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**When Personal and Professional Worlds Collide:  
An exploration of trainee counselling psychologists'  
experience of having a relative with mental health  
problems**

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**Professional Doctorate of Counselling Psychology**

**City University**

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**February 2014**

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### **Declaration of powers of discretion**

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## Key

<b>Abbreviation</b>	<b>Name</b>
APA	American Psychological Association
BACP	British Association for Counselling and Psychotherapy
BPS	British Psychological Society
CBT	Cognitive Behavioural Therapy
DA	Discourse Analysis
ED	Eating disorder
FDA	Foucauldian Discourse Analysis
FM	Family member
GAD	Generalised Anxiety Disorder
GP	General Practitioner
GT	Grounded Theory
IPA	Interpretative Phenomenological Analysis
NAT	Negative Automatic Thought
NICE	National Institute for Health and Care Excellence
PHQ-9	Patient Health Questionnaire-9
TA	Thematic Analysis
UK	United Kingdom
VS	Versus
NHS	National Health Service

# 1 Preface

## 1.1 Introducing the portfolio

This portfolio contains a selection of work completed for the Professional Doctorate in Counselling Psychology at City University, London. The portfolio is split into four main parts: Preface, Research, Client Study and Journal Article.

Firstly, the Preface explores how the portfolio is connected to the researcher's own personal and professional journey. Secondly, the Research part of this portfolio explores and introduces the reader to the research entitled: '*The experience of having a relative/friend with a self-reported mental health condition for trainee counselling psychologists personally, professionally and academically*'. This consists of a literature review, methodology, method, analysis and discussion section. It employs a qualitative methodology using an Interpretative Phenomenological Analysis framework (IPA) using procedures outlined by Smith, Flowers and Larkin (2009).

The third part of the portfolio is a Client Study entitled '*Working with perfectionism and self-blame within the cognitive behavioural model*'. It focuses on one client and took place during the researcher's Professional Doctorate in Counselling Psychology course placement at an NHS counselling centre. The final part of the portfolio is a Publishable Paper in the form of a journal article and adheres to the contributor's guidelines of the *Counselling Psychology Review*. This is a quarterly peer-reviewed research publication created by the Division of Counselling Psychology. The subordinate themes: 1. '*Not knowing in an expected therapy role*'; 2. '*Negotiating identity: Family versus therapy role*'; and 3. '*A depletion of mental and physical energy for trainee counselling psychologists*' were derived from the research study and are presented within the journal article. The journal article supports the criteria for publication in the *Counselling Psychology Review* as the research study is carried out within the UK and the findings may also be of interest to other psychology disciplines. The journal article is directly related to the work of counselling psychologists.

All parts of the portfolio share similar concepts which will be discussed below.

The confidentiality of research participants and clients have been protected throughout this portfolio. The names of individuals and any identifying places or characteristics have been changed, omitted or anonymised.

## **1.2 My philosophical journey**

Firstly, I would like to comment on the personal and professional journey I embarked upon in becoming a trainee counselling psychologist. My path to becoming a counselling psychologist started at the age of fourteen. I wanted to have a better understanding of the individuals in my life so that I could help them. As a young adolescent I could not understand why some people behaved the way they did and I remember wanting to find answers. I also remember feeling very affected by these behaviours as a child and feeling very alone, with no-one to talk to. I always wished I had someone to talk to and I vowed to myself that I would be that someone for others. This is where my passion for psychology started and it motivated me to complete an A-Level and degree in Psychology.

During that time, I was educated by many different schools of psychology, all of which displayed different philosophical and epistemological views. I was taught works by behaviourists such as John Watson and Burrhus Skinner who held the view that individuals' were conditioned by their environment to behave in specific ways. Their epistemological view supported a positivist view which looked at what you can observe and measure and nothing beyond that. I learnt works from post-modernist figures who viewed humans as intrinsically good and empowered clients to gain control of their own lives in order to facilitate positive therapeutic change. The positivist view was rejected as it worked predominantly with thoughts, emotions and perceptions, etc., which cannot be scientifically measured.

After my studies I worked for three years within the mental health sector on an NHS acute mental health ward and I then went on to work in a forensic personality disorder unit for two years. At that time of my life, I did not have a clear idea of my philosophical stance. With hindsight I can see that my philosophical stance was a humanistic one due to my perception that humans were intrinsically good in nature and had the potential for growth. However, I also understood the importance of

working within the medical model as it enabled me to understand mental health diagnoses. I also identified with the behaviourist philosophy as I understood how an individual's environment can have a direct effect on their behaviour. At the time, I was beginning to understand my own personal way of working which I felt represented my personal and professional philosophical underpinnings. With regards to the medical model I began to see that medication and diagnosing symptoms were not the only or complete answer. I wanted to gain skills working with the individual's psychological process, thus helping to facilitate therapeutic change to aid in recovery through talking therapies. This influenced my decision to further my education and I made the decision to enrol onto the Professional Doctorate in Counselling Psychology course. The foundations of the course supported my philosophical and epistemological underpinnings:

*Counselling psychologists understand diagnosis and the medical context to mental health problems and at the same time work with the individual's unique subjective psychological experience to empower their recovery (...) It has its origins in the UK within the humanistic movement with influences from counselling psychology in the USA and European Psychotherapy on the one hand; and the science of psychology (cognitive, developmental, and social) on the other (...) it seeks to develop phenomenological models of practice and enquiry in addition to that of traditional scientific psychology.*  
(BPS, 2013)

The research study within this portfolio also reflects the epistemological underpinnings that I personally hold, which is reflected within the methodology under the concept of phenomenology to interpret the participant's lived experience. Phenomenology is a central component of the study, contributing to the way the study is carried out and analysed. Phenomenologist's aim to understand the experience of being human and what our lived-world consists of (Smith, Flowers & Larkin, 2009) (further explored in section 2.9.5). This fits in with the value of counselling psychology, as stated by the BPS, that one of the aims of counselling psychology is to develop phenomenological models of enquiry and practice (2013). This supports my counselling psychologist identity and forms part of the way I practice, which informs my therapeutic work with a client. This is reflected within

the phenomenon that is presented within the client study. Within this portfolio, my client, Sophia, displayed perfectionist characteristics, which served a different function for her than my perfectionism served for me. This demonstrates how two individuals can have different interpretations of a similar entity; also a concept of phenomenology.

Phenomenology also forms part of my personal identity. The way I view the world is through interpreting what my experience means to me and I recognise that my experience and perception of things in life are different to others. This puts me in a position where I can respect other opinions that may be different to mine. As a result, I am able to gain a deeper understanding of an individual's lived experience within my personal and professional life. I believe this enhances the relationships in my life as it puts me in a position where I am better connected to others.

Since commencing this course, I have been constantly challenged to define my professional identity and philosophical stance. It has been a process which has constantly changed and evolved, one which I believe will continue to do so after the course. Over the years, I have found myself progressing from a cognitive behavioural therapy approach (CBT) to a more integrative one. I enjoy working in a workplace which may not adopt a purely CBT framework. The work within my NHS placement allowed me to formulate with my supervisor and client which model of therapy may best suit the client. It was a richer experience to be able to fit the models around the client, instead of the client within the models.

My epistemological positioning is one of critical realism (Archer et al. 1998), where I believe that each individual has a unique way of viewing the world. In other words, what is real for them may not be real for another individual; however it does not mean that their view does not exist. I situate myself within the critical realist perspective, as described by Bhaskar and Parker (1998). My epistemological positioning, as a critical realist, is a part of me and helps shape how I view the world and the individuals and experiences within it. This is a view which is present within all aspects of my life. This is further explored within the Methodology chapter of this thesis.

Completing this portfolio has been a journey where I have developed and grown personally and professionally. The IPA of the data was a very intensive process which required an in-depth analysis of the data (Smith, Flowers, & Larkin, 2009). I found myself being challenged throughout, as I found I had to look deeper at how I viewed the data in order to be able to gain some depth within my analysis. Heidegger (1962) believed that the individual will bring to light what they are talking about within their discourse. As a researcher, I helped to facilitate the appearance of the phenomenon and assisted in interpreting the appearance. I did this by using the hermeneutic circle to aid me in analysing the participants' transcripts, as suggested by Smith, Flowers and Larkin (2009). Here, each word was looked at in connection to the sentence and each sentence was looked at in connection to the words. As I developed through the data analysis, looking deeply from word to word, sentence to sentence, looking for hidden meanings and what was present and not present. I found that the way I viewed the world in my personal and professional life was changing. Within my personal life, I found I was listening more to what individuals were telling me, how they were saying it, picking up on specific words they were using and questioning why they may have used a specific word and if it had a deeper meaning. I would ask questions in response to my new observations and I found that I was seeing more than I had before. The pearls of communication that were given to me by others were less likely to be missed. This added to my personal relationships as I was engaging in more meaningful conversations. I also found the therapy sessions with my clients were having a similar effect as I was really listening to each word the participants' were saying, what they were not saying, why they used specific words, pauses in their language, hesitations, tone used, metaphors used, etc. This led to a much richer and deeper therapy session and the client-therapist relationship became increasingly stronger. It also aided in nurturing trust between myself and my clients.

I never thought that this research study would have such an impact on me to the extent that it changed the way I view life. I feel that I have become a much better person because of it and I have also come to know myself better as a result. The research study has challenged me by encouraging me to raise and explore my preconceptions by using formal reflexive techniques (Duck, 1992; Smith, Flowers & Larkin, 2009), which is a concept of phenomenological studies (Moustakas, 1994). Caelli (2001) stated that true phenomenological research requires the researcher to

adopt reflexive techniques as they give a more faithful representation of the way in which the world is seen. A critical realist epistemology also implores us to be critical of our own understanding (Bhaskar, 2008). I feel that since the research study, I have become more reflective within my personal and professional life and it has helped me to align my perceptions and gain a different point of view. My counselling psychology skills have improved from this research study and not only through the skills I learnt through carrying out the study but through the experience overall. The research project was a personal and professional challenge to me and there were times when I felt I could just give up. However, I persevered through it and I feel a wondrous sense of achievement and strength in completing this portfolio.

An additional theme which I feel links the pieces of my portfolio together is the art of self-awareness. The growth of my personal self-awareness was a lengthy process, which I will explain below.

### **1.3 Self-awareness**

Within the realm of psychology, the psychoanalytical model has always been interested in encouraging the therapist to use their own personality, skills learnt and intuition within the counselling room with a client. It expects trainees to be self-aware, reflect and understand themselves within their social-cultural context and apply this knowledge in service of their clients (Reinkraut, Motulsky & Ritchie, 2009). A therapist's awareness of their own presence within a therapy room and what it can bring or take away from the therapy room is seen as a fundamental aspect of the therapeutic relationship between client and therapist (Woolf, 1996). In the past, psychoanalytic institutes took on Freud's theories and trained their counsellors to develop their self-awareness and to understand themselves more (Rizq, 2005). The therapist as an entity within the therapy room is acknowledged within the counselling psychology profession and more attention is paid to it than other divisions of psychology. Counselling Psychology is one of the few divisions within the British Psychological Society (BPS) that has made it compulsory for trainees to undertake a minimum of forty hours of personal therapy as a requirement of the course. Personal therapy is therefore seen as crucial for counselling psychologists to increase their level of self-awareness on a continuous basis (Woolfe, 2006).

As a requirement of the course, I started personal therapy for the first time in my life. Instead of participating in the mandatory forty hours of personal therapy, I found myself participating in approximately one hundred and twenty hours of personal therapy over the space of four and a half years. I found it an enlightening experience, one where I was able to look at the way I experienced and interpreted life and understand why I behaved and felt in certain ways. For me, the therapy process authenticated just how influential personal therapy can be for an individual, both personally and professionally, and I felt honoured to have such a vocation in life where I could help facilitate positive change for another individual. Geller et al., (2005) stated that “*Personal therapy or analysis is, in many respects, at the centre of the mental health universe. Our training, our identity, our health and our self-renewal revolve around the epicentre of personal therapy experience*” (p. 3). Personal therapy had one of the biggest impacts on my trainee counselling psychology identity. My self-awareness developed through personal therapy as I began to understand my own personal process. This enhanced my abilities as a counselling psychologist in a positive way. In connection to my thoughts and feelings in a therapy room with a client, I was able to acknowledge if they were or were not my own. I was able to reflect the client’s projections back to them, which highlighted the client’s unresolved issues and assisted in facilitating further therapeutic change (Macran, Stiles & Smith, 1999).

The client study within this portfolio reflects this process within the therapy room. As previously mentioned, Sophia demonstrated a need to be perfect. Within the sessions, I found Sophia’s perfectionism activated a desire within me which I was not originally aware of, to be the perfect counsellor for her. I explored this within supervision and personal therapy and I learnt a lot about myself within that time. This act of reflection allowed me to be more self-aware, which made me a better therapist for my client and further facilitated therapeutic change for Sophia. This theme was also reflected within the research study; the participants also recognised that thoughts and emotions in connection to their relative/friend with a mental health problem spilt over into their client sessions. They took these processes to supervision and personal therapy and found it beneficial for themselves and their client work.

These unresolved thoughts and emotions were found to have a negative impact within the therapeutic process.

As my counselling psychology identity was changing and I was becoming more self-aware, I recognised that I was not just pre-occupied in mastering the theoretical and technical tools as I did in year one and most of year two. I was looking beyond that and seeing how my presence as a therapist was being implemented within the counselling room. This is in regards to how I am as a therapist, e.g. how I use my tone of voice in the room with the client, my intuition, my body language, my caring nature, my warmth and how it may be received by the client. I am also aware of how the client impacts on me within the therapy room. Counselling psychology acknowledges what a huge part the therapist plays within the therapy room with a client and how the therapist's own internal world can present itself when with a client if not properly acknowledged. I decided to write my client study on Sophia, with the aim of demonstrating my growing awareness of the two-person nature that psychological therapy involves and my ever-evolving identity as a trainee counselling psychologist through reflexive processes. These changes are further explored within the client study (chapter 3). This theme was also shared amongst some of the research participants within the study. Some of the participants struggled with their trainee counselling psychology identity in relation to experiencing a relative with a mental health condition. Some of the participants revealed how having a relative/friend with a mental health condition generated a positive experience with clients who reminded them of their relative/friend, as the participants were able to empathise more with their clients. However, some participants also spoke about how the experience with their relative/friend resulted in a negative client-therapist interaction as the client who reminded them of their relative/friend triggered negative thoughts and emotions in the therapist. In my own personal experience, I too struggled with my trainee counselling psychology identity in relation to my own experience. In my placement sessions I found my own experience coming into my mind when I was presented with a client whom reminded me of a family member. I found I empathised more with that particular client and felt a deeper insight and connection to that client's world.

This portfolio also reflects themes of self-awareness in the form of reflexivity. Willig (2008) states that “(...) *researcher influences and shapes the research process, both as a person (personal reflexivity) and as a theorist/thinker (epistemological reflexivity)*” (p. 218). I am aware that I am personally close to the research topic and I have taken extra care to ensure that I am not imposing my own views onto the participants (explored further in section 2.10.23). I have remained as open as possible to alternative experiences that may be different to mine.

#### **1.4 Personal experience**

For me, within this portfolio the research study contains the greatest meaning. Around the first year of my Doctorate in Counselling Psychology course, a family member was diagnosed with a mental illness and given medication which caused adverse side effects on their mood and behaviours. The research study was inspired from my experience of this and explores the lived experience of trainee counselling psychologists who have a relative/friend with a self-reported mental health condition and their experience of it in relation to the academic, professional and personal aspects of their lives. The research study aims to interpret the lived experience of each individual participant using phenomenology. It aims to reveal what the individual may be experiencing so that others can gain an awareness and understanding of this phenomenon. Once an understanding is made, future research can be carried out to explore ways in which individuals are able to support trainee psychologists at a vulnerable time in their lives for better service for themselves and for the clients they may be treating. It also aims to raise awareness for psychology trainees who may be in a similar position and highlights the importance of seeking extra support which would be beneficial to the trainee and their clients.

## 1.5 References

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## **2 Research**

The experience of having a relative/friend with a self-reported mental health condition for trainee counselling psychologists personally, professionally and academically.

## 2.1 Abstract

This research has attempted to gain an insight into the lived experience of trainee counselling psychologists who have a mentally ill relative and how they experience that personally, professionally and academically. The study was conducted using semi-structured interviews and the findings were analysed using Interpretative Phenomenological Analysis (IPA). The sample consists of eight individuals who are on a UK-based Professional Doctorate in Counselling Psychology course. Four super-ordinate themes were identified: 1. Negotiating roles: Personal identity versus therapy identity; 2. Continuing a therapy role within a personal space: Personal impact 3. Personal influence within a professional role; and 4. A space for personal development. The results highlight that the participant experience had a considerable negative and positive impact on the trainee psychologist's personal and professional lives. The study has demonstrated that the participants need more support within this area and it may be beneficial for trainees to seek extra support from their universities and for educators to gain awareness of the demands placed on a trainee who may be in a similar situation so that they can offer them additional support.

*Keywords: trainee counselling psychologist, mental illness, IPA, relative, counselling psychology*

## **2.2 Introduction**

### **2.3 Aims of the research**

The aims of this research were to explore trainee counselling psychologist's experiences of having a self-reported mentally ill relative/friend. The research explores how the trainees experience this personally, professionally and academically. This study hopes to capture each individual's lived experience and unique perspective of this phenomenon. In association with an Interpretative Phenomenological Analysis methodology (IPA), the captured data was filtered through the researcher's own interpretation of the meaning of the data and presented within the study. This study hopes to give the reader the unique experience of understanding what each trainee experienced within this phenomenon.

