranged for a mutually convenient time and place. At the start of the interview, the researcher will go through the Participant Information Sheet and give potential participants the opportunity to ask questions. Participants will be asked to sign a consent form prior to taking part. During the interview, it will be helpful to identify the therapeutic approaches most often used by the participant, and the type of service they work in (e.g. is the number of sessions pre-defined?). Interviews are expected to last about an hour, and will explore the clinician's experience of endings and how they make sense of the process.

Following the initial interviews, it may be necessary to conduct further interviews to explore particular concepts in more depth. Later waves of recruitment will be led by methodology consistent with a Grounded Theory approach. The staged recruitment procedure will be employed again to identify more potential participants. If it is possible to gain more information from the original participants then they will be contacted directly and asked to take part in a further interview. The later stages of recruitment are likely to be more focused and may mean seeking participants who meet particular demographics. For example, the data gathered may indicate a need to test the emerging theory against data gathered from child psychologists. In this case, I would attend targeted forums such as child psychology special interest groups. If this does prove to be necessary / advantageous, the same material would be used as is contained within the application the committee has had sight of (e.g. Participant information sheet / invitation email). Consequently I am requesting approval for utilising the same materials, but across a range of professional forums, the selection of which will be done in a parsimonious manner.

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Ethics

Ethical approval for this study will be sought from Lancaster University Research Ethics Committee. Initially, Research and Development (R&D) approval will not be sought and so interviews will take place outside of NHS properties and normal working hours. If recruitment proves too difficult using this strategy, then R&D approval will be sought through the SPEAR process.

Consideration will be given to the following:

Participant information – Participants will be informed of the study via email or an online advert. They will be provided with a Participant Information sheet at the earliest opportunity, which will have the contact details for the research team should the potential participant require any further information.

Informed consent – Participants will be given an information sheet prior to the interview and encouraged to contact the researcher with any questions. The information sheet will also be briefly reviewed face-to-face prior to commencing the interview, and participants will be asked to sign a consent form in order to take part.

As an unavoidable result of recruiting from the North West of England, it may be the case that I have met potential participants previously. All documentation will clearly state my name and trainee status, and potential participants will have access to this information prior to agreeing to take part.

Withdrawal – Participants will be informed that they are free to withdraw from the study up to two days after the interview, without giving a reason, and it will not affect their legal or employment rights. After this time, all data will be made anonymous and therefore it will not be possible to trace a specific individual's data. Due to the nature of the analysis, subsequent interviews cannot be conducted until preliminary analysis of the previous interview has been completed.

Confidentiality – Participant information will be kept strictly confidential at all times, in accordance with Lancaster University and NHS policies and guidelines. Individuals who will be contacted via email have already consented to being contacted by the course administrative team. An administration team member will be asked to send the project information out to clinical psychologists in the North West, and the researcher will not have access to individual email addresses until those individuals express an interest in the study by contacting the researcher directly.

Participants will not know who else has taken part in the study. The interviews will be audio-recorded with the consent of the participant, and will be heard by the researcher and at times the academic and research supervisors to aid data analysis and future data collection. This will be stated on the consent form. Participants will be given the option to request for one of the supervisors not to access their transcripts, in case they know one of the supervisors well.

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Participants will be informed that disclosure of any information considered to place or have placed any person at risk must be shared with the relevant individuals and/or authorities, in line with professional guidance.

Anonymisation – All data will be made anonymous, and no identifying data will be published.

Reimbursement – It is expected that interviews will be held in buildings close to where participants work. Participants will be informed that they can claim travel expenses up to £10.

Data Collection and Analysis

Data will be collected in the form of individual interviews, lasting about an hour each. The interviewer will aim to explore clinical psychologists' experiences of therapeutic endings using a semi-structured format. As is considered appropriate for grounded theory techniques (Charmaz, 2008), a topic guide will be used to initiate exploration of the topic and to re-focus discussions, but not to restrict conversation with *a priori* assumptions. It will be important to allow full exploration of participants' understandings to increase the likelihood that theories generated from the research will be grounded in the experiences of the participants.

The interviews will elicit qualitative data which will be transcribed verbatim, and then subjected to detailed analysis using a grounded theory approach (Strauss & Corbin, 1998). In this approach, data analysis starts immediately after the first interview, so that subsequent interviews can be adapted to develop the theory further. Following each interview, the audio-recordings will be played back and an anonymous transcript created which accurately reflects the discussion that took place.

Participants will be given a copy of this transcript if they request it to reflect further on the discussion.

Each transcript will be read and re-read to help immersion in the data. Initial codes will be identified on a line-by-line basis (Charmaz, 2008). These codes will be used to conduct focused coding, a method of capturing larger extracts of the data. Next, conceptual categories will be developed using the codes to make sure the theoretical concepts are grounded in the data, and memos will be used to create a narrative around each category. At this point it will be helpful to engage in 'theoretical sampling', where further interviews are conducted focusing on exploring the categories further until 'saturation' has been achieved (Strauss & Corbin, 1998). Given that this project is being submitted as part of a degree programme, it is unlikely that I will be able to continue theoretical sampling until data saturation. Instead, I aim to engage in further data collection to explore concepts in as much depth as possible within the constraints of this project.

Following completion of data collection and analysis, participants will be sent a short summary of the findings via email.

Timetable

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Mar 2012 - July 2012: submit ethics application
July 2012 – Aug 2012: conduct and write up literature review
Aug 2012 - Feb 2013: data collection, analysis and submission of first drafts
Mar 2013 – Apr 2013: write up critical review
May 2013: submit thesis
June 2013: viva

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Strauss, A. & Corbin, J. (1998) *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Newbury Park, CA: Sage.

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Participant Information Sheet

Clinical Psychologists' Understandings of Endings in Therapy

My name is Rosie Noyce (Trainee Clinical Psychologist) and I am conducting this research as a student on the Clinical Psychology Doctorate programme at Lancaster University. You are being invited to take part in a research study, so it is important that you understand why the research is being done and what it will involve. Please take time to read the information carefully and discuss it with others if you wish. Feel free to contact me if there is anything that is not clear, or if you would like more information.

What is the study about?

The purpose of this study is to explore clinical psychologists' experiences of ending therapy with a client. Specifically, I would be interested in meeting with you to discuss your understanding of endings and how you have made sense of them within the therapy setting.

Why have I been approached?

You have been approached because the study requires information from people who are qualified clinical psychologists based in the North West of England. Unfortunately I may not be able to interview everyone who contacts me, so an expression of interest in the study does not necessarily mean you will be able to take part.

Do I have to take part?

No. As entry to the study is entirely voluntary, it is up to you to decide whether or not to take part. You should not feel under any pressure to make a decision. If you do decide to participate, you will be asked to sign a consent form. You are still free to withdraw up to two days after the interview without giving a reason. This will not affect any of your rights now or in the future. After the end of the interview your responses will be made anonymous and therefore it will not be possible to trace your data. Due to the nature of the analysis, subsequent interviews cannot be conducted until preliminary analysis of the previous interview has been completed.

What will I be asked to do if I take part?

If you decide you would like to take part, you will be invited to attend an interview with me to discuss therapeutic endings. This meeting is expected to take no longer than an hour. You will need to make time to attend the interview, which will take place in a mutually convenient location for us both and may be outside of normal working hours.

Will my data be confidential?

The information you provide is confidential. The data collected for this study will be stored securely and only the researchers conducting this study will have access to this data:

- Audio recordings will destroyed and/or deleted after they have been transcribed and checked by me. Some of the transcripts will be shared with my Academic and Research Supervisors, to aid data analysis. You have the option to request if you do not want one of the supervisors to access your transcripts.
- Hard anonymised copies of the transcripts will be kept in a locked cabinet.

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- The files on the computer will be encrypted (that is no-one other than myself will be able to access them) and the computer itself password protected.
- At the end of the study, hard copies of the transcripts will be kept securely in a locked cabinet for five years. At the end of this period, they will be destroyed. Should the study be accepted for publication, raw data will be retained for a further five years post-publication.
- The typed version of your interview will be made anonymous by removing any identifying information including your name. Anonymised direct quotations from your interview may be used in the reports or publications from the study, so your name will not be attached to them.

There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and share this information with the relevant individuals and/or authorities, in line with professional guidance. I will tell you if I have to do this.

What will happen to the results?

After the study is completed, I will write up and analyse the findings, in order to submit them as part of my degree programme. I will also submit the findings for publication in a scientific journal and/or for presentation at scientific conferences.

All data will be anonymous and any identifying data will not be published. A short summary of the findings will be sent to you via email on completion of the study.

Are there any risks?

Taking part in this study should involve no particular risks to you, and as such this study has been classified as 'low risk' by the research team. You do not have to answer any questions you do not wish to. However, if you experience any distress following participation, I would encourage you to contact me so that we can organise a debrief session and identify any resources which might be helpful.