An initial search of the literature reveals that although there are many quantitative studies which explore the experience families (Greenberg, Greenly & Benedict, 1994; Herz et al., 1976) and therapists (Lefley, 1985; Lefley, 1987) have with a relative with a mental health condition, it does not offer a deep insight into the individual's lived experience of having a relative/friend with a mental health condition. This study takes the findings in the existing literature further by producing insight into the lived experience of trainee counselling psychologists who have a relative/friend with a mental health condition. The literature shows numerous studies which look at how therapists experience their own mental health problems and their experience of it within a psychology work setting (Gilroy et al., 2002; Givelber & Simon, 1981; Sherman & Thelen, 1998). It gives insight into how a therapist's own personal problems can impact on their therapeutic work with a client. This research study went on to explore how counselling psychology therapists in training experienced a relative/friend with a mental health condition and their experience of it at their place of work. The findings demonstrate that the participants mental health experience with their relative/friend, as they were studying to be a trainee counselling psychologist, resulted in their thoughts and emotions around that entering the therapy sessions with a client in a negative and positive way. The findings also show that participants chose the counselling psychology course as a consequence of their relative/friends mental illness in order to gain an increased understanding or to take up a wounded healer role.

Secondly, the literature reveals the stresses (Kumary & Baker, 2008) and personal changes (Faber, 1983a; Seashore, 1975) that psychology trainees experience during their course. It has been illustrated within the literature that burnout amongst counselling trainees can have a severe impact on the counselling psychology trainees and their clinical practice (Shapiro, Shapiro & Schwartz, 2000). The findings within this study show that participants experience concepts of burnout, in the form of a depletion of mental and physical energy, when balancing the demands of the course and continuing a therapy role at home.

Lastly, the literature reveals trainee psychologists experiences during training (Hamilton & Mackenzie, 2007a) and some of the stresses they face (Truell, 2001). No studies were found which explore the trainee's experience during training with a relative with a mental health condition. This study reveals that a trainee counselling psychologist's experience with their mentally ill relative creates additional burden which negatively impacts the course in numerous ways as personal emotions spill over.

The majority of the studies found were quantitative which aim to measure observable data and find a connection between the cause and effect. There is usually a pre-made hypothesis that the study will prove or disprove. This process will not allow the participants to construe what they have experienced from their own realities and allow for new experiences to be shared, which is something that a qualitative methodology can facilitate and one of the reasons why the IPA methodology was selected for this research study. The researcher's experience as both a trainee counselling psychologist and having personally experienced a relative with a mental health condition whilst on a counselling psychology course indicate that there is much to explore and learn from this phenomenon. However, this could not be properly explored from the subjective sample of one person's individual experience and so the research study was carried out to further explore this phenomenon.

## **2.4 The context of the research**

### **2.4.1 What is a self-reported mental health condition?**

A self-reported mental health condition within this study refers to the participants' belief that an individual they know has/had a mental health condition regardless of having been diagnosed by a clinician. This study is not looking to prove whether the individual was right or wrong in their view of mental illness, instead this study wants to hear their experience of it.

### **2.4.2 What is a trainee counselling psychologist?**

Within this portfolio, a trainee counselling psychologist is an individual who is on the British Psychological Society (BPS), UK and academic training programme of the Professional Doctorate in Counselling Psychology. According to the BPS, counselling psychologists are:

*(...) concerned with the integration of psychological theory and research with therapeutic practice. The practice of counselling psychology requires a high level of self-awareness and competence in relating the skills and knowledge of personal and interpersonal dynamics to the therapeutic context. (2013)*

### **2.4.3 Why use trainee counselling psychologists for this research study?**

There were various reasons why this study decided to only use trainee counselling psychologists from the BPS accredited Professional Doctorate in Counselling Psychology course. Firstly, there are so many different psychology courses that offer so many different ways of practising therapy. There are different areas of study (forensic, occupational, educational, child psychology, etc.) within different schools of psychology (person-centred, existential, psychodynamic, etc.) within different bodies of psychology (BPS, BACP, APA, etc.). All courses offer different subjects of learning and different ways of learning which provide different skill sets. With all these variations, it was considered that by staying within a particular course it meant that all participants had similar training and a similar skill set.

Secondly, personal therapy is compulsory for trainees on the BPS Doctorate in Counselling Psychology course, whereas it is not compulsory on other courses and this may alter the skill set of the trainee. The BPS Professional Doctorate in Counselling Psychology requires all students to undertake a minimum of 40 hours of personal therapy. Rizq and Target's (2007) study concluded that through personal therapy, participants felt they were able to "*establish authentic emotional contact with themselves*" (p. 46). All participants in the study felt it was important that personal therapy should remain mandatory in counselling psychology training programmes within the UK. Many studies found that personal therapy for trainee psychologists was a positive experience (Rizq & Target, 2007; Kumari, 2011); however, others found it to be a negative experience (Grimmer & Tribe, 2001; Atkinson, 2006). This experience changes the skill set of the individual and as the methodology used within this study was IPA, a homogenous sample was appropriate. This study employed the tactic of purposive sampling which was a closely defined sample group where the research question would be significant (Smith & Osborne, 2003). It is recognised that the participant sample reflects a minority sample of the population. It is inferred that other individuals in similar courses would still be able to relate to this research and gain something from it.

This literature review within this portfolio is set out to present literature which looks at the impact of personal experiences for trainees and mental health professionals in their personal and professional lives. It explores the impact of the psychology training course on trainee psychologists. The literature review also highlights the impact of a mentally ill relative/friend on their families, mental health professionals and psychology trainees. It explains the rationale and aims of the current study.

## **2.5 Literature review**

### **2.5.1 Search strategy**

The following literature review has drawn upon information which has been found in various literature databases. Part of the search was in electronic journal databases such as: Ovid, Counselling and Psychotherapy Transcripts, Client Narratives and Reference Works, Ebscohost and Scopus. City University Library and the British Library were also searched for electronic and non-electronic journals and books. The search engine Google Scholar was also searched for electronic journals, books and articles.

During the literature search the most current literature was sought for. However, if current literature was not found on a specific topic area, the scope of the search was widened or older literature used. Books, journal articles and professional conference presentations from the disciplines of counselling, counselling psychology, clinical psychology, psychotherapy, psychiatry and mental health workers were all part of the literature search. These disciplines were researched because they all incorporate counselling skills and they all work with mentally ill individuals which are all part of the topic area.

The following keywords were put together and used to ignite searches: trainee counselling psychologist, counselling psychologist, counselling psychology, clinical psychology, clinical psychologist, trainee psychologist, trainee counselling psychologist, therapist, trainee therapist, mental health, family mental health, caregivers, mental health burden, countertransference in trainee psychologists, counselling psychology course, psychology course, psychotherapy course, stress in psychology trainees, experience of psychology trainees, relative with mental health, families perceptions of trainee psychologists, friends perceptions of trainee psychologists, impact of relative with mental illness at work and Interpretative Phenomenological Analysis.

A literature review mind map was constructed which looked at what the current study wanted to explore and different avenues in which to explore. The articles were

also viewed in order to see how relevant the literature was to the research, the type of research method used and how it contributed to the literature review.

### **2.5.2 Mental health impact on therapists**

Many individuals experience mental health symptoms within their life. Goldberg and Huxley's 1992 census reports that one in four adults will experience a mental illness in their lifetime. Around three out of ten individuals will experience mental health problems every year within the UK. It is not known how many, however amongst these statistics are trainees and professionals within the psychology field (Gilroy, Carroll & Murra, 2001).

Givelber and Simon's (1981) study looked at their own personal experience as a therapist who lost someone close to them through death and explored its impact on the therapy with a client. It was found that a grieving therapist often felt "*fragile, sad and depressed*" (p. 143). It was also found that therapists may discourage the discussion of specific feelings from their client for fear they may break down, which can result in disregarding the patient's needs in the therapy session. The authors found that their personal pain from loss, at times, also resulted in limiting their ability as therapists to work effectively with their client which may have had a negative impact on the therapy. However, the study also found that the therapist's experience of loss could improve the therapeutic relationship with a client. Givelber and Simon stated that a positive outcome of mourning was that "*suffering deepens one's ability to listen...one responds to a loss in a patient's life in a keener more sensitive way*" (p. 145). The study noted that the positive outcome did not lessen the distress they experienced. This information can help others gain a better understanding of some of the experiences that a therapist may have with their clients. The study also identified that the therapists did not look after themselves properly as they did not take time off work after the loss of a loved one. Givelber and Simon claim this may be due to financial worries, seeking comfort from therapeutic relationships at work and wanting to maintain the structure that work gives them. There did not seem to be any methodological design to this study. It appears the authors spoke about their own experiences and asked colleagues about their experiences. The use of participants that they knew may have added bias to the

study. This study is personally close to the therapist's and it does not mention how they managed to cope with their loss. Nor does it mention if they were able to work effectively with clients and conduct the study at the same time. A lack of appropriate support may have had a negative effect on the therapists personally and professionally which could have impacted on the outcome of the study (Pais, 2002).

Pappas's (1989) study presented a psychotherapist experiencing grief due to divorce and found that the effects of "*grief affects both his/her inner emotional state and his ability to accurately hear and respond to patient material*" (p. 512). It was also identified that "*(...) therapist's personalities are major tools in their work, and what affects them often affects their work*" (p. 511). Both these studies demonstrate that the personal issues of grief and divorce do spill over into a therapist's professional work with a client. This may be generalised to include other personal issues a therapist may face in their life and be further explored to find out a therapist's experience of this at work.

Deutsch's (1985) study looked at the personal problems of therapists and their treatment route. It was found that the therapists experienced relationship problems, depression, suicide attempts and substance abuse in their lives with 10% of therapists hospitalised and 26% on medication. Clayton et al. (1980) found that females from a psychology profession had a higher rate of major affective disorder than females from the general population. In Mausner and Steppacher's (1973) study it is evident that the rate of suicide for female psychologists from the American Psychological Association (APA) was much higher than the rate of suicide in the female general population. However, the rate of male psychologists was lower than the rate of males in the general population. Participants in these studies disclosed very personal information, and in Deutsch's (1985) study participants spoke about the sense of relief they experienced in being able to share their secret. Some participants may have been unwilling to disclose such personal information and it is possible that the percentage of personal problems could be higher than reflected. This shows how delicate this subject area is and a research methodology needs to be carefully explored so that it facilitates a therapeutic and safe environment for participants to be able to share their experiences.

All of these studies demonstrate that a therapist having knowledge and experience within the psychology field does not mean that they are exempt from being affected by mental illness themselves.

### **2.5.3 Depression and therapists**

It has been well documented within the literature that depressive symptoms can impact a professional psychologist's functioning in a negative way (Gilroy, Carroll & Murra, 2001; Gilroy, Carroll & Murra, 2002; Guy, Poelstra & Stark, 1989; Moursund, 1993; Sherman 1996; Sherman & Thelen, 1998). It has been identified that depression is one of the most common symptoms of distress amongst psychotherapists (Mahoney, 1997; Pope & Tabachnick, 1994). The consequences of depressive symptoms have also been found to result in a decrease in the quality of clinical work for a therapist. This has resulted in the therapist experiencing memory problems at work, being unable to maintain focus with their client, feeling tired and having a lack of energy for their therapeutic work (Gilroy et al., 2002; Sherman & Thelen, 1998). As a result of their depressive symptoms at work, some therapists also experience an "*increased sense of isolation from their colleagues and lessened energy and ability to concentrate on their relationships with their clients*" (Gilroy, Carroll & Murra, 2002, p. 402). This can result in boundaries and ethical codes being broken (Gilroy et al., 2002; Sherman & Thelen, 1998). However, some therapists continue with clients even when they are feeling distressed as they are worried that the consequences of admitting impairment may result in feelings of embarrassment, loss of clients or professional status and being judged by others (Barnett & Hillard, 2001). As a result of this, some therapists avoid seeking personal therapy (Deutsch, 1985). This could be detrimental to the therapist's well-being; indeed some of the literature states the importance of personal therapy for the therapist (Henry, Sims & Spray, 1971; Lackie, 1983).

Gilroy, Carroll and Murra's study (2001) explored therapist's experience with depression and treatment. Out of their 220 participants, 76% of therapists had experienced a depressive illness and 85% of those participants said they had received treatment in the form of personal therapy. The study explored what aspects of personal therapy the participants benefited from; however the study did not explore

the impact of personal therapy on client work and the use of therapy sessions in relation to the impact of their depression on their client work. The study asked therapists to describe how their depression may have impacted on their client work. The positive consequences the therapists experienced were; increased empathy, ability to make a more accurate assessment and diagnosis, less fear of a client's anger, increased sensitivity to a client's depression, increased compassion, greater insight into a client's experiences, increased knowledge base and increased patience and understanding. Negative consequences which impacted the therapist in a session with a client were: low/lack of energy, lack of confidence, concentration difficulty, decreased enthusiasm, a decreased ability to be emotionally present, fatigue and memory problems. As in Barnett and Hillard's (2001) study, therapists also feared that their colleagues would learn about their depression which may result in them losing respect and questioning their competency as a therapist. As a result of these fears, therapists felt forced to hide their depression.

Gilroy, Carroll and Murra (2002) furthered their previous (2001) study by exploring the prevalence of depressive symptoms in counselling psychologists. Counselling psychologists suffering from depression also found their mental health symptoms to be a positive and a negative experience. Psychologists experienced increased empathy for their clients and felt more effective as a therapist. They also felt a loss in energy, decreased patience, distracted concentration and decreased emotional availability and burnout. Gilroy, Carroll and Murra (2002) highlight the importance of self-care as a prevention method of psychological symptoms for the therapist and believe personal therapy should be mandatory for all trainee psychologists.

A limitation of both studies was that the therapists may have not been completely honest about receiving treatment for their depression and the impact it may have had on their clients due to fear that they may be viewed negatively or that it may pose a risk in questioning their job competence. The study was a mixed-methods design employing both quantitative and qualitative methodologies to acquire the data. The positive and negative consequences described above were acquired in the form of a qualitative methodology which presents the reader with a greater insight into the participant's experience and would allow for new data to be conveyed. Gilroy, Carroll and Murra's (2001) study cannot be generalised to male therapists as only female

participants were recruited; however Gilroy, Carroll and Murra's (2002) study employed both male and female therapists. The study did not recruit any trainee psychology participants, therefore the data collected cannot be generalised to the trainee psychology population. Both studies used a self-selection bias which may have contributed to the credibility of the results as the participants would not have been able to show the full extent of their experience.

All studies presented, demonstrate that a therapist with a mental health condition can impact on the therapeutic work with a client in both negative and positive ways and that adequate self-care in the form of personal therapy and supervision is important for therapists to be ethically safe within their client sessions.

#### **2.5.4 Stress and a depletion of mental and physical energy in therapists**

The literature shows that qualified professionals in psychology related professions are particularly susceptible to stress and burnout, which has associated effects on the delivery and quality of their care to clients (Cushway, Tyler & Nolan 1996; Fothergill, Edwards & Burnard, 2004; Moore, Deakin & Cooper, 1996; Vredenburg, Carlozzi & Stein, 1999). Part of a psychologist's job is to be sensitive, understanding and empathic towards their client. Psychologists have to be able to contain their emotions and responses in intense sessions with a client. This can be a hard job at times and can cause psychologists to feel emotionally drained, which on occasions can be difficult and may affect their quality of work with a client (O'Conner, 2001). This can cause stress which can manifest into problems for professional psychologists (Cushway & Tyler, 1996; Murtagh & Wollersheim, 1997; Schoup, 1995).

Guy, Poelstra and Stark's (1989) quantitative study explored the impact of psychotherapist's personal distress on the quality of care delivered to their clients. The study established that psychotherapists experienced personal distress in the form of job stress (32.9%), illness in the family (23.2%), death in the family (17.9%), marital problems (15.9%), personal mental illness (3.1%) and drug abuse (3.1%). 36.7% of the clinical psychologists felt that their personal distress decreased the quality of client care and 4.6% felt that their personal distress was sufficient to create

inadequate care for their clients. The study collected data in the form of self-reported surveys with multiple choice answers. As a result, the answers would not have demonstrated the full extent of the psychotherapist's experience. Some of the survey questions were vague and it is possible that participants may have had different interpretations to certain questions which may have affected the results of the study. A response bias could also cause participants to hold back with their personal disclosures in an attempt to be viewed in a better light in regards to their therapy skills.

### **2.5.5 Wounded healer – choice of profession**

Some of the literature indicates that individuals embark on a psychology career as a consequence of earlier emotional pain (Menninger, 1975). A less than desirable family environment is thought to be influential in the decision of a psychotherapist's career choice (Strupp, 1973). Walter et al., (2003) found that 5% of trainee psychiatrists chose psychiatry as a career because they had a mentally ill relative. The study also showed that having a relative/friend with a mental health condition did not only influence individuals to pursue a career in mental health but it also impacted on their training; the study does not say how.

In the psychology literature there have been many studies which discuss the wounded healer theory. It has been recognised that some individuals select a career where they help others, as they want to try and fix their own lives (Sedgwick, 1994). Within this part of the literature there are different views on the impact of a past emotional trauma in relation to a therapist's competence in the therapy room with a client. One argument by Strupp (1973) is that the therapist's childhood trauma could present itself in the therapy room with a client. There is a possibility that this could then lead to countertransference through projection and identification which would be a negative experience for the client. In comparison, this childhood trauma could be an asset to the therapist because the therapist may have a better understanding of the client's pain and be able to respond in a more constructive way (Gustafson, 1986). This cultivates optimism and empathy in the therapist which can have a positive impact on the therapeutic process between therapist and client (Bonny & Fussell, 1990).

DiCaccavo's quantitative study looked at the early family experiences of counselling psychologists to try and determine their motivations for becoming counselling psychologists (2002). He highlights the importance of self-care for counselling psychologists. DiCaccavo (2002) stated that:

*Individuals who, from an early age, have had their own care needs neglected are likely to have learned that caring for others is more important than caring for themselves. They are likely to find it difficult to ask others for help and thus risk becoming burnt out. This is compounded by mental health service cultures, which deny opportunities for students and workers to discuss fears and needs, instead adopting a macho stance to psychologist-client issues. (p. 471)*

This information indicates that therapists and trainees of psychology are not immune to having their own mental health problems or problems of any kind. As the previous studies show, these problems may elicit positive and negative responses, not only for the individual but also if these personal problems were to spill over into the therapy room with a client. Gilroy, Murra and Carroll (2002) argue that "*psychologists may not realise how much their own diagnosable emotional problems can impact their practices*" (p. 402).

### **2.5.6 Psychology training and the trainee**

The literature suggests that as a therapist's age increases, burnout decreases (Hellman, Morrison & Abramowitz, 1986; Rupert & Morgan, 2005). This implies that with time, therapists build on their skills which can inhibit the onset of burnout symptoms (Rosenberg & Pace, 2006). This indicates that trainee therapists may be more vulnerable (Halewood & Tribe, 2003; Truell, 2001) to stress-related problems (Jensen, 1995). It can be a hard task for trainee psychologists to sit in an intense session with a client and stay emotionally and verbally composed. This can result in trainees feeling emotionally drained which may affect the quality of their client work (O'Conner, 2001). This can add to a trainee's stress levels (Cushway & Tyler 1996;

Zemirah, 2000) and research indicates that stress levels rise during training (Cushway & Tyler, 1996; Skinner, Elliot & Wheeler, 2010).

Part of the literature also explores the experiences that training as a psychologist may have on interpersonal relationships. The literature suggests that the interpersonal relationships of individuals who go into training as psychologists are likely to change (Seashore, 1975; Owen, 1993). These changes can be a confusing and negative experience for the trainee. It can result in trainees decreasing their circle of friends and socialising less during their counselling career (Faber, 1983). Skinner et al. (2010) said that training is a:

*(...) potentially disturbing personal journey that requires a deconstruction of the self in order to make space for the new therapist-self to emerge. This change process appears to be influenced and supported by experiential learning exercises such as role-play and group supervision, but may be fundamentally driven by the experience of working with real clients. (p. 91)*

Millon, Millon and Antoni (1986) state that training in the psychology field is “*full of intrinsic stressors*”, presenting “*student practitioners with multiple academic and clinical demands which often lead to early self doubt*” (p. 242). Identified stressors were; long hours required from the course, deadlines and dealing with different roles such as; therapist role, student role, client role, professional role and personal role (Cahir & Morris, 1991; Schwartz-Mette, 2009).

### **2.5.7 Counselling psychology training and the trainee**

Truell’s (2001) study reflects how UK counselling psychology trainees on a Diploma course reported feeling stressed as they felt that they were viewed differently when they told individuals in their personal lives that they were on the counselling psychology course. Trainees also felt stressed as a result of the course as they felt judged by others, experienced feelings of guilt in their inability to solve everyone’s problems and realised that the course did not meet their expectations. Within a professional setting, trainees reported feeling stressed when they experienced difficulties integrating their counselling skills. They were also fearful of harming

their clients, questioned their own mental health and did not disclose anything personal on the course. Trainees also spoke about not knowing how to be themselves and not knowing how to be a counsellor. Truell's (2001) study showed one trainee saying that "*the most difficult was self-disclosure in the group...Nobody was responsible in the class to support people when they self-disclosed. The tutors aren't aware of how difficult it is*" (p. 82). Another trainee in Truell's (2001) study spoke about the tutors: "*I think they could have given more support to us at an individual level. I don't think they knew what it was like for each of us*" (p. 82). A limitation of this study is that it can be argued that six participants is a small participant sample and cannot be generalised to the rest of the student population. However, because this was a qualitative study, the sample number was sufficient and it gave a deeper insight into some of the stresses experienced on a counselling psychology course. The study also only recruited participants from one university which meant that a generalised view of the phenomena was not obtained. Another limitation of this study was that it only looked at the negative experiences of being a trainee counselling psychologist, which meant that the negative components were not put into context and a fuller trainee experience is not reflected. Personal therapy was not mandatory on this training course and consequently the findings may vary with a course that does require its trainees to undergo personal therapy.

Hamilton and Mackenzie (2007a) found that 44% of trainee counselling psychologists in their study reported a positive change in their relationships with family members from the counselling course. In Hamilton and Mackenzie's (2007a) study the students found:

*Improvement to abilities and skills learned, or developed further, during the course, such as improved communication/listening skills; having greater patience and tolerance; giving more consideration to other people's decisions and feelings; responding in different ways in relationships; and learning to prioritise different areas in life. (p. 238)*

Participants also said that "*the course had helped to deepen their understanding of self, which, in turn, had helped family relationships and allowed respondents to view these in a different light*" (p. 238).

Hamilton and Mackenzie's (2007b) study looked at the student's experience of a counselling skills training course and found that the students had gained something positive from the course as they believed that they had a "*greater understanding of self and others, improved communication skills and enhanced confidence*" (p. 1). One of the drawbacks of this study was the small number of participants for the quantitative research design, as it meant that a detailed analysis was not possible. A strength of the study was that it was a longitudinal study and it took nine years to extract all the data, which meant that it reflected much more than a single moment of student experience.

Kumary and Baker's (2008) study looked at stress and psychological distress in 109 UK trainee counselling psychologists on the British Psychological Society Diploma course. Their study concluded that the stress levels proclaimed by trainee counselling psychologists were "*unacceptably high*" (p. 25). The highest stressors reported by trainees were in; placements, the course, personal and professional development and feeling unsupported. Trainees also felt stressed in feeling de-skilled in their role. This was a quantitative study and collected its data in the form of a questionnaire which meant that a deeper more detailed account of the participants' experience could not be captured. A methodological limitation was that the study had no established level of reliability or validity as the questionnaire used was un-standardised.

Counselling psychology trainees also reported stress from the financial costs of the course, something clinical psychologists reported much less of. Trainee counselling psychologists reported experiencing stress in paying course fees, loss of financial support whilst training, paying for personal therapy, paying for supervision, childcare costs, having an unpaid placement and taking out a non-psychology-related paid job for financial income (Jensen, 1995; Bor, Watts & Parker, 1997).

The literature indicates that stress from an academic psychology course can have negative consequences personally and professionally for the trainee psychologist.

### **2.5.8 Families experience of having a mentally ill relative**

As there was not much literature available on mental health professionals or trainees with a mentally ill relative, the research net was widened to look at family members experiences of having a mentally ill relative (Caqueo-Urizar & Cuierrez-Maldonado, 2006; Lefley, 1989; Weimand, 2010; Ostman, 2007). Families with mentally ill relatives have been well researched as far back as the 1950s (Goldman, 1982) and it is explored within this review to give the reader a better understanding of a family members experience. This would give the reader a better idea of what a trainee may experience when they have a relative/friend with a mental health condition.

The literature shows that there are families who look after a mentally ill relative, and it can have a negative effect on their lives (Caqueo-Urizar & Cuierrez-Maldonado, 2006). Angermeyer (1985) remarks that *“you will find every major event conceivable in an individual’s life but you will miss the fact that a close relative has become mentally ill...one of the most devastating and catastrophic events that they can experience”* (p. 473). According to the literature, caregiver burden is thought to be an important consequence of caring for someone with a mental illness. Dillehay and Sandys (1990) defined caregiver burden as *“a psychological state that ensues from the combination of the physical work, emotional and social pressure, like the economic restriction that arise of taking care of the patients”* (p. 268). Within this definition two descriptive categories have been identified; objective burden which *“deals with the actual, objective problems”*; and subjective burden which looks at the *“psychological distress engendered by the illness”* (Lefley, 1989, p. 556). The literature does suggest that family members looking after a mentally ill relative did carry with them some amount of subjective burden (Herz et al., 1976). As a result of their relative’s mental illness, family members would worry about the future, financial problems, have trouble sleeping, feel distressed, feel nervous and try not to upset their relative. Families also experienced objective burden and the most common themes were loss of financial support from relative, taking on relative’s responsibilities and having to take time out to look after or do things for their relative (Herz et al., 1976). Family members also experienced poor health, social isolation (Weidmand, 2010), grief, empathic pain (Marsh & Johnson, 1997) and financial loss (Lefley, 1987).

Greenberg, Greenly and Benedict's (1994) quantitative study found that families with a mentally ill relative reported that the relative's contribution to the family was a positive one. The families reported that the relative contributed by preparing meals, completing chores in the home, providing emotional support to the family, providing companionship and assisting with family finances. They also said that these positive contributions increased when the relative was ill compared to when they were not ill. This shows that a relative with a mental health condition can contribute to the family in a positive way; not just negative. However, this study recognises that its client sample may be biased towards higher functioning clients, as clients with a much more debilitating mental illness may not be able to function as well. The study only looked at the contributions that the clients made to the family and did not explore any other phenomena that the same families would have experienced. A wider breadth of the whole of the participants' experience was not reflected within this study. This study used a questionnaire and telephone interviews to collect the data. The questionnaire asked specific questions which would have resulted in the presence of a self-selection bias.

The literature shows the positive and negative effects that a relative with a mental health condition can have on a family as a whole and on individual family members. The literature also shows the effect the family has on the relative with a mental health condition. All of the literature found was quantitative; none of the literature found was from a qualitative research perspective which may have been able to show an increased insight and understanding of the experience.

### **2.5.9 Therapist's experience of having a mentally ill relative**

This section demonstrates what the literature contains regarding how personal life experience can impact a professional therapist's work life when with a client.

There was limited research within this area, however the majority of research carried out was by Lefley from the 1980s onwards. One of her studies demonstrated that 67% of mental health professionals had at least one person in their family who was affected psychologically and 38% medically, by the experience of having a family member with a chronic mental illness (Lefley, 1985). Participants within this study

had been clinically diagnosed. This statistic supports my research by showing that there is a reason to carry out this study.

Another of her studies was a quantitative study which demonstrates that 72% of mental health professionals had been to therapy in relation to their family member's mental illness (Lefley, 1987). It was also reported that participants "*felt unwilling or unable to apply their information or expertise to successful treatment of their FM's case*" (p. 616) (FM= family member). In relation to this, mental health professionals felt confusion in what their family role may actually be, in regards to being a mental health professional and having a family member with a mental health condition. 66% of the mental health professionals in the study also reported that they felt their relative was misdiagnosed. The mental health professionals explained that they suffered from "*emotional and financial burden, unsatisfactory experiences with the mental health system, recurrent stressful life events, and a range of disturbing behaviours*" (p. 618) in regard to having a relative with a mental health condition. Lefley's study also revealed that "*an aspect of family burden unique to mental health professionals, or at least to this sample, appeared to be role conflict and cognitive dissonance regarding issues of family pathogenesis and self-disclosure to colleagues*" (p. 618). Lefley (1987) also claimed that "the issue of role conflict because of perceived stigma or contradictory personal experience is an important one for therapists and would certainly seem to warrant further investigation" (p. 618).

Both studies were quantitative studies and obtained data in the form of questionnaires which gave limited understanding of the experiences that professional mental health workers had with a mentally ill relative. It did not provide information on the mental health professionals' unique perspective in their experience of having a relative with a mental illness. A qualitative study may have shown deeper insight into the individual's experience and evoked new perspectives. Both studies failed to report any positive experiences which demonstrate that it is a possibility that only negative experiences were explored. Therefore the study does not show the whole experience of the individuals.

### **2.5.10 Trainee psychologists experiencing a relative/friend with a mental illness**

There was limited research in the literature which explored the experience of trainee psychologists who had experienced a relative with a mental illness. One study which commented on this within their findings was Connor-Greene's study of abnormal psychology undergraduate students (2001). Out of the 56 participants, 54 reported that they knew at least one person with a mental illness. 63% of the participants reported that the individual was an immediate family member and when an expanded definition of the word 'family' included 'relatives', the percentage rose up to 82%. The participants reported that that they knew at least one person with a mental illness very well. Connor-Greene (2001) found that most of the undergraduate students in the study "*reported a close personal relationship with someone who had been diagnosed and treated for a psychological disorder*" (p. 210). Connor-Greene (2001) also stated that "*students who planned to pursue an advanced degree in counselling or psychotherapy were significantly more likely to report a history of psychological treatment*" (p. 193).

A limitation of this study was that students may have chosen a career in psychology because they knew someone with a mental illness, therefore this data may be exclusive to this sample group and should not be generalised to other students on other courses. This study also obtained information by using self-reported data which cannot be verified and so reliability is not absolute. The study had a quantitative research method design and does not reflect an in-depth experience.

### **2.5.11 Counselling psychology trainees experiencing a relative/friend with a mental health condition**

There was no literature found which explored the experience that a counselling psychology trainee had with a relative/friend with a mental health condition. However, this is not surprising as it is a small sample area. No literature was also found exploring a trainee psychologist's experience with a relative/friend with a mental health condition.

The implications of the literature review and the rationale of this research study will be drawn together before considering the research aims of the study.

## **2.6 Conclusions from existing research**

As already mentioned, the topics addressed within the literature review explore how personal experiences of a mental health worker can have a personal and professional impact. It goes on to highlight the impact that training and working in a psychology career can have on trainee and professional psychologist's personal, professional and academic lives. A number of studies suggest that the impact of psychological distress for trainee and professional psychologists are quite extensive and can impact their own mental well-being and that of their clients both in a negative and positive way. The literature review also explored how an individual with a mental health condition can impact on their family in both positive and negative ways. The impact of a mentally ill relative on a mental health professional was explored in both of Lefley's quantitative studies and negative effects were reported (1985; 1987). Connor-Greene's (2001) quantitative study also found that the majority of the psychology students within their study reported that they had a relative with a mental health condition. There were no studies within the literature which reflected how a relative/friend with a mental illness impacts on a psychology student, especially when they are studying a topic which is directly connected to their personal experience. This further extends to trainee psychologists, with the literature suggesting that there is a high probability that a trainee's personal experience will interfere with their clinical work.

This absence of such research gives the researcher an opening to further explore this phenomenon and contribute with new literature to this part of the counselling psychology field. Through an exploration of the lived experience of trainee counselling psychologists whom have a relative/friend with a self-reported mental health condition, it would be possible to understand the dialectical experience of the trainee. An improved understanding of this experience will benefit counselling psychology in many different ways. Firstly, it may assist the academic staff of trainee psychology courses by producing an awareness of some of the struggles that their students may be experiencing on an already challenging course. Connor-Greene

(2001) exclaimed that *“in addition to teaching accurate information, the abnormal psychology class can be a vehicle to teach strategies to cope with the challenges and stressors that precipitate or accompany a psychological disorder within a family”* (p. 211). Lunsford and Connors (1997, as cited in Connor-Greene, 2001) concluded that *“determining an audience’s prior knowledge and experiences is typically the first step in preparing an effective oral or written presentation”* (p. 211). Nilson (1998, as cited in Connor-Greene, 2001) went on to say that *“the practice of audience analysis is often ignored in teaching, but it can help inform both what and how faculty teach”* (p. 211). This may offer consideration for incorporating revised teaching tools concerning the utility of current teaching practices to better support the trainee.

Secondly, this research study supports and assists counselling psychologists on a personal level in responding to their own and others’ experience of having a relative/friend with a mental health condition. Thirdly, it may open up consideration of wider issues concerning a trainee counselling psychologist’s experience of having a relative with a mental health condition. Finally, most of the literature found was of a quantitative nature and the qualitative design of this research would be able to give the reader a deeper insight into this phenomenon. The qualitative aspect of this study would be able to generate new information which may be insightful to others in the future.

## **2.7 Rationale for this study**

The primary aim of this study was to explore the experiences of trainee counselling psychology trainees whom have a relative/friend with a self-reported mental health condition. A search of the existing literature suggests that there are as yet no published studies which apply an IPA approach to the topic currently under exploration.

The secondary aim of this study is to explore the trainee’s experience of this personally, professionally and academically. This study aims to heighten awareness within the counselling psychology field so that individuals can gain knowledge and an increased understanding of this experience which may lead to producing new

innovative ideas to better support trainees at one of the most challenging times of their lives. Adding on to Connor-Greene's (2001) quantitative study, Grafanaki (2010) stated that "*learning more about the experience and challenges counsellors encounter during their training years can significantly contribute to the advancement of counsellor education and to the delivery of better counselling services*" (p. 152). This kind of effective support may lead to better therapists and happier clients which may be a significant contribution to their lives.