Are there any benefits to taking part?

Although you may find participating interesting, there will be no direct benefits to taking part. However, as a result of the study it is hoped that a theory can be developed of how different kinds of endings are understood by clinical psychologists (including 'forced' and unexpected endings). We anticipate this will be shared amongst the community of clinical psychologists and other therapists to raise awareness and provoke reflection on these issues.

Participants will not receive financial incentives for taking part. However, some interviews may require participants to travel a short distance and therefore they will be reimbursed for travel expenses up to £10.

Who has reviewed the project?

This study has been reviewed by the Faculty of Health and Medicine Research Ethics Committee, and approved by the University Research Ethics Committee at Lancaster University.

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Where can I obtain further information about the study if I need it?

If you have any questions or concerns about any aspect of this study, you should contact the Chief Investigator (Rosie Noyce) who will do her best to answer your questions. You may also contact the Academic Supervisor (Dr Stephen Weatherhead) or Research Supervisor (Dr Anna Daiches) if necessary.

Chief Investigator: Rosie Noyce (Trainee Clinical Psychologist, Lancaster University, tel: [redacted], email: [redacted])

Academic Supervisor: Dr Stephen Weatherhead (Clinical Psychologist, Lancaster University, email: [redacted])

Research Supervisor: Dr Anna Daiches (Clinical Psychologist, Lancaster University, email: [redacted])

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the research team, you can contact:

Dr [redacted] Tel: [redacted]
 Research Director, DClinPsy; Email: [redacted]
 Division of Health Research
 Bowland Tower East
 Lancaster University
 Lancaster
 LA1 4YT

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

Professor [redacted] Tel: [redacted]
 Associate Dean for Research Email: [redacted]
 Faculty of Health and Medicine
 (Division of Biomedical and Life Sciences)
 Lancaster University
 Lancaster
 LA1 4YD

Please keep this information sheet. Thank you for considering this proposal.

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Consent Form

Study Title: Clinical Psychologists' Understandings of Endings in Therapy

We are asking if you would like to take part in a research project. The aim is to explore clinicians' experiences of endings in therapy, with a view to developing a theory of endings in therapy from the perspective of clinical psychologists.

Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the chief investigator, Rosie Noyce.

Please initial box after each statement

1. I confirm that I have read the information sheet and fully understand what is expected of me within this study.
2. I confirm that I have had the opportunity to ask any questions and to have them answered.
3. I understand that my interview will be audio recorded and then made into an anonymised written transcript.
4. I understand that audio recordings will be kept until the research project has been examined.
5. I understand that I am not obliged to take part in this study and can withdraw my participation up until two days after the interview.
6. I understand that the information from my interview may be shared with the research supervisors.
7. I consent to anonymised information and quotations from my interview being used in future publications and reports (e.g. doctoral thesis), conferences and training events.
8. I understand that any information I give will remain strictly confidential and anonymous unless it is thought that there is a risk of harm to any person, in which case the researcher will need to share this information with her supervisors.
9. I consent to Lancaster University keeping written transcriptions of the interview for 5 years after the study has finished.
10. I consent to take part in the above study.

Name of Participant _____ Signature _____ Date _____

Name of Researcher _____ Signature _____ Date _____

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Clinical Psychologists' Understandings of Endings in Therapy

SEMI-STRUCTURED TOPIC GUIDE

How important do you think endings are in therapy?
Why do you think this is?

How do you tend to go about addressing endings with clients?
How early do you tend to discuss the end of therapy?
Are you able to negotiate endings with clients?
Are you in a service whereby the number of sessions is pre-defined?

Do you consider yourself to have a particular therapeutic orientation?
If no, what approaches do you often draw on during therapy sessions?

Can you think of a time when an ending did not go as well as you had hoped?
Could you explain what happened?
How did you feel about this?
What would you have liked to happen instead?
What is your understanding of what happened?

Can you think of a time when you had an unexpected ending with a client?
Could you explain what happened?
How did you feel about this?
What would you have liked to happen instead?
What is your understanding of what happened?

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Clinical Psychologists' Understandings of Endings in Therapy

EXAMPLE EMAIL TO POTENTIAL PARTICIPANTS

Dear [potential participant],

I am writing to inform you about a study I am conducting for my Doctorate in Clinical Psychology thesis project. I am interested in therapeutic endings and would like to meet with clinical psychologists in the North West for individual interviews lasting about an hour to discuss this further. Specifically, I would like to find out more about your experiences and understanding of endings in therapy, in the hope of developing a deeper understanding of how clinicians make sense of this process.