This study hopes to reach out to all other psychology professionals and trainees, not just counselling psychologists, who may be able to relate and develop from some of the concepts illustrated within this portfolio.

The Literature Review illustrated that Lefley's (1985; 1987) quantitative studies went into a little more detail and explored the impact of a relative with a mental health condition for mental health professionals in their personal and professional lives. Other studies found within the literature were of families' experiences' of having a mentally ill relative which highlight the positive and negative impact it had on them. These were all issues that became clear to me in my own experience of having a relative with a mental health condition whilst training on the Professional Doctorate in Counselling Psychology course; which preceded this research. During my experience I was very aware of the impact it was having on me personally and professionally. I was aware of feeling stressed, burdened and overwhelmed to be working with clients with mental health conditions and then coming home and dealing with mental illness in my personal life. I recognised my own thoughts and emotions, in regards to my brother, coming into the therapy room when I was with a client and I was enlightened at how personal therapy assisted me in processing my experience and remaining ethically safe for my clients through the process of self-awareness. The focus of this study is inspired by personal and professional considerations.

The predominant use of quantitative research demonstrates that the studies mainly look at cause and effect. Qualitative research proposes that additional understanding can be gained from using a qualitative methodology. The qualitative approach used within this study (IPA) intends to "*explore in detail how participants are making*

*sense of their personal and social world*' (Smith & Osborn, 2003, p. 51). The IPA approach explores what a participant is thinking and experiencing, and is likely to gain a better understanding of the processes involved in a trainee counselling psychologist's experience with a relative with a mental health condition. The decision to use IPA for the research study is further discussed in the Method chapter (section 2.10).

## **2.8 Aims and research question**

The aim of the current study was to gain an in-depth lived understanding of the experiences of trainee counselling psychologists who have a relative/friend with a self-reported mental health condition using an IPA approach (Smith & Osborn, 2003; Smith, Flowers & Larkin, 2009). Therefore, the main research question was:

**The experience of having a relative/friend with a self-reported mental health condition for trainee counselling psychologists personally, professionally and academically.**

In relation to the main research questions the following aspects were explored:

1. A trainee counselling psychologist's personal experience with a mentally ill relative/friend.
2. A trainee counselling psychologist's experience with their mentally ill relative/friend in relation to their psychology work/placement.
3. A trainee counselling psychologist's experience with their mentally ill relative/friend in relation to their counselling psychology course.
4. The experience of the counselling psychology course in relation to a relative/friend with a self-reported mental illness.

## **2.9 Methodology**

### **2.9.1 Introduction**

Having introduced and defined the research question, this chapter presents the methodological approach taken. The chapter begins with my personal epistemological positioning and the exploration of whether to use a qualitative or quantitative methodology. It then goes on to describe what a qualitative methodology entails and its epistemological underpinnings. The methodological approach used for this study was Interpretative Phenomenological Analysis (IPA). This chapter goes on to describe two philosophical underpinnings of IPA – phenomenology and hermeneutics – in an attempt to familiarise the reader. The chapter ends with a discussion reflecting why IPA was selected over other methodologies.

### **2.9.2 Epistemological position**

The word epistemology is a philosophical term and is derived from the assembly of two Greek words. Episteme means knowledge/understanding and logos means the study of. Brown (2002) describes epistemology as how we come to know what we know. Epistemology explores what knowing consists of and the limitations of knowing (Larsson, Brooks & Loewenthal, 2012).

There are various philosophical views on epistemology and there have been continuous debates amongst psychologists around which approach to take when studying psychology. The debates consist of identifying how research should be conducted, what assumptions can be made and which approach is the most suitable in order to acquire knowledge about the world. My epistemological belief is that phenomena and structures exist, but our perceptions of these phenomena are conveyed by our individual perspectives which are generated from our social situation, environment, cultural contexts, etc., that are available to us. The critical realist approach suggests that individuals use their senses, their scientific view of the world and their own experiences (thoughts, perceptions, etc.) to form their own interpretation of the world (Archer et al. 1998). Critical realism “*does not deny that there is a real world*”; nevertheless it “*questions whether individuals’ observations*

*can fully reflect the real world*” (Howitt, 2010, p. 34). I therefore situate myself within the critical realist perspective as described by Parker (1998) as it supports the way in which I view and interpret the world. I shall take these considerations further in sections 2.9.4 and 2.9.8, where the epistemological underpinning of qualitative research and how it fits in with my epistemological beliefs are discussed

### **2.9.3 Qualitative and quantitative approaches**

In considering which philosophical position from which method should be obtained, it was important to first consider both qualitative and quantitative methodologies for what they both had to offer and their suitability in relation to the research study. A quantitative methodology operates mainly from a positivist philosophy which measures observable data to explore and identify a relationship between cause and effect. A statistical analysis is then usually conducted to establish findings and acknowledge significance. Research using a quantitative methodology is seen as mostly numerical and intended to ensure reliability, generalisability, objectivity and truth (Crotty, 1998). However, qualitative methodologies adopt a different philosophy. It is recognised that the participants and researcher define their own realities based on their own values, beliefs and personal assumptions, from which there can be no objectivity. Qualitative researchers study phenomena in its natural setting. The empirical materials used can be in the form of a case study, interview, personal experience, visual data, observational material, historical, interactional, etc., which all aim to explore experiences within individuals’ lives. The data is then interpreted by the researcher to make sense of the phenomena (Denzin & Lincoln, 1994). It is not straightforward to draw out the data and easily quantify, observe and verify the data as quantitative methodologies are able to do. The aim in qualitative methodologies is not to find truth or validity but to explore how the participants interpret their experiences, the world around them and how they construct meaning from it. Qualitative methodologies wish to further the understanding of the complexity of human activity in an enquiring way, rather than the experimental nature of quantitative methodologies.

A disadvantage of the quantitative approach is that it can be artificial and inflexible. Many quantitative studies do not give you a rich understanding of the actions of others and they do lend themselves to generalisations.

#### **2.9.4 A qualitative approach and its epistemological positioning**

Part of the reasons why a qualitative approach was employed for this study, was because the researcher's epistemological positioning fit in with the qualitative epistemological underpinnings with regard to the nature of the answers it would provide to the research questions. Qualitative research tries to understand how the world was constructed (McLeod, 2001) by looking at the meanings of how individuals experience realities and make sense of their world (Willig, 2008). Qualitative researchers are concerned with the quality of the experiences and the meaning attributed to the events, rather than the cause-effect relationship (Willig, 2008). This meaning is subjective and formed from the participant's own individual account of their experience.

Denzin and Lincoln (2000) affirm that qualitative researchers are generally seen to not overlook characteristics of their participants' everyday lives. As a result of this, qualitative research papers are seen to have much greater detail about the lives of their research participants than would be seen in quantitative research papers overall. Qualitative methodologies all employ data collection methods which facilitate this (e.g., focus groups, in-depth interviewing methods, diaries, etc.). The richness of the data collected allows the individual perspective to be seen. The qualities of this methodology are the most appropriate in accordance with the nature of the research questions. Given the small amount of existing literature within this research area, a qualitative approach would allow the possibility of producing new insights into a trainee counselling psychologist's experience of having a relative/friend with a self-reported mental health condition. It would also allow for a rich in-depth account of the participant's experience.

The various methods within qualitative research all hold different epistemological positions and this has an influence over the knowledge that a methodology will intend to produce. In accordance with the methodological approach, the

epistemology best applies to the researcher in connection with the personal and epistemological concepts obtained in order to make sense of the data. Each of the individual qualitative methodological approaches offer their own perspectives of what data represents and what can be taken from it (Smith, Flowers & Larkin, 2009); this also supports the researcher's epistemological positioning. The researcher has a different role in qualitative research than in quantitative research. Within qualitative research, it is recognised that the researcher influences the research process as a theorist (epistemological reflexivity) and as a person (personal reflexivity) (Willig, 2008). The researcher embeds themselves into the data and endeavours to interpret and make sense of it. The interpretations that the researcher makes of the data are partly from their own subjective judgement; there is no such view of a correct or true interpretation (Lyon, 2007). As the meaning of how the world and everything in it is constructed can never be entirely construed, understanding will always be incomplete. Preconceptions and life experiences cannot be pushed aside to look at any given phenomena for the first time. A qualitative methodology allows for this reflexive approach to be employed. It allows the researcher to understand how their own process around the research data contributes to the interpretation of the data and the documented findings (Willig, 2008). This is especially significant to this study because of the personal nature of the research to the researcher. As this research study was inspired from personal experience, the qualitative methodology would enable the researcher to consider personal issues related to the study as well as to the participant's experience within the research.

### **2.9.5 Phenomenology**

Phenomenology is a psychological approach in the study of experience (Smith, Flowers & Larkin, 2009). This philosophy of research derives from the perspective that reality is socially constructed and it is the individuals who give it meaning; it is not objective or exterior (Husserl, 1946). Phenomenology looks at the way individuals experience phenomena within the world and define its meaning,

There are many different phenomenological routes that all share different interests and aims. They all have particular concepts in common; which are to explore how individuals think about, perceive and experience their lived world. These also

support the research aims of the study. Willig (2008) describes phenomenology as the study of phenomena that appear in our consciousness as individuals interact with the world around them. Husserl was the founder of phenomenology and altered the nature of philosophy. He believed that if you focused on the perception of phenomena as it appeared then you may be able to arrive at ultimate truth (Langdridge, 2008; McLeod, 2001). Husserl's phenomenology encouraged individuals to take a more reflexive attitude in stepping out of their everyday worlds and the objects within them by directing those objects inward so that they could be experienced within the consciousness of the individual. Husserl describes phenomenological inquiry as focusing on what the individual experiences in their consciousness (Smith, Flowers & Larkin, 2009). Husserl did not agree with the perception that empirical science is the foundation for constructing an understanding of the world; instead he spoke about the importance of an individual's lived experience. He believed that what exists within the world can be understood by viewing it in a way that does not contain an individual's experiences and perceptions. Husserl's view of phenomenology did not fit in with my own view of how the participants interpret data, as I believe that the participants do view the world by their experiences and perceptions. Husserl's philosophical ideas were expanded by other philosophers; Heidegger, Merleau- Ponty and Sartre. Their beliefs focused predominantly on existence and human nature which were all still phenomenological in nature. Heidegger saw individuals surrounded by a world of language, relationships and objects. He believed that "*our being-in-the-world is always perspectival, always temporal, and always 'in-relation-to' something*" (Smith, Flowers & Larkin, 2009, p. 18). This perception of how individuals' interpret meaning within the world is one of the main components of phenomenological inquiry within psychology. Smith, Flowers and Larkin (2009) stated that "*the lived experience of being a body-in-the-world can never be entirely captured or absorbed, but equally, must not be ignored or overlooked*" (p. 19).

In relation to the perception of social and personal relationships, Sartre went on to say that individuals are able to form experiences from the connection between the presence and absence of relationships within their lives (Smith, Flowers, & Larkin, 2009). Furthermore, Smith, Flowers and Larkin (2009) state that Sartre offers one of

the most coherent views of what a phenomenological analysis of the human model can look like.

Researchers that carry out phenomenological studies try to raise an awareness of their preconceptions (Howitt, 2010; Moustakas, 1994) by using formal reflexive techniques (Duck, 1992; Smith, Flowers and Larkin, 2009). It has been discussed that true phenomenological research requires the researcher to adopt these reflexive techniques due to the fact that they give a more faithful representation of the way in which the world is seen (Caelli, 2001). This study uses reflexive techniques throughout the research process (explored later in sections 2.10.14 & 2.10.23).

The different philosophical approaches of phenomenology have shown that to understand experience each individual has their own perspective, interpretation and meaning of their own lived experience. These are all unique to how the individual views the world and how they see themselves embodied in the world. By employing IPA methods with a phenomenological view, the researcher interprets and makes sense of the individual's interpretation of their world. This is referred to as hermeneutics which is explored in more detail below.

### **2.9.6 Hermeneutic interpretation of phenomenology**

One theoretical aspect of IPA is hermeneutics – the theory of interpretation. Heidegger speaks about a hermeneutic phenomenology in which the researcher's interpretation and analysis play an important part within the phenomenological analysis. Heidegger remarks that the natural attitude is the main focus of inquiry and it is through the researcher's engagement with the subject of inquiry that knowledge is obtained (McLeod, 2001). Heidegger's interest was with the ontological concern of existence itself, the different relationships we compose and how we interpret and construct meaning of the world as it presents itself to us through these relationships (Smith et al., 2009). In 'Being and Time' (1962), Heidegger displays how the word phenomenology is comprised of the Greek word phenomenon, which means 'to appear'. For something to appear it means it is showing itself in a different form or state to that it was previously in, which is also in contrast to the previous state where this state was not present. This is key to Heidegger's reading (as cited in Smith,

Flowers & Larkin, 2009) as he views phenomenology as examining what is seen and not seen; in that they are both connected but also separate. The logos part in phenomenology means discourse, reason and judgement (Smith, Flowers, & Larkin, 2009). Heidegger (1962) believed that the individual will bring to light what they are talking about within their discourse. Within phenomenology, the researcher plays the part of helping to facilitate the appearance of the phenomenon and then helps to interpret the appearing. Interpretative phenomenology looks at the quality and nature of the phenomena as it presents itself and aims to obtain a better understanding of it. Interpretative phenomenology obtains insight from the hermeneutic tradition and debates that all description constitutes a form of interpretation. As Willig (2008, p. 56, cited in Giorgi & Giorgi, 2008) stated; “(...) *the (phenomenological) ‘facts’ of lived experience are already meaningfully (hermeneutically) experienced. Moreover, even the ‘facts’ of lived experience need to be captured in language (the human science text) and this is inevitably an interpretative process*” (p. 168). Here, the interpretation and description are not separated. To understand the meaning of what is trying to be understood, interpretative phenomenology looks at the hermeneutic circle; to understand any given part you look at the whole and to understand the whole you look at the parts. The meaning of a word becomes clearer when seen in the context of the whole sentence; the meaning of the sentence depends on the connected meanings of the individual words. Heidegger (1962) states that the reader of any given text will bring their own judgements, experiences and interpretations, etc., when reading the text. He elaborates further that the researcher should always try to bracket their experience and focus on the interpretation of the text or object. However, as already mentioned, this is where bracketing is connected with reflexive practices and will be explored further within the text (section 2.10.23).

Drawing on Heidegger’s notions, the present research aims to explore the experiences of trainee counselling psychologist’s who have a relative/friend with a self-reported mental health condition. The researcher aims to gain knowledge of how the participants construct and interpret the phenomenon being looked at; the researcher takes an interpretative stance. This can be carried out using Interpretative Phenomenological Analysis (IPA). The next section will explore IPA and the role of the researcher.

### **2.9.7 Interpretative Phenomenological Analysis**

IPA is one of the phenomenological methods which acknowledge that one cannot gain direct access to a participants' lived experience (Willig, 2008). It is a qualitative research approach which has a commitment to explore how individuals make sense and interpret life experiences. IPA is phenomenological in that it aims to explore the individual's lived experience and the significance the experience holds for them. When an individual experiences something significant within their life, there is a process of reflection. IPA aims to engage with these reflections in an attempt to interpret the individual's account; in order to gain a better understanding of their experience.

IPA is interpretative as it recognises the researcher's personal perceptions and accepts the view that in order to understand something it has to be interpreted. Within IPA, the researcher's perception is not perceived as a bias to be removed but as a tool for interpreting the experiences of the participants. Reflexivity is also seen as a tool to allow the researcher to professionally recognise their interpretative role, rather than just seeing it as a tool for removing bias. Reflexivity is explored further within this chapter (section 2.10.23).

Within this research study, the researcher's role is a dual role (Smith, Flowers & Larkin, 2009). IPA is connected to the hermeneutic tradition and it recognises that the main role of the researcher is to make sense of the individual's personal experience (Palmer, 1969). However, within IPA there is a double hermeneutic. The researcher is trying to make sense of their own personal and social world and they are then trying to make sense of the participant making sense of their personal and social world. The phenomenological analysis which the researcher then produces is always viewed as an interpretation of the participant's experience (Willig, 2008). This is achieved through the use of IPA, which is a compilation of the researcher and the researched (Smith, 2003). It is acknowledged that the phenomenon understood is the researcher's own interpretation of the phenomenological world. It is recognised that the researcher can never fully interpret or understand a participant's phenomenological world, although they can get close to accessing it (Howitt, 2010).

Detailed accounts on how to implement IPA were provided by Smith and his colleagues (Smith & Osbourne, 2003; Smith, Flowers & Larkin, 2009). Various components of their methodology were adopted within this research study. Smith, Flowers and Larkin's (2009) method of IPA was consistent with the research aims of this study because it allowed the exploration of each participant's subjective experience. It did this in great detail; in the form of phenomenological inquiry. IPA's double hermeneutic supported the study's aim to interpret the participant experience.

IPA attempts to understand personal experiences of the world, it does not make quick hypotheses about large populations (Howitt, 2010). IPA has a commitment to the idiographic perspective of the detailed analysis of individual cases using only a small participant sample. An idiographic approach was achieved through close engagement with each participant's transcript with regard to the particular (individual meanings). IPA is concerned with the particular and this supports the framework of this study. IPA's commitment to the particular functions on two levels:

1. The sense of detail and the depth of the analysis.
2. The researcher's interpretation of how certain phenomena have been interpreted from the perspective of the participant within a particular context. (Smith, Flowers & Larkin, 2009)

The idiographic nature of IPA supports the aims of this research study as it investigates in detail the lived experience of a group of participants rather than generalising an understanding for a larger population (Smith & Osborn, 2003). Smith and Eatough (2007) claim that the experience of even one individual can give insight into their unique life which also gives insight into humanity. This study proposes to learn something new from the participants' experience; a fundamental concept of IPA.