If you are interested in taking part in the project or would just like to find out more, then please contact me on [redacted] or via email at [redacted].

Thank you very much for your time.

Regards,
Rosie Noyce.

Trainee Clinical Psychologist
Lancaster University

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Clinical Psychologists' Understandings of Endings in Therapy

EXAMPLE ONLINE ADVERT

What is your experience of endings in therapy?

I am conducting a study to explore the experience of therapeutic endings by qualified clinical psychologists. This will involve conducting individual interviews lasting about an hour with clinical psychologists in the North West to discuss your experiences of endings in therapy and how you have made sense of them.

Whether you place a lot of importance on endings, or consider them to be an inconvenient by-product of therapy, your participation would help me to develop a deeper understanding of how therapeutic endings are conceptualised and experienced by clinical psychologists.

If you are interested in taking part, or would like some more information, please contact **Rosie Noyce** on [redacted] or [redacted]

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FHMREC Approval Letter

Applicant: Rosie Noyce
Supervisor: Dr Stephen Weatherhead
Department: DHR

LANCASTER
UNIVERSITY



27 July 2012

Dear Rosie and Stephen,

Re: Clinical Psychologists' Understanding of Endings of Therapy

Thank you for submitting your research ethics application for the above project for review by the Faculty of Health and Medicine Research Ethics Committee (FHMREC). The application was recommended for approval by FHMREC. On behalf of the Chair of the University Research Ethics Committee (UREC) I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact the Research Ethics Officer, [REDACTED] ([REDACTED]) if you have any queries or require further information.

Yours sincerely,

[REDACTED]

[REDACTED]

Secretary, University Research Ethics Committee

Cc Professor [REDACTED] (Chair, UREC); Professor [REDACTED] (Chair, FHMREC)

Research Support Office
Research and Enterprise Services

Lancaster University
Bowland Main
Lancaster LA1 4YT
United Kingdom

[REDACTED]
Web: <http://www.lancs.ac.uk>

FHMREC Approval for Amendments Letter

Applicant: Rosie Noyce
Supervisor: Dr Stephen Weatherhead
Department: DHR

LANCASTER
UNIVERSITY



09 January 2013

Dear Rosie and Stephen,

Re: Clinical Psychologists' understandings of endings in therapy

Thank you for submitting your amendment to the above project for review by the Faculty of Health and Medicine Research Ethics Committee (FHMREC). The amendment was recommended for approval by FHMREC, and on behalf of the Chair of the University Research Ethics Committee (UREC), I can confirm that approval has been granted for this amendment.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact the Research Ethics Officer, [REDACTED] if you have any queries or require further information.

Yours sincerely,

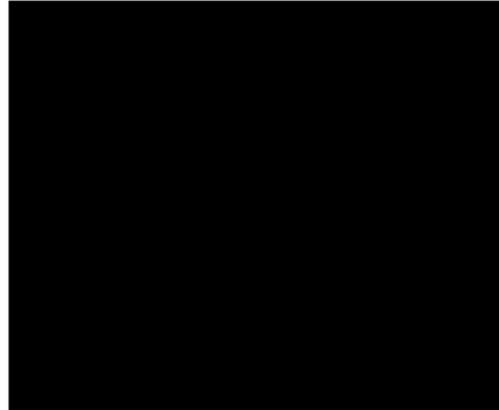
[REDACTED]
Secretary, University Research Ethics Committee

Cc Professor [REDACTED] (Chair, UREC); Professor [REDACTED] (Chair, FHMREC) Research Support Office
Research and Enterprise Services

Lancaster University
Bowland Main
Lancaster LA1 4YT
United Kingdom

Web: <http://www.lancs.ac.uk>

An Example Research and Development (R&D) Approval Letter



12th October 2012

Miss Rosie Noyce
Trainee Clinical Psychologist
Lancaster University
Clinical Psychology Programme
Division of Health Research
School of Health and Medicine, Whewell Building
Lancaster
LA1 4YW

Dear *Miss Noyce*,

Re: NHS Trust Permission to Proceed

Project Reference: [REDACTED]

Project Title: *Clinical Psychologists' Understanding of Endings in Therapy*

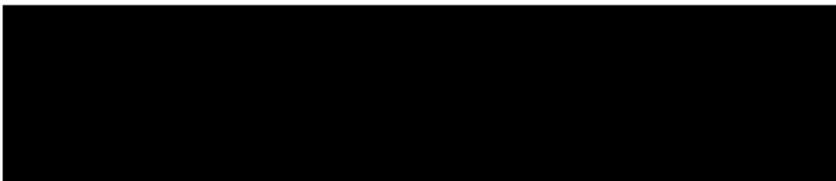
I am pleased to inform you that the above project has received research governance permission.

Please take the time to read through this letter carefully and contact me if you would like any further information. You will need this letter as proof of your permission.

Trust R&D permission covers all locations within the Trust; however, you must ensure you have liaised with and obtained the agreement of individual service/ward managers. You must also contact the relevant service/ward managers prior to accessing the service to make an appointment to visit before you can commence your study in the trust.

Honorary Research contracts (HRC)

All researchers with no contractual relationship with any NHS body, who are to interact with individuals in a way that **directly affects the quality of their care**, should hold Honorary Research NHS contracts. Researchers have a contractual relationship with an NHS body either when they are employees or when they are contracted to provide NHS services, for example as independent practitioners or when they are employed by an independent practitioner (*Research Governance Framework for Health and Social Care, 2005*). If a researcher does not require an HRC, they would require a Letter of Access (LoA). For more information on whether you or any of your research team will require an HRC or LoA please liaise with this office. It is your



[REDACTED]

responsibility to inform us if any of your team do not hold Honorary Research NHS contracts/Letters of Access.

Staff involved in research in NHS organisations may frequently change during the course of a research project. Any changes to the research team or any changes in the circumstances of researchers that may have an impact on their suitability to conduct research **MUST** be notified to the Trust immediately by the Principal Investigator (or nominated person) so that the necessary arrangements can be put in place

Research Governance

The Research Governance Sponsor for this study is Lancaster University. Whilst conducting this study you must fully comply with the Research Governance Framework. This can be accessed at: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4108962&chk=Wde1Ty

For further information or guidance concerning your responsibilities, please contact your research governance sponsor or your local R&D office.

Risk and Incident Reporting

Much effort goes into designing and planning high quality research which reduces risk; however untoward incidents or unexpected events (i.e. not noted in the protocol) may occur in any research project. Where these events take place on trust premises, or involve trust service users, carers or staff, you must report the incident within 48 hours via the Trust incident reporting system. If you are in any doubt whatsoever whether an incident should be reported, please contact us for support and guidance.

Regardless of who your employer is when undertaking the research within [REDACTED] Trust you must adhere to trust policies and procedures at all times.

Confidentiality and Information Governance

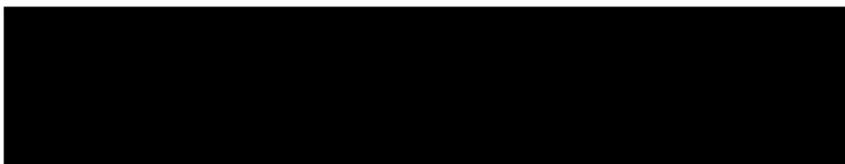
All personnel working on this project are bound by a duty of confidentiality. All material accessed in the trust must be treated in accordance with the Data Protection Act (1998) For good practice guidance on information governance contact us.

Protocol / Substantial Amendments

You must ensure that the approved protocol is followed at all times. Should you need to amend the protocol, please follow the Research Ethics Committee procedures and inform all NHS organisations participating in your research.

Monitoring / Participant Recruitment Details

If your study duration is less than one year, you will be required to complete an end of study feedback report on completion. However if your study duration is more than one year, you will be required to complete a short electronic progress report annually and an end of study report on completion. As part of this requirement, please ensure that you are able to supply an accurate breakdown of research participant numbers for this trust (recruitment target, actual numbers recruited). To reduce bureaucracy, progress reporting is kept to a minimum; however, if you fail to supply the information requested, the trust may withdraw permission.





Recruitment

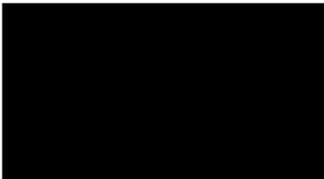
Please provide the trust details of your recruitment numbers when requested. If you have any concerns with recruitment please contact the R&D team immediately for assistance.

Final Reports

At the end of your research study, we will request a final summary report so that your findings are made available to local NHS staff. The details from this report may be published on the NHS Trust internet site to ensure findings are disseminated as widely as possible to stakeholders.

On behalf of this Trust, may I wish you every success with your research. Please do not hesitate to contact us for further information or guidance.

Yours sincerely,



Quality & Research Lead
On Behalf of the Research Governance Sub-Committee

Cc: 