When the formulation for this research idea started to form, I was very aware of the sensitive nature of the context that this study contained. When thinking about what research method to use, I looked for something which would be centred around the need for sensitivity as it was a delicate research area and it was important that the participants felt comfortable talking within the setting that was provided and the

framework that the research was built upon. The one-to-one data collection method supported by IPA allowed me to carry out the interview in a private space where the participant may have felt more comfortable to talk about sensitive issues. It was established that IPA works well within this chosen topic as it encourages an open-ended dialogue between the researcher and the participant, which produces a highly detailed and rich account. Using the idiographic approach and IPA methodology, meant that a small sample size could be used; therefore I could take the time to support the participant and pay particular attention to how each participant responded and felt within the interview. It supported the aims of this study, whereas a questionnaire which may have been used within a time-constrained quantitative research project would not have provided the rich, in-depth information that the one-to-one interview provided within the study. IPA guides the data collection and analysis and this type of data collection may result in unforeseen answers surfacing, which may produce a whole new perspective on the research study.

The philosophy of IPA is embedded within symbolic interactionism; where meanings are constructed by the individual within a personal and a social world (Howitt, 2010). This study aims to look at how trainee counselling psychologists experience the phenomena of having a relative/friend with a self-reported mental health condition. Within IPA, the participant is seen as the expert to their experience; however the researcher plays a part in interpreting the experience given to them by the participant. The researcher wants to gain an insider's perspective into what the participant is experiencing in order to empathise what it is like from their point of view (Conrad, 1986). However, the researcher will never be able to know entirely what the participant was experiencing as the participant's experience belongs only to their own embodied position within the world; which shares Merleau-Ponty's view as previously stated. As also previously stated within the literature, IPA recognises that the researcher's role will in some way influence the research process (Smith & Osborn, 2003).

To ensure transparency is present, IPA employs reflexivity to facilitate this and to show the personal and epistemological reflexivity of the study. This is an important aspect of IPA as the research study is of a personal interest to the researcher. A detailed reflexive exploration is crucial to be transparent in how the researcher may

have influenced the research and how the researcher thinks about their research and its findings (Howitt, 2010).

Even though IPA can provide meaningful interpretations of the research questions, there are limitations to this approach. One of its limitations is the dependence of the representative faithfulness of the language used (Willig, 2001). Even though IPA implements some regard to how language shapes experience, it will not allow the analysis of how individuals construct themselves and other phenomena in their use of language (Eatough & Smith, 2008). Willig (2001) also speaks about the difficulty in capturing suitable accounts. This is due to the fact that the participant's composition of their accounts requires an insight and sophistication of their own understanding. However, this is not just relevant to the IPA approach but to all qualitative approaches. The researcher can never fully understand a participant's account in its entirety; however this is where the interpretative part of IPA is valuable because one looks beyond the words. The interpretation part of IPA allows the researcher to go beyond the language.

### **2.9.8 IPA and its epistemology underpinnings**

IPA adopts a broad critical realist stance and supports the epistemological position adopted within this study. Willig (2001) states that on behalf of the participant and researcher, IPA accepts an element of construction but it does hold onto the belief that there is an empirical world which must be acknowledged. This study does not aim to establish facts about behaviour, create theories which can be tested or predict behaviour; essentially the aims of a realist approach.

Through IPA, the researcher is not only looking to understand individual's experiences but to understand these experiences at a specific point in history; a particular period in their lives. It's also looking to understand these experiences when interacting with relevant subsets of their environment, e.g., cultural, political, social and economic contexts. These cannot be overlooked as they are very present in the participant's world whether they are aware of it or not. It is certain that the participants in the study will bring with them their own personal knowledge, experience (e.g., interests, culture, life perspectives) and expectations and these will

influence the findings of the research (Howitt, 2010). Even though this study accepts that the participants' experiences are real, it is acknowledged that the only access to those experiences is through a particular lens used by the researcher (in this study it was through a semi-structured interview), which means that reality cannot be precisely glimpsed as each lens or window distorts reality in its own way (Howitt, 2010). There will be different perspectives of reality depending on which window it is being examined through (e.g., which research method is used). When an individual interacts with its environment, it processes its input using the five physiological senses (sight, hearing, taste, smell & touch). The individual then interprets the information coming in and the act of this interpretation shapes the information in a way that is understood for that particular individual. This is then retained within the memory as information with varying degrees of interpretation. The recollection of this interaction (e.g., through the research interview process) may introduce further additional distortions or even improve the interpretation of the data. Howitt's (2010) view is that each method of measuring reality is flawed in some way; however it is acknowledged that if the participants' views of reality concur, than this may assist in gaining a better understanding of what their reality may be.

This research study adopts a critical realist perspective of how knowledge is acquired. This fits in with the researcher's own epistemological positioning of how knowledge is acquired within the world. The IPA methodology used within this study also supports the critical realist approach.

### **2.9.9 Why not use a different qualitative methodology?**

IPA shares many techniques with other qualitative methodologies. A particular technique is the identifying of themes from the participants' experiences. Many other approaches share this technique: Discourse Analysis (DA), Thematic Analysis (TA) and Grounded Theory (GT). In this section, a rationale is given for selecting IPA over other forms of qualitative analyses', which were also considered as alternative approaches within this study.

GT is frequently referred to as the closest alternative to IPA (Smith, Flowers & Larkin, 2009). GT advances hypotheses to develop and test emerging ideas (Howitt, 2010) and this frequently requires a much larger sample than IPA. It can create a less detailed analysis of the lived experience of the participants and, as a result, IPA is favoured for this study. IPA also uses general psychological theory to make sense of what the participants may be saying, however GT claims to be incompatible with psychological theorising. GT is a theory which is built up from the data and there are no preconceptions about what the researcher may find. There is less interpretation involved than there is within IPA.

TA and IPA have very similar methods. TA is a straightforward form of qualitative analysis and has a similar methodology to IPA. It is the analysis of what is said rather than how it is said. Whereas IPA is the analysis of what is said and how it is said. TA analyses textual information and highlights the major themes in the text (Howitt, 2010). However unlike IPA, it does not look beyond the written words of the text. As such, the researcher is unable to get the detailed interpretation that IPA is able to obtain from the participants' lived experiences. TA does not have the content specificity and theoretical underpinnings that are attributed to IPA (Howitt, 2010). TA would not provide a detailed interpretation of the data and therefore would not meet the research aims of this study.

DA was not chosen as the methodology for this research study as it only focuses on the dialogue. The participants may not want to disclose all to the interviewer; therefore a detailed interpretation of the data would not be possible and meanings could be lost. DA focuses to understand the processes of particular phenomena. Foucauldian Discourse Analysis (FDA) focuses on the power relationships within society and takes a subjective position (Foucault, 1982). FDA allows an in-depth interpretation of the data; however unlike IPA it does not look at the participant experience.

IPA has been chosen over other qualitative methods as it is believed that this chosen method is best suited to explore this research question. By using IPA, this study aims to show an understanding of the participants' lived experiences, rather than producing a theory which is imbedded within those experiences. The main

characteristics and parameters of IPA have been explored in detail and the next chapter will describe the components of the study's design and how it was carried out. The chapter closes with sections which put forward how the credibility of this study can be assessed and the ethical considerations which inform this research.

## **2.10 Method**

### **2.10.1 Semi-structured interview**

A reason for choosing this type of data collection was because it allowed the researcher to influence some focus and structure within the interview whilst at the same time allowing the participant and researcher to feel flexible and fully present within the narrative. The nature of the semi-structured interview encouraged the participants to offer their own definitions, vocabularies and ways of thinking (Silverman, 1993). This allowed the narratives to take a lead and guide the data collection process.

The reason for using this method and not for example a focus group, was because it assisted in providing a less threatening atmosphere and facilitated a safer environment for the participants to share their personal background and experience with the researcher. This research topic was personal, intimate and confidential, therefore there was a need for a high level of sensitivity from the researcher in dealing with this topic. In relation to this and keeping in line with the use of qualitative methods, the in-depth semi-structured interview was a useful and sensitive approach to obtain first-hand narrative accounts from the participants. Semi-structured interviews are appropriate when a participant is communicating complex or sensitive phenomena (Smith, 1995). It can enable the researcher to abandon incorrect assumptions and discover different perspectives to those expected (Farr, 1982). As a researcher, I felt that my experience as a trainee counselling psychologist meant that I had the tools to create a dialogue where topics could be explored. However, I was mindful that the interview was not a counselling session.

A semi-structured interview schedule was developed (Table 1), which reflected the aims of the study. The interview schedule was compiled from relevant literature and discussions with the research supervisor. Guidance on developing a semi-structured interview was retrieved from recommended frameworks (Howitt, 2010; Smith, Flowers & Larkin, 2009; Smith & Osbourne, 2003). The interview schedule consisted of open-ended questions about the trainee counselling psychologist's experience of having a relative/friend with a self-reported mental health condition and their experience of that personally, professionally and academically.

It was decided that one interview per participant would be used instead of multiple interviews. Even though the researcher would have to build rapport quickly with the participant and ask all the interview questions at once, the participants would only have to take part on one occasion (Flowers, 2008). As the study was a sensitive topic, it felt this would cause the least amount of distress for the participant.

The interviews were on a one-to-one basis, and due to safety precautions the interviews were to be held either at the researcher's or participant's university. All eight participants chose to have the interview at their own university. The interviews took place at a time and date which was convenient to both the researcher and the participant. The university was contacted by either the researcher or the participant and a room was booked. The interviews ranged between 40 and 127 minutes.

### **2.10.2 Interview structure**

The research questions within IPA aim to draw out the participants' understanding of their experience. As a result, the research questions are exploratory and open-ended and aim to reflect mainly process rather than outcome, and meaning rather than cause and effect (Smith, Flowers & Larkin, 2009). A flexi-interview schedule (Table 1) was adopted to guide the topics of discussion. This was employed in an adaptable format in order to enable the participants to speak about matters which may be important to them; as is typical within an IPA methodology (Smith, Flowers & Larkin, 2010).

<b>Interview Topic Guide</b>
<ul style="list-style-type: none"> <li>a. What is your experience and interpretation of having a loved one with a self-reported mental health condition?</li> <li>b. How do you experience it all?</li> <li>c. How do you make sense of your loved one with a self-reported mental illness in relation to your psychology course/trainee role?</li> <li>d. How do you make sense of a loved one with a self-reported mental illness in relation to interpersonal relationships with family, relative friend, others?</li> <li>e. What was the impact, if any, that the experience with your loved one may have/had at your work/placement?</li> <li>f. How do you make sense of the experience of having a loved one with a self-reported mental illness? How do you make sense of how it has affected you, if it has?</li> <li>g. What has the experience allowed you to do?</li> <li>h. What has the experience not allowed you to do?</li> <li>i. Is there anything else you would you like to talk about with regard to your experience?</li> </ul>

**Table 1: Interview topic guide**

### **2.10.3 Pilot study**

A pilot study was first carried out with a participant from the course who had a relative with a mental health condition. She agreed to talk about her experience and reflect on how the interview felt for her. The aim of the pilot study was to gain insight into the interview questions and style. It was also to explore whether the interview questions gave the researcher the information needed for the study, or if anything needed to be amended or clarified for the participant. The feedback from the pilot study reflected that the interview was smooth, the participant felt comfortable and the questions were clear. The participant also said that there was nothing else that she would have wanted to talk about in her experience. The researcher felt the interview went well as the questions asked and information received were in line with the research questions of the study. The pilot study was beneficial for the researcher as it familiarised the researcher with the interview

process and made the researcher feel more comfortable and at ease. It was hoped that if the researcher felt at ease and confident with the interview schedule, than the participants would also feel more comfortable with the process.

The participant also reflected back that instead of beginning with questions which elicited quite sensitive information, it may be an idea to ease the participants into the interview first. It was decided to ask the participants how they were finding the course and why they decided to take part in the study. This would allow the participants to start their story from a place that they wanted to, instead of the researcher starting it for them. The other questions would then be asked in accordance with the flow of the interview. The revised interview schedule is shown in Table 2.

The data from the pilot study was not used within this study as it was a trial, which the participant was aware of before the start of the study.

<b>Revised Interview Topic Guide</b>
a. Tell me little bit about which year you are on and how you are finding it (to ease the participant into the interview).
b. Why did you want to take part in the study?
c. What is your experience and interpretation of having a loved one with a self-reported mental health condition?
d. How do you make sense of a loved one with a self-reported mental health condition in relation to interpersonal relationships with family, relative/friend, others? How do you experience it all?
e. How do you make sense of the experience of having a loved one with a self-reported mental health condition? How do you make sense of how it has affected you, if it has?
f. What is the impact if any, that the experience with your loved one may have/had at your work/placement?
g. How do you make sense of your loved one with a self-reported mental health condition in relation to your psychology course/trainee role?
h. What has the experience allowed you to do?

- |  |
|--|
| <ul style="list-style-type: none"><li>i. What has the experience not allowed you to do?</li><li>j. What is your experience with the course in relation to your mentally ill relative?</li><li>k. Is there anything else you would you like to talk about with regard to your experience?</li></ul> |
|--|

**Table 2: Revised interview topic guide**

#### **2.10.4 Ethics and permissions**

The study complies with the basic ethical guidelines (Elmes et al., 1995). It is also in line with the BPS code of Ethics Conduct (2006).

Ethics approval for the study was sought from the Ethics committee and submitted to City University, London (Appendix 6). It follows the guidelines for minimum standards of ethical approval in psychological research from the British Psychological Society (2009). Ethics approval was granted.

#### **2.10.5 Researcher**

Throughout this process, I was supervised by a City University personal tutor and research supervisor. Both supervisors were chartered psychologists and any concerns, questions or reflections were taken to them. I was also under the supervision of a placement supervisor who was also a chartered psychologist. If any concerns came up surrounding my placement, it could be spoken about here.

Due to the sensitive context of the research and the close personal relationship with the research topic, I thought it best to stay in personal therapy throughout the entire research process. This allowed me to explore personal reflexivity in regards to the study. It is highlighted that all ethical issues cannot be solved and considered within the research planning and some may emerge during the research process (Brinkmann & Kvale, 2008). Therefore, it was crucial that I remained ethically conscious throughout the study.

### **2.10.6 Recruitment procedure**

A list was made of all the Greater London (UK) universities that offered the Professional Doctorate in Counselling Psychology programme which was accredited by the BPS.

In stage one of the recruitment process, an email was sent out to each programme director of the course (Appendix 7) explaining the reason for the study. Within the email was an attachment of the contents of another email which the programme directors were to send out to the trainee counselling psychologists within that university (Appendix 8). The programme directors were also given an Information Sheet (Appendix 9), which the researcher then sent out to any trainees who contacted the researcher and expressed an interest in taking part in the study.

After stage one of the recruitment process there were not enough participants to take part in the study. Stage two of the recruitment process was implemented. The programme directors were asked once again to circulate the email to their trainee counselling psychologists. Eventually, stage one and stage two produced eight participants altogether who agreed to take part in the study. Stage three and four of the recruitment process was not needed. Stage three consisted of colourful posters (Appendix 10) which were to be displayed around the universities. These contained information regarding the study and the sample process required. Stage four of the recruitment process was to revise the research question so that it would include a wider research sample. Instead of specifically using trainee counselling psychologists, it was going to look at trainee psychologists within other courses within the Division of Counselling Psychology within the BPS. The aim was to widen the number of recruitable participants, with the hope of giving the researcher a higher probability of obtaining more participants to take part in the study. The overall response within the recruitment stage was quick and the clarity of the recruitment information given out meant that the participants who responded met the inclusion criteria needed for the study.

### **2.10.7 The sample**

A homogeneous sample is usually employed by IPA researchers (Smith & Eatough, 2006), which furthers the method's aim in highlighting a specific experience. For this study, a purposive sampling of participants was used for the data collection as the research question would be significant within a well-defined group sample. Within this sampling method, participants were selected who acquired the characteristics needed to obtain information that the research was exploring (Charmaz, 2006).

Keeping within the IPA framework, a small homogenous sample of eight participants were used for this study.

### **2.10.8 Context**

Participants who were on the Professional Doctorate in Counselling Psychology course, accredited by the BPS, at universities within the Greater London area, were recruited for this study. The participants were in Year 1, Year 2 or Year 3 of the course. All participants had previous or current ongoing experience of being in personal therapy. All participants had experience of what it was like to be on the Professional Doctorate in Counselling Psychology course whilst experiencing a relative/friend with a self-reported mental health condition. The mental health condition perceived by the participant did not have to be one that was clinically diagnosed.

### **2.10.9 Sampling considerations**

The participants of this study were selected on a first come, first served basis on the condition that they met the inclusion criteria. If all inclusion criteria were met, the participant would be invited to an interview. This was determined when the participants contacted the researcher either through email or telephone, where the inclusion and exclusion criteria were then identified:

1. The participants had to be enrolled on a (UK) Professional Doctorate in Counselling Psychology training programme which was accredited by the BPS. The reason this course was selected was because all courses in different universities are required to adhere to the BPS guidelines. All participants would have had a very similar standard of training; therefore selecting

courses which were constructed from a similar framework would increase the homogeneity of the sample.

2. The researcher was aware that there were different stages of training on the Professional Doctorate in Counselling Psychology programme: Year 1, Year 2 and Year 3. This could impact the participant's level of self-awareness, self-care and experience. However, due to the demands of recruitment and sample selection, the year of training was not included within the selection process.
3. All participants had experience of a relative/friend with a self-reported mental health condition whilst they had been on the Professional Doctorate in Counselling Psychology course. The reason for this was because the aim of the study was to see how their trainee role interacted with their mentally ill relative/friend.
4. The participants were to have experienced a relative/friend with a self-reported mental health condition for no less than 1 year.

In regards to the participant sample, all of the participants within the study refer to experiencing a relative with a self-reported mental health condition. Only Eve in one instance within her transcript refers to a friend who has a self-reported mental health condition; however the majority of her transcript is in relation to a relative with a self-reported mental health condition.

#### **2.10.10 Informed consent**

Informed consent for the interview was given to all participants at the invitation stage of the interview in the form of an Information Sheet (Appendix 9). The Information Sheet explained the purpose of the study, a step-by-step explanation of what was involved, a time estimate, benefits to the participant, risks to the participant, the voluntary nature of the study and confidentiality. The Information Sheet was clear and the participants understood what would be required from them. The researcher briefly explored whether they felt they would be emotionally robust enough to take part in the study and not become too overly distressed.

Within the Information Sheet, the researcher and research supervisor's contact details were provided with the permission to contact them at any point if there were any questions or concerns about the study. When the Information Sheet was provided, the participants were able to take as much time as they needed to consider the information before they decided if they wanted to participate with the study or not. It was made clear to each participant that they were able to withdraw from the study with no questions asked at any point during the research.

Each participant was asked if they wanted a signed copy of their consent form (Appendix 13) for their own records. A signed copy was also placed in each participant's research file and stored in a secure location by the researcher.

#### **2.10.11 The interview**

Once the consent form had been signed and all questions answered, the interview could commence. The participants were aware that the in-depth semi-structured interview would take approximately 60-90 minutes to complete and that it was only between the participant and the researcher. The interview was audio recorded using a digital voice recorder.

A de-briefing stage followed after each interview. Each participant was given a de-brief sheet (Appendix 11). The de-brief sheet thanked the participant for taking part in the study and acknowledged how difficult it may have been for them. It also spoke about the confidentiality of their data and gave contact information of the researcher and research supervisor in case they needed to contact them after the study. In the de-briefing stage, the researcher checked how the participant was feeling and whether they had any questions or concerns. The participant was asked if they suffered from any psychological distress as a result of the interview and if they wanted any counselling information so that they could talk to somebody about it if they did not have a professional space to take it (Appendix 14). The participants were also asked if they wanted to be contacted in the future by the researcher to learn the outcome of the study.

### **2.10.12 Support and monitoring**

The researcher was aware that because of the sensitive context of this study and the personal questions asked, it was possible that some participants may have felt uncomfortable or psychologically distressed at certain points of the interview or after. These risks were outlined to the participants within the Information Sheet (Appendix 9), which was given at the recruitment stage of the study. Before the start of the interview, the researcher was transparent with the participants and outlined any possible risks. The researcher also outlined the topics which would be addressed within the interview so that potential participants could make an informed decision of whether they wanted to take part in the study or not. It was explained that the researcher would only explore what the participant was willing to explore and reassured the participant that they did not have to answer any questions if they did not want to. During the interview, the participant was aware that they could take a break at any time. The participant also knew that if they wanted to withdraw from the study they could at any point with no questions asked.

During the interviews with the participant, the researcher was aware of the sensitivity of the context and strived to demonstrate empathy and genuine admiration to each of the participants. The researcher believed that the genuine warmth to each and every one of the participants and the genuine interest in what they had to say added to the interview by allowing the participants to feel a little more comfortable in the room. The researcher tried to recognise any interactional difficulties that the participants may have had within the interview and was transparent with them by voicing any concerns. The researcher was aware of the power play that may have been present within the room; with the researcher possibly being perceived as the research expert and the participant being the experiential expert. It was hoped that all of the above helped to level out the environment and make both participant and researcher equal.

This study took great care to not have any deception present. The participants were made aware at the beginning of the study that if they were to disclose anything that was a risk to themselves or others, than the researcher would be required to disclose it to the relevant bodies. The participants were also aware that if they made an unethical disclosure about one of their clients, then the researcher would also be

required to disclose this to the relevant academic bodies. However, if the possibility of a disclosure posed a problem for the researcher in relation to recruitment, the researcher may have been forced to consider focusing only on the experiences of the trainee counselling psychologist's personal and academic experience of having a relative/friend with a self-reported mental health condition and would refrain from exploring their experience at work with a client. None of the participants withdrew from the study; however with regard to the authenticity of the analysis, the researcher acknowledges that participants may not have felt that they could be completely honest within the interview in fear of being reported. It was expected that on the Professional Doctorate in Counselling Psychology course, all trainees were required to have personal therapy and supervision, so there was an increased likelihood that the participants had relevant support and a space to speak about their issues.

#### **2.10.13 Confidentiality and note-keeping**

The raw data collected from the study was in the form of voice recordings, demographic sheets (Appendix 12), consent sheets (Appendix 13) and written participant transcripts (Appendix 16). The participants were aware that the raw data was to be securely stored for the appropriate period of time according to the ethics committee and would then be destroyed.

All data on the researcher's personal laptop was encrypted in a password-protected folder on a password-protected laptop. This laptop was only accessible by the researcher and was kept in a locked filing cabinet when not in use. All hard copies of the research were also kept in the locked cabinet, which was only accessible to the researcher.

The participants were fully informed about confidentiality and its limitations. The participants were aware that their names were to be converted into a pseudonym so that they remained anonymous. The participants were made aware that even though transcript quotes would be used in the research write-up, all identifying characteristics would be removed from the transcripts and write-up. The participants were also aware that the research supervisor and individuals from professional and academic bodies may look at the anonymous transcripts and data for academic

purposes only. All professional and academic personnel were bound by confidentiality.

#### **2.10.14 Methodological reflexivity**

Some of the participants' interviews brought up thoughts and emotions within me as I related it back to my own personal experience. I found myself empathising deeply with some of the participants' accounts. The practice of bracketing helped me to stay focused on what was actually presented within the transcript (Husserl, 1999). It allowed me to think about and acknowledge my personal processes in a contained space, which helped me to bracket and keep my own assumptions and experience from coming into the analysis minimal (Spinelli, 2005). I kept a research diary and documented my experience. I was able to record details of the nature and origin of my interpretations. I used the practice of bracketing throughout my analysis process. I also took some of my thoughts and emotions to personal therapy where I explored my process further. This helped me to understand myself better in regards to having an increased awareness with my emotions and cognitive processes. This increased my confidence and transparency as a researcher.

I had previously used a quantitative methodology for a research study I carried out within my psychology degree and I recalled that if I used a quantitative methodology for this study, I would not have been able to obtain a detailed experience of the participants' experienced phenomena. My interest in qualitative methodology grew further when I read literature around my research study which showed the lived experience of participants within a specific phenomenon. I enjoyed obtaining a detailed insight and I felt this raised awareness within the specific field. When I read quantitative research studies, I sensed there was more behind the responses given from the participants and it only told part of a story. Choosing IPA felt like the correct choice for me as it allowed the participants to share their lived experience. The semi-structured interview allowed the research aims to be explored and also allowed for the participants to talk about what they felt should be shared which may elicit new information about their experience. Within the interview process I found that participants at times would answer a combination of the interview questions at

once. However, by the end of the interview, I felt that the participants had answered all of the questions even if they did not follow the interview schedule exactly.

#### **2.10.15 Transcription**

Once all participants had been interviewed and all data collected, the audio recordings were transcribed verbatim as faithfully as possible. All pauses, mishearings, un-verbal communication and mistakes in speech were displayed within the transcripts. The non-verbal communication and physical actions of the participants were recorded in brackets '[ ]' within the transcript. Any pauses were either recorded within the brackets or conveyed using full stops. The amount of full stops used indicates how long the pause was: one second is one full stop '.....'. Where a participant quote had been cut mid-sentence, for illustrative purposes, a '(...)' was recorded within the transcript analysis. The non-verbal communication accompanying the text gave a deeper insight into the participants' lived experience and aided in the psychological analysis later on.

All participants identifying information were anonymised and each line on each transcript was given a line number (Appendix 16).

#### **2.10.16 Analysis**

Smith, Flowers and Larkin (2009) explain that IPA's analytical focus centres on the participants' efforts to make sense of their lived experience. In this part of my analysis, I was aware of the theoretical underpinnings of IPA and my epistemological positioning. My task was not to find one true meaning, but to obtain an interpretation of each participant's lived experience.

Through a further period of reflexivity and to increase awareness of any personal factors which may have impacted on the analysis, I dedicated a section in my research diary to explore my shared experience with the participants and a space to write my comments on the analytical work (explored further in section 2.10.23).

A consideration before commencing the analysis was in deciding which process would be employed to analyse the participants' accounts. As already described, the

hermeneutic circle was explained by Smith (2007), who described that the analysis would proceed from repetitive and inductive. It would go between and from the particular to the shared and the descriptive to the interpretative. The analytical process was therefore based on the six stages described by Smith, Flowers and Larkin (2009). These are explained below in the following sections; 2.10.17-2.10.22, where each transcript was analysed using parts of the IPA procedure.

### **2.10.17 Stage one: Reading and re-reading**

In the first part of the analysis I familiarised myself with the data. The audio recordings of each participant were listened to at least twice and the transcribed data was checked alongside the audio to make sure it was faithfully represented. As IPA analysis focuses on the close reading and re-reading of the text, the transcripts were read several times each to aid me in familiarising myself with the data (Smith, Flowers & Larkin, 2009). I made notes of any observations, thoughts or reflections that appeared to me whilst reading the transcripts. As the research was inspired from my own personal experience, I found myself resonating with some of the transcripts. My thoughts and emotions which were generated from sharing an experience with a participant were recorded within my research diary and this helped to bracket off my personal process and ensure that the participant remained central to this part of the analysis. The transcripts appeared to be quite rich in data and the rapport and trust appeared to build as the interview commenced. The participants appeared to be quite open and honest about their experience.

### **2.10.18 Stage two: Initial noting**

Following Smith, Flowers and Larkin's (2009) method, my aim within this part of the analysis was to create detailed and extensive notes and comments on the data. I commenced by developing descriptive commentary which was handwritten on the left hand side of each transcript (Appendix 16). This captured the content of the conversation between the participant and I. I also developed linguistic commentary on the transcripts. I commented on the participants' use of word repetition, use of laughter, pauses, hesitations and I also found the use of metaphor to be a very powerful tool which the participants used to convey their experience. The development of conceptual comments was also used to analyse the data.

### **2.10.19 Stage three: Developing emergent themes**

Within this part of the analysis there was a change within the analytical process. The amount of detail which was generated within the initial noting stage was reduced; however the themes were to reflect any patterns and relationships between the exploratory notes. Here, I worked with my previous notes rather than the transcript itself. Smith, Flowers and Larkin (2009) reflected that if detailed exploratory commentary was successfully carried out by the researcher, then the exploratory commentary would have a close connection to the original transcript. The emerging themes reflected the interpretation and description of the initial notes. Even though the themes were generated from a particular point within the text, the whole account was considered and reflected within the theme when required. The themes reflected the participants' world and the psychological interpretations of the researcher (Appendix 16).

### **2.10.20 Stage four: Searching for connections across themes**

The themes and line number of each transcript were then typed up in chronological order and displayed in the form of a list (Appendix 17). Each theme list was then printed in a different colour for each participant. Each individual theme was cut out and placed on a large surface area on the floor. The aim within this part of the analysis was to map the relationship between the emergent themes. I found this method suitable because I was able to see all of the themes at once and I was able to move the themes physically to try and find connections between them. Smith, Flowers and Larkin (2009) suggested methods which could aid this process and some were used within the analysis process. Abstraction was used, which involved contemplating whether a collection of themes could be considered under a super-ordinate theme, whereas subsumption considered whether an emergent theme became a super-ordinate theme and brought other related themes together. Polarisation looked at the differences between themes, whereas contextualisation regarded contemplating whether themes were connected to specific contextual or narrative aspects of the account. Through numeration I was able to review the frequency of the themes. Lastly, a review of the function allowed me to explore the

function of the language used which are deeply connected with the process and meanings of the participants' world.

#### **2.10.21 Stage five: Moving to the next case**

Each stage of analysis was carried out on one transcript at a time before moving onto the next stage of analysis where the process was repeated; as in line with the idiographic process suggested by Smith, Flowers and Larkin (2009). Any prior assumptions were also bracketed by writing in my research diary so that full justice was given to each participant transcript.

#### **2.10.22 Stage six: Looking for patterns across cases**

This stage of the analysis considered patterns across the accounts. I repeated the process in section 2.10.19 and reflected upon the power of each theme. There were so many themes that came up and I knew I could not reflect them all within the study (see section 2.11.1 for excluded themes). Therefore I focused on the potent themes and themes which reflected the trainee counselling psychologist's experience of having a mentally ill relative/friend and how it impacted on them personally, professionally and academically. The analysis resulted in an overall table of four super-ordinate themes which appeared best to represent the meanings within the participants' accounts. The super-ordinate and sub-ordinate themes were evidenced with individual participant quotes and line numbers for each theme (Appendix 15).

I shall now close this Methodology chapter with a discussion on reflexivity

#### **2.10.23 Reflexivity**

This section explains the manner in which I understood myself to have shaped this research. My own personal experience of being a trainee counselling psychologist whilst having a relative with a mental health condition during my training on the course inspired my interest in this research area. Bound up in my experience were feelings of helplessness, not knowing, anger, sadness, tiredness and extreme concern, to name a few. I felt overwhelmed with the demands of the course and the intensity of the placements, whilst at the same time trying to deal with everything that was

happening with my relative and the impact it had on me and my family. I was grateful to be in personal therapy as a requirement of the course. Once I had completed my required hours I decided to remain in personal therapy as I found it was extremely beneficial to have a space where I could reflect on and talk about my problems. It was not until the end of my second year that I confided to my course tutor about what was happening for me at home. I did not confide to any of my university friends until the final year. In the first and second year, I remember feeling as if I did not have a space to take it. I saw my tutorials as a space to talk about things happening to me at university, placement supervision as a space for me to talk about things that came up in my placement and I felt personal therapy was a space to take my personal material. Each of my reflections were categorised into specific settings and so they remained separate from each other in the most challenging years of my life. I wondered how many other students on the course or similar courses were going through a similar experience. After I had chosen this topic as my research study, the students on my course became aware of my research title and it was at this point that I learnt that other students had gone through or were going through a similar experience. When I researched literature within this topic area in my personal time, I was surprised that I could not find any literature on this subject area. I am aware that it reflects a small sample of the population; however, I personally would have expected some insight into the experience of trainee psychologists who have a relative/friend with a mental health condition.

I am aware that the participants in the study could have a very different experience and interpretation to my experience. This is where I find the reflexivity process contributes to the researcher remaining true to the participants' lived experience of their phenomena. I am aware that as a researcher, I already have a bias for the outcome of the study and I continuously have to assess that my conflicting intuitions interfere with the study as minimally as possible. I am aware that I can bracket part of myself but not all.

A safeguard which was set up during the research process in an attempt to deal with this was by remaining in personal therapy and speaking to my supervisor about my reflections in an attempt to limit my influence as a researcher to the study. Willig (2008) commented that the researcher is likely to influence the research process both

as a theorist and as a thinker. Personal reflexivity gave me, the researcher, space to reflect on how I may be moulding the outcome of the research. It allowed me to reflect how my life experiences, beliefs and preconception, etc., may influence the outcome of the research. As the idea to conduct this research came from my personal experience as a trainee counselling psychologist and the personal experiences within my life, I felt it was important that I continuously reflected throughout the research process. I found it useful to reflect how carrying out the research and the developed themes impacted on me as an individual and as a researcher. I was aware that these experiences may influence the findings of the study, therefore it was important that these potential influences were recognised by the researcher at the start of the study and extreme caution employed. As already mentioned, I used the method of bracketing and kept a research diary to document my thoughts and preconceptions at every stage of the research. This activity allowed me to reflect back and gain a deeper understanding of the personal research process as a whole. This view of preconception can be placed within the hermeneutic circle of the research process. In this instance, the 'whole' is the researcher's ongoing reflective research journal and the 'part' are the participant interviews' of the research study. My interpretations, thoughts and questions always existed as a whole throughout the research process. Here is a segment of my reflections after an interview with a participant which is taken from my personal reflective research journal:

*When Sue spoke about her brother who has mental health problems, I really resonated and identified with her because of my own personal circumstances. A part of me wanted to say 'hey me too', but I knew it was not about me and I was able to put it to the side and focus on her.*

It is refreshing, both as a researcher and an individual, to be able to acknowledge thoughts and feelings and be given a space to offload and reflect on them. It is commendable that the research process has space for a sense of self and that personal process is acknowledged and encouraged to be expressed. With this in mind, within IPA, it was important for me to remember that at the heart of the research were the participants and the researcher. Halling (2008) states that "(...) *in everyday life, each of us is something of a phenomenologist insofar as we genuinely listen to the stories that people tell us and insofar as we pay attention to and reflect on our own*

*perceptions*” (p. 32). It is important as a researcher to also look after oneself. The personal therapy and reflection which was maintained throughout the research process enabled me to care for myself.

The perception of my function as a researcher was an important influence on this study. My background as a scientist-practitioner meant that I was able to add an additional perspective to the accounts given by the participants and the use of IPA would allow me to compose an added multi-layered interpretation of this phenomenon. As an individual, and from my personal and professional experience of working with individuals with a mental health condition, it is acknowledged that mental health stigma exists. The fundamental priority in this study was to be respectful to the participants taking part and to any family members with or without mental health conditions that would be referred to within the participant’s account. This concern for respectful engagement meant that I was sensitive in the way that I carried out my research study and the terminology that was being used (Willig, 2001). In my research question, I used the phrase “self-reported mental illness” instead of “mental illness” because I was aware that a mental illness may not have been clinically diagnosed, although it did not mean that it did not exist. It was important that the participants responded to the study with their own interpretation and assumptions about their experience. Within the interview, Clare conveyed her opinion of the research question, explaining that “...*that’s what I like about your question, that you were interested rather than having assumptions, that’s correct I know. Because sometimes people in qualitative think they are qualitative but they’re not*” (Claire; 1919-1922). Clare also reflected what she felt about the phrase ‘loved one’ which was part of the original research question stating that; “*I think it’s funny that you used the word loved one, coz I wouldn’t. I don’t feel close to my brother who actually has been diagnosed with ‘schizophrenia’*” (Claire; 40). After this reflection, I revised my research question to exclude the phrase ‘loved one’, as I realised I was making an assumption that the participant would be close to their relative.

My sense of self, developed as a trainee counselling psychologist, ignited the start of this research and its implementation. By exploring the experiences of others, I aim to inform trainees and professionals within the counselling psychology world of the experiences that some trainee counselling psychologists have whilst undertaking a

psychology course and their experience of having a relative/friend with a self-reported mental health condition. I aim to connect to other students who have experienced something similar so that they can relate to the research and feel that they are able to talk to others about it and obtain relevant support from their universities to assist them in coping. I also feel it is important to highlight to other students the importance of self-awareness and how personal experience may impact on professional and academic work.

As referred to in section 2.9.4, the research process is also influenced by the researcher's epistemological positioning (Willig, 2008). I was unable to put my own life experience to the side whilst analysing the data as my experience is a part of me. I was aware that there is no true or correct interpretation of any given phenomena (Lyon, 2007) and that the participants' experience of interpretation would be different to my own. My personal connection to the research study meant that I had my own interpretation of the given phenomenon.

## 2.11 Analysis

<b>Super-ordinate themes</b>	<b>Sub-ordinate themes</b>
<i>Negotiating roles: Personal identity versus therapy identity</i>	<ul style="list-style-type: none"> <li>- <i>Not knowing in an expected therapy role</i></li> <li>- <i>Negotiating identity: Family versus therapy role</i></li> <li>- <i>Balancing self-care with personal and academic demands</i></li> </ul>
<i>Continuing a therapy role within a personal space: Personal impact</i>	<ul style="list-style-type: none"> <li>- <i>A depletion of mental and physical energy for counselling psychology trainees.</i></li> <li>- <i>Personal identification with relative/friends mental illness</i></li> </ul>
<i>Personal influence within a professional role</i>	<ul style="list-style-type: none"> <li>- <i>Working with personal experience in a positive way within a professional environment</i></li> <li>- <i>Working with personal experience in a negative way within a professional environment</i></li> <li>- <i>Personal identification within an academic setting</i></li> <li>- <i>Personal identification with a counselling career</i></li> </ul>
<i>A space for personal development</i>	<ul style="list-style-type: none"> <li>- <i>Developing personal insight through a professional role</i></li> <li>- <i>Looking for personal support within a university setting</i></li> </ul>

**Table 3: Super-ordinate and sub-ordinate themes**

### 2.11.1 Overview

The Interpretative Phenomenological Analysis (IPA) of the eight semi-structured interviews resulted in the emergence of four super-ordinate themes and their constituent sub-ordinate themes. An exploration of these themes will form the basis of this chapter and each theme is represented by a small selection of verbatim extracts from the participants. The four super-ordinate themes and their sub-ordinate

themes are illustrated in a Master Table (Table 3). An in-depth illustration of the themes, including participant quotes, can be found in Appendix 15. The four super-ordinate themes are:

1. Negotiating roles: Personal identity versus therapy identity
2. Continuing a therapy role within a personal space: Personal impact
3. Personal influence within a professional role
4. A space for personal development

This study does not represent all aspects of the participants' experience, and themes were elected due to their relevance to the research title. Some of the excluded themes were:

1. Belonging on the course: this theme illustrates how participants felt a sense of belonging and acceptance on the counselling psychology course.
2. Loss in relative/friend: this theme illustrates how some of the participants went through a mourning process as they felt they lost their relative/friend as a result of their mental illness or their relative/friend had lost a part of themselves. Participants also mourned the loss of a role they used to have (e.g., a mother-daughter relationship). Participants experienced the loss of their relative/friend on a physical, emotional and social level.
3. Making sense of personal process over time: participants' comment on an increased personal awareness of their personal processes over time as a result of the counselling psychology course. They speak about an increased insight into their own emotions and personal process and an increase in their self-awareness and personal change.
4. Hidden mental illness: this theme highlights family members hiding their relative/friend's mental illness from others as a result of shame or denial. This theme also shows the relative/friend hiding their mental illness. Participant's experience some degree of mental health stigma.
5. Differing views to family: this theme illustrates the participants having a different view to their family about how their family may be dealing with their relative/friend's mental illness or their perspective of it. Participants felt frustrated and separate from their family as a result.

It is acknowledged that the final generated participant themes are one account of the experience that trainee counselling psychologists have with a relative/friend with a self-reported mental health condition. This is a subjective interpretation and it is recognised that other researchers may have focused on different parts of the account. The super-ordinate themes with its constituent sub-ordinate themes will be explored below.

*All identifying information has been altered or removed and alias names have been adopted to protect confidentiality.*

### **2.11.2 Negotiating roles: Personal identity versus therapy identity**

This super-ordinate theme reflects the participants trying to balance and negotiate their new expected therapy role within a home setting. It also captures how the participants struggle to implement and cope with this new role whilst on the course.

### **2.11.3 Not knowing in an expected therapy role**

All participants comment on their continued therapy role at home and the expectations from their families, relative and selves. They also explain that in the midst of everyone's expectations, they themselves do not know how to use their therapy knowledge to help their relative with their mental illness. Eve's family have unrealistic continuous expectations of her and are unable to view her as separate from her therapy role:

*My family think I'm a therapist so I like listening to people's problems, so listen to my problems like 24/7. (Eve; 638)*

The phrase '*my family think I'm a therapist*' implies that Eve does not feel like a therapist even though she is seen as one by others:

*I think with the course, I get a little bit annoyed because we don't really get specific training on it (...) you don't actually say what do you do with schizophrenia, what do you do with, urm, um, borderline personality*

*disorders and stuff and I feel it's not adequately preparing me for working with that group of people. (Eve; 263)*

Within this part of the text, Eve is referring to her clients, however it is interesting to explore because Eve's brother and grandfather were both diagnosed with schizophrenia and it appears that Eve may be trying to learn how to help a schizophrenic client so that she can help her relatives. When previously speaking about her grandfather she explains:

*I sort of am probably trying to save him through working with other people who have mental health problems. (Eve; 193)*

Here, Eve is placing a huge expectation and responsibility on herself to do what others could not; to 'save' her grandfather from his mental illness. Eve not only has expectations from others to help with others mental illnesses, she also has the same expectation of herself.

Sue uses a powerful metaphor to describe the expectations she has of herself and the reasons why she uses her therapy techniques with her mother:

*Because I knew the tools, it's kinda like you have food and there's your starving mum (...) It's like well, what do you do? Do you not give it to her? (...) I want to help her (...) But then it's kind of, you know, it's not helping me because it's, it's not fair on me in a way. (Sue; 683)*

The selection of the word 'starving' indicates that Sue feels she has the tools to help her mother and like Eve, she puts an expectation on herself to take up a therapy role. The metaphor implies that if Sue did not give her mum food then she would physically deteriorate; if she did not give her mum the tools to help her then her mental health would deteriorate. Like Eve, Sue places a huge expectation on herself. Sue recognises that taking up a therapy role with her mother impacts negatively on herself, however she continues to put herself last.

*I think there is the thing of the device, people looking for a device, thinking that you know better because you are doing something like that (...) you must have a better, yeh, coping strategy. It mustn't hurt you as much as it hurts us, so things like that (...) she [colleague] said to me, how do you want to be a counsellor if you haven't worked this issue with your own mother (...) there is an expectation there, if I tell people I don't have a relationship they're like what? She's a counsellor, she hasn't got a relationship with her mother that's laughable really. (Lea; 514)*

Lea's competence as a counsellor is judged by others in her ability to deal with her mother's mental illness. There is an expectation that she should be able to deal with it successfully and that she can do it all without being emotionally affected. Lea uses the phrase 'it's going back to', which demonstrates that this expectation has been a re-occurring theme within her life.

*I can excuse and justify all the behaviours and see the reasons um, but it's true, I'm not able to help her. (Lea; 112)*

Here, Lea acknowledges her own limitations of her therapy role at home which demonstrate that she does not have a self-expectation to help her mother. Pam also feels like everyone expects her to use her psychology knowledge to help her sister:

*I'm also expected from my parents and from everyone else to be the one who understands psychologically what's going on for her, to ask the right questions to the doctor, what therapeutic support is she going to get, what groups is she going to attend, you know we met the dietician and they were like oh what kind of foods will help lift her mood. How am I supposed to know, you know. (...) she [sister] would say that to me, you should understand, you should understand what I'm going through. (Pam; 121)*

Others expect Pam to use her psychological knowledge to help her sister but she does not know how to help. There is a sense of separation from the family because of her expected role. The question 'how am I supposed to know' is expressed within the

interview but not to her family. Pam hides her true feelings and takes up the therapy role as expected, which further separates her from her family.

*Imagine a loved one with a mental health disorder; it activates the therapist in you. It's just what you do, so yeah. (Pam; 675)*

Pam also expects herself to be able to help. The use of the phrase 'it activates the therapist in you' indicates that her therapy role feels like a natural duty regardless of what setting she is in. Both Sue and Pam find it hard to come out of their therapy role and have a self-expectation to help others as they feel they have the knowledge to make a difference. Their therapy role appears to have no boundaries.

Amy has noticed a difference with her mother's expectations of her since she started the course:

*But since I've been doing it she would say to me; well you're a psychologist why don't you fix me. That's really difficult. Really really difficult. (Amy; 587)*

Like Lea, Amy also questions her therapy role as she feels that because she cannot help her mother then she cannot help her clients:

*But it does make me feel inadequate. It makes me feel like she's saying; well how can you possibly help anyone else when you can't help me. (Amy; 516)*

The comments from her mother have impacted on Amy in a different way to the way in which similar comments impacted on Lea. Lea deflects her peer's comments and acknowledges her own limitations, whereas Amy does the opposite by internalising her mother's comments and questioning her competence as a therapist.

*(...) a lot of people in my family would be like, yeah let's ask Clare, she's the psychologist, like I'm this universal power, God that has all the answers. And I'm like, I don't know, and they're like how can you not know? Don't you*

*learn this? And I'm like, no I don't, what do you think and they like, I don't know. (Clare; 1934)*

Clare's use of the phrases '*universal power*' and '*God*' show how unrealistic she feels her family's expectations of her are and she demonstrates that she has an awareness of her own limitations. In contrast to Pam, this honesty means that Clare does not take on the therapy role expected of her and is able to be more transparent to her family about not being able to help.

In contrast to all other participants, Joy, whose mother has depression, states that her family have been very supportive and do not expect anything from her because of her trainee counselling psychologist role:

*I don't think any of them think I've got a magic wand. No one thinks I know stuff and I don't suppose to play that card. I don't pretend to be the phantom of all knowledge you know (...) I just know that the more I know the more there is to know and does anyone ever know. (Joy; 500)*

Joy and her family have realistic expectations and Joy does not attempt to take up a therapy role with her mother. She questions if anyone would be able to help her mother; indicating she may not feel her mother can be helped.

*I don't think they expect any more of me than they would anyone, which is just quite nice really. (Joy; 509)*

It feels '*nice*' for Joy to not have the expectations of others, in contrast to Lea who feels '*hurt*'; Amy, who finds it '*really really difficult*'; and Eve, who feels '*annoyed*' at everyone else's expectations.

#### **2.11.4 Negotiating identity: Family versus therapy role**

Most of the participants speak about their continued therapy role within their home environment and the internal push and pull experienced between their family role and their therapy role. Some of the participants have a conscious awareness of their

internal struggle in taking up two roles, whereas others do not. Most of the participants display a struggle in developing/accepting an altered identity.

*I think unfortunately I do try to fix them. I have definitely changed the way I listen to them...and....I still try to keep the balance and remember that I'm still their daughter or brother or sister or whatever, but I feel that its um....yeh I do put my needs aside quite often I think. (Eve; 505)*

Eve recognises the therapy role she adopts within her home environment. The use of the word 'change' indicates two different ways of listening, one which she recognises was before the course and one since the course. Eve employs the skills learnt from the course to try and communicate with her family; her role at home has changed. Her use of the word 'unfortunately' indicates that her therapy role at home is not a positive experience as she finds that by continuing her therapy role at home, it takes away from her. Eve speaks about actively trying to keep a balance between both her family role and her therapy role and her use of the phrase 'quite often' indicates that the therapy role is the most dominant within her home environment.

*I know CBT and I know ways to help her which I have used. (...) I just felt that this wasn't my place, I just felt really like resentful. In one way I wanted to help her but then at the same time I was like I shouldn't be doing this. (Sue; 682)*

Sue took on a therapy role at home because she felt she was able to help her mother as a result of her trainee counselling psychology role. Sue's comment of 'this wasn't my place' and 'I shouldn't be doing this' show the dissonance felt between her natural family role and her forced therapy role. She struggles to accept the new identity she is taking up at home. She demonstrates insight into the ambivalent thoughts she is feeling. Like Eve, the therapy role is the more dominant role here.

Pam talks about the conscious struggle she has in trying to work out which role she should take up:

*(...) I'm like her sister but I also want to be her therapist and so when I talk to her I start doing CBT and I'm like, no I'm her sister, so it's really hard to be like what position am I taking up. I don't know who am I to her, who am I trying to be? And I felt like oh, I should be the therapist because that's who I am, that's what I'm doing, so I should be the one who's like no come on think about this and do like crisis plans around helping her.(...) I felt pressured, I felt like split, like a split person. (Pam; 80)*

Pam is actively moving between two different roles: a therapy role at home and her natural family role. This active force comes from within Pam and from the expectations of others. Pam questions her own identity and struggles to combine the two roles as they currently exist as separate identities within her. In order to combine the two roles, Pam has to alter and develop a new identity. Pam's comment about feeling like a '*split person*' reveals just how separate the two roles are for her. Pam's use of language conveys the notion that she is in an identity battle.

Lea recognises that, like Pam and Sue, she also struggles with ambivalent parts of herself:

*(...) there are parts of me, the few.....that even though I have this understanding, that I can be forgiving and empathic, there is still the child that was not cared for properly. I'm still human as well, so there is the part of me that was not cared, not looked after, and I can't deny that part as well. I can only understand why she couldn't do it, but of course it still hurts. It doesn't mean that because I understand it doesn't hurt. (Lea; 389)*

Lea's reference to her psychological '*understanding*' and her use of empathy demonstrates the therapy role she tries to take up with her mother. She refers to the child within her as if it is a separate part of her, which indicates that there still remains some conflict within this part of her. Lea's therapy role appears to be more dominant at times as Lea has to ascertain that she is '*still human*', that she is not just a therapist but a daughter with feelings as well. Lea's descriptions of the separate roles are similar to Pam's comments on her two roles as a '*split person*'. There is a

separation of roles here; they are not integrated into one identity but two separate identities and there is a conscious struggle between the two.

### ***2.11.5 Balancing self-care with personal and academic demands***

Some of the participants' struggle to balance the course, their own life and the impact and responsibilities of their relative's mental illness.

*I still try to keep the balance and remember that I'm still their daughter or brother or sister or whatever, but I feel that it's um....yeah I do put my needs aside quite often. (Eve; 508)*

Eve is aware that she is in the middle of balancing her own needs and the needs of her family. Her use of the word '*quite often*' indicates that Eve puts her own self-care last on a frequent basis. At the end of the interview, when Zoe was asked if there was anything else she wanted to talk about, she summed up her experience by questioning how she was going to move forward with all the things going on in her life:

*I guess for me really is where it leaves me now is how am I going to continue with my work and studies with this going, kinda running alongside me.(...) I have thought about taking a long break, but then that would set me back. (Zoe; 406)*

She refers to her brother's mental illness as '*running alongside*' her. She sees it as an active process, something that she cannot get away from. She is experiencing a loss of control here and stopping her academic life will mean she can regain some control and balance within her life; however it will also result in a personal loss for her as it '*would set me back*'.

Sue has a huge personal investment in supporting her mother and is either unaware that she does not look after her own needs, or she has normalised the process:

*(...) when I went back to travel and visit her, to see her, coz I would, I was now here in England at University and I'd go back during the holidays...It depended, it could have been anywhere from two weeks to the longest is two months, so it really depended on what holiday it was. If it was the summer it was two months, if it was a little holiday it was two weeks. (Sue; 127)*

Sue's therapy role is more dominant and she appears to have little interest in her own well-being. Her main aim is to support her mother; her own identity does not really come into it. She does not appear to demonstrate any self-care. There is no balance within her life, she does everything she can to support her mother. She further elaborates:

*(...) it's kind of like my mum's walking on a tightrope and has been doing that and there's everyone behind her holding up a sheet, you know coz people are supporting her, some of my family are supporting her financially and I'm supporting her emotionally, and so he [therapist] said, you know, she kind of can walk on this tight rope because she knows that if she falls there are people there to catch her. Which I think is true and he said you know, it seems, I think with me, that I'm living more of a life where I'm careful of the steps that I take. (Sue; 569)*

Within this metaphor about support and balance, Sue is able to recognise that her mum has support but she doesn't. There is a sense of Sue not being seen, and if she falls no one will be there to catch her. She is alone in balancing her own life. Pam also demonstrates the overwhelming difficulty she experiences in balancing her work life with her personal life and how she feels she has no space to self-care:

*Sometimes it's like, you're leaving placement and you go home and you've got like five missed calls from home and you're like oh I wonder what's happened, I wonder what's happened now. Like I remember then that's what it was. Missed calls from my mum or missed calls from my sister, you're like I don't want, I've just done this, I've just done this, I just want to go home and be me. I don't want to be, you know. It's hard to separate, it's hard to deal with that. (Pam; 624)*

The phone calls from home represent a physical intrusion into her professional and personal space and Pam's immediate reaction is to reject the intrusion, however she finds that it is too hard to separate and it is not something she can ignore. Pam wants to make space for herself and regain some balance in her life but the prevalence of her sister's eating disorder tips the balance of her life by becoming the more dominant entity. There is a sense of a loss of control which is also demonstrated in Sue's 'tightrope' metaphor and Zoe's description of it 'running alongside me'.

*I was on the phone to my stepdad getting him to make a doctor's appointment and I said when I've finished my exam on Friday I'll come home, pick her up and we'll go straight to the doctors. And he filled the doctor in, and uh, that's what happened. I went and did the abnormal psychology exam, I mean that was ridiculous, I got the worst result; it's not really a surprise, the subject area and what was going on at home. (Joy; 141)*

Joy appears to be in control on the surface as she seems clear with her instructions and is not afraid to ask others for support. However, underneath it all, she is falling apart and this is demonstrated in her failed exam result. Joy is unable to balance supporting her mother and maintaining a successful professional role.

*So there was a lot, a lot, a lot on my mind and often I would just start crying and not be able to take it. And at the same time I was trying to make sense of my course, I was trying to get the grades. (Clare; 547)*

Clare experiences an emotional overload in attempting to connect with her brother. She struggles to balance the expectations from the course and support her brother. The repetition of the phrase 'a lot' demonstrates just how much pressure it was for Clare to balance all areas of her life.

## **2.12 Continuing a therapy role within a personal space: Personal impact**

This super-ordinate theme captures the continued therapy role within a home environment and the impact it has on the participant. Some participants experienced

feeling drained and helpless as a consequence, whereas others experienced feelings of happiness and a sense of achievement in being able to help their relative with their mental illness. The participants also reflect a worry that they too would develop a mental illness like their relative.

### ***2.12.1 A depletion of mental and physical energy for counselling psychology trainees***

This sub-ordinate theme explores the participants deriving a feeling of self-worth from their continued therapy role at home. Whilst this conveyed feelings of happiness and at times a sense of achievement, it also caused participants to feel drained and weak.

*I go back home and stay with my brother now who is drunk every single day and in and out of hospital every couple of months. It would definitely make me much weaker and feel helpless. I think by being away and maybe talking to him once a week on Skype it would do more good. I mean, what I mean is that I can only support someone if I am strong myself. If I bring myself back there it will kind of drain all my energy and it would be no good. (Eve; 632)*

Eve uses the words ‘weaker’ and ‘drain’ to describe the physical and emotional experience she feels in supporting her brother. Her use of the word ‘helpless’ demonstrates her experiencing a loss of control and a decrease in her own self-worth as she is unable to help her brother. She describes her experience as ‘every single day’ and major events taking place ‘every couple of months’, which demonstrate that she views her experience as a repetitive cycle which does not change; one she has limited control over. Each event takes away from her resources. Eve takes control of the situation by moving country as it gives her the space to look after herself and her resources are not depleted on a daily basis which feels more manageable to her. She naturally takes up a therapy role with her brother; there is no conversation about it, she just automatically takes up the role. Eve goes on to further describe her experience:

*I guess my family has a tendency of dumping problems on me. Also coz they think I'm a therapist so I like listening to people's problems, so listen to my problems like 24/7. (Eve; 637)*

The use of the word 'dumping' demonstrates a heaviness that her family put on her. She describes the 'dumping' as a '24/7' process, indicating that she feels her family give her no space to be herself and again, her depletion of resources feel like a constant process.

*I thought, why don't I use the CBT to look at this (...) I encouraged her to write down the pros and the cons of alcohol (...) And um, after the three hours you could see that there definitely like was a change (...) and I was happy for her but it was just kind of like self-destructive in a way because I knew I was helping her but in doing that I felt like it was kind of, it sucked a lot out of me. (Sue; 326)*

Sue's comment 'I thought why don't I use CBT' comes quite natural to her. The therapy role is activated within her and she immediately tries to use her learnt therapy skills to help her mother. Sue's therapy session and duration immediately show her over-investment in her mother's problems and as previously highlighted, she does not take any time to look after herself. This over-investment causes Sue to feel emotionally and physically drained as she is only giving and not putting back into herself ; feeling 'just really drained and um happy that I could help her'. Sue describes the experience as 'self-destructive', which conveys that she feels like she is losing her sense of self. Sue's continued therapy role also brings feelings of happiness in her succession of helping her mother. Her comment 'drained, and um happy that I could help her' display the self-worth that she gains from helping her mum but at the same time it is a drain on herself. In an earlier part of her account, Sue describes a drive to fix other people's mental illness: 'I love the practical side of it, love giving therapy' (Sue; 5). The use of the phrase 'giving therapy' indicates that Sue sees counselling as a cure to mental illness and she has a huge self-expectation to cure her mother. When her mother relapses after their therapy session, Sue explains how much it took away from her physically and emotionally:

*I saw that she'd drunk a bottle and a half in one night and it's just so demoralising (...) Especially when you put in all that work. So it's not just like seeing a client and you know, it's disappointing. (...) It's your mum so there's that connection, especially when you spent three hours talking about it, three and a half hours, so draining, and then on top of it that happens.*  
(Sue; 338)

Sue's describes her failed therapy session as 'demoralising'; this is a really powerful word and instantly conveys Sue's loss of spirit and confidence within her therapy role and herself, which contributes to her decrease of self-worth.

*(...) because of that attached to me I had to be the one, no I can hold the whole family and get through this, I'm the one that will you know, sort things out, understand everyone's feelings. Everyone's pouring stuff into me and I was left holding it, you know, and you kind of have to be that person, it's tiring. I don't want to be that person who's listening, I do it in my job, I don't need to like come home. It's like, but then the whole thing comes under self-care, if you are a therapist and you do have someone, a loved one, there's a lot of self-care involved, more than usual.* (Pam; 614)

Pam uses phrases like 'attached to me', 'pouring' and 'holding', which describe a sense of heaviness associated with her therapy role at home. All of this makes Pam feel 'tired' which emphasises a depletion of her personal resources. Pam experiences a loss of control over the situation and feels she is responsible for keeping her family together; indicating that if she did not 'hold' her family together then they may all fall apart. This is a process which requires a considerable amount of energy and demonstrates just how much effort Pam is putting into the process. Pam has insight into her sense of self, as she recognises that the process is taking from her own personal resources and she acknowledges that she has to look after herself. Pam again wants to reject the therapy role but does not actually do it. She expresses her thoughts within the interview but not to her family, and she takes up her therapy role as expected. Pam is not true to herself and this makes her feel tired and drained.

*(...) my mother has physical disabilities but she also has very long term depression. So she tells me she wakes up every morning and her first thought is will I see Amy today. And there's some days she doesn't see me. And I find that quite a heavy thing to carry. (Amy; 44)*

Amy does not talk about a specific therapy role, however she sees herself taking up more of a caring role with her mother. Her mother's dependency feels heavy on her. She uses the word 'carry', indicating that she holds this with her constantly and it conveys a continuous weight within her life. Amy goes on to say:

*When I compare myself with my peers, their lives are not as tied up with their parents as mine is. And it's that sense of she doesn't manage to live completely independently. So I've got responsibilities for her that I wouldn't have if she didn't have depression. (Amy; 659)*

Her social comparison to her peers indicates a sense of separation from others and a sense of loss from the possibilities of a different life. Amy sees herself as 'tied up', which shows that she does not lead an independent life but is constantly carrying her mother's dependencies with her. This limits what she can do and restricts her from growing as she is confined by her mother's mental illness.

### **2.12.2 Personal identification with a relative/friends mental illness**

Some participants explored their own mental illness which they felt developed as a result of their relative's mental illness. Other participants also questioned a possible development of their own mental illness in the future which they feared would develop because of their relative's mental illness.

*(...) one friend of mine, and in the moment when she was hallucinating and I found it freaky coz I'm not sure whether, I guess I started challenging my own sanity coz if she's seeing certain things right next to me, what if they actually exist? What if it's me who doesn't see them? And I guess I start doubting the concept of reality, whether it exists and maybe I am just locked up in my own mind and maybe its girl gone crazy, I don't know, it makes me question my*

*own sanity and I worry that working in intense care with acute cases it would escalate a lot and it would be quite intense. (Eve; 312)*

Eve questions her own 'sanity' when she experiences her friend hallucinating; just like her brother and grandfather did. Eve loses her sense of self as she experiences a strong underlying fear that she may develop a mental illness or that she already has a mental illness but just cannot see it. Eve questions whether she would be able to work with future clients without doubting her own mental health.

Lea uses a metaphor to describe the impact of her mother's mental illness on her families own mental health:

*(...) we are all walking DSM's in our family because it has had a major impact on everybody. (Lea; 340)*

Like Eve, Lea also has an underlying worry that she would develop a severe mental illness like her mother in the future. Lea sees her learnt psychology knowledge as a defence against developing a mental illness:

*(...) there are the projections I make in the future, if I ever have a family I will have knowledge that she didn't have, therefore there is almost a pressure on me to do better. Yeah, to be a better mother. (Lea; 173)*

Joy conveys that she is self-aware of her own mental illness and like Lea, she believes that by addressing her mental illness it will prevent her from developing one like her mother's. There is a sense of seeing herself as separate from her mother because of her learnt insight through the course.

*(...) one of the things that I became quite concerned about was my own mental health and um, coz I've got a history of my own personal addiction. It was nice to have a safe place to explore that and things like that. And I suppose in some way it was reassuring to know that I'm dealing with my neurosis already, so the chances of it escalating won't be anything like mums (...)*  
*there's no reason that that's gona happen to me or anything like it's*

*going to happen to me. In fact I'd actually feel quite the opposite because of the level of self awareness that I have and will continue to develop I'd imagine. I can see myself coming and I know when I'm sort of behaving in a way that's not healthy. Whereas my mum has no insight. (Joy; 279)*

Amy's mother had a fear that Amy would develop a mental illness like herself and she described this as a fear that Amy may 'go bad'.

*(...) my mother's experience of depression has often led her to feel very negatively about herself and so in a way by association of anything that comes from herself, which is me. And so, she was quite critical, is still quite critical. Always had the feeling as a child, and actually still do as an adult; it's as though she's going around policing that I don't go bad coz I've come from her side so I must be bad. (487; Amy)*

As a result of her mother's constant fear, Amy recognised that she internalised some of her mother's negative behaviours and throughout the course has been able to understand herself more:

*I think being able to recognise that's what's going on and that the impact that has on me is that I've kind of all my life had that negative voice and understanding where that's come from has been really helpful. (487; Amy)*

Like Joy and Lea, Amy also felt she was able to use her learnt psychology knowledge to prevent the development of any future mental illnesses stemming from the experience with their relatives and their mental illnesses.

### **2.13 Personal influence within a professional role**

This super-ordinate theme captures the personal influence experienced from having a relative/friend with a mental illness and its impact within a professional setting. The participants talk about how their personal experience can influence the therapy session with a client in a positive and negative way. The participants also express

how their personal experience is triggered and spills over into an academic setting and how it has influenced their professional journey.

### ***2.13.1 Working with personal experience in a positive way within a professional environment***

This sub-ordinate theme addresses the participants' experience of their relative's mental illness and its positive influence of the therapeutic process between their therapy role and client. It was interpreted that there were positive perceptions towards a client, an increased level of understanding, insight and empathy.

*With...a particular client who had schizophrenia, I know that I change a little bit, I become much more patient. (...) Staying with the client is the best I can do and I'm hoping that they benefit from it because they, well I hope that they feel that they've been accepted for who they are rather than judged, criticised. (Eve; 202, 240)*

Eve acknowledges that her cognition changes when she has a client diagnosed with schizophrenia; she finds herself having more time and space for a schizophrenic client than she would with any other client. This is a positive process for a schizophrenic client, however it may be a negative process for any other client, which will be explored further on. The 'hope' within Eve is cultivated from her emotions which stem from the treatment her grandfather, who had schizophrenia, received from his family in the past:

*(...) it makes me feel a bit angry that people feel that people who have mental health diagnosis, they're crazy and you absolutely can't talk to them. (...) what makes me angry is this trying to hide it, like it's such a stigma (...) But I, I think...I really like people to accept it. (Eve; 33, 70)*

Eve is aware that her feelings around her grandfather's treatment directly influence her therapeutic delivery within a client session with a schizophrenic client because she acknowledges that:

*I sort of am probably trying to save him through working with other people who have mental health problems. (Eve; 194)*

*When I have a client that's like my brother, um, I feel like I can empathise with him a lot more, but also because I don't have that relationship with him. I don't have that emotional tie, I haven't grown up with him, but with my brother I've grown up with him and I feel like there's another dimension to our relationship which kind of takes away from that professional setting which I think is actually a lot more um, effective than having another relationship which is a sibling. (Zoe; 162)*

Zoe recognises an increased empathy with a client whom she finds has a similar mental illness to her brother. She goes on to describe that the relationship with her client is a better relationship than the therapy role with her brother because she does not have an increased personal investment which she has with her brother:

*I've got more of an agenda with my brother coz I'm thinking when I'm around him I want him to get better because it affects my whole family (...) but then with a client I don't have any relationship like that coz I don't know his family'. (Zoe; 176)*

*I'm able to understand all the family members positions within that individuals life, you know, coz I've gone through such a systemic kind of work with my own family around this, um and I can deal with the complex personality, coz I can understand it from my personal experience (...) So I really have that insight . (Pam; 351)*

Pam's experience, not just with her sister's eating disorder but the way her whole family respond to it, mean that she feels better equipped to work systemically with a client as she feels her own experience has increased her insight. Pam goes on to describe the positive impact of her personal experience in a client session.

*If you don't know anyone, like a loved one that has, and you never, I don't know if you would have the same understanding, not that they can't work*

*with people with mental health disorder but their level of understanding might be different and they might have to draw upon different experiences to understand, whereas I can draw from direct experiences. (Pam; 376)*

Pam feels that her personal experience has had a positive influence on her ability to be a therapist:

*The stuff that goes on at home makes me who I am in my therapy sessions and if I didn't have that stuff going on, I wouldn't be the good therapist that I am. (Pam; 560)*

Like Zoe, Pam and Lea, Amy shares an increased level of insight and empathy with clients who share a similar experience to her own.

*I think it has given me an insight which has also been really quite positive. I think in working with clients, actually I've noticed that a lot of clients have had parents with mental health difficulties themselves. And I think that my own experience with my mother does help me to have an insight into what that is like. (...) well I think it probably does help in the therapeutic alliance because it gives you your resource to draw on for empathy I suppose. (Amy; 276, 310)*

### **2.13.2 Working with personal experience in a negative way within a professional environment**

This sub-ordinate theme addresses the participants' experience of their relative's mental illness and its negative influence of the therapeutic process within their therapy role with their client. It was interpreted that participants became more impatient, felt disconnected from their therapy role and their client, were distracted by intrusive thoughts within a session and experienced counter-transference within a client session.

*(...) with my other clients who are so... like more functional in a way, I can get impatient and I want to see, um, they are improving fast. Whereas with...a*

*particular client who had schizophrenia, I know that I change a little bit, I become much more patient. (...) when I think about this schizophrenia, or things like that, I don't understand what it is. (...) I think it's easy to get angry (...) well I think that I don't know what to do for the client. Like yes we can work through some of the symptoms, but hallucinations will not go away.*  
(Eve; 202)

In comparison to feeling more '*patient*' with a client who has schizophrenia (like her grandfather), Eve acknowledges feeling '*impatient*' with a client whom she perceives as more '*functional*' than a schizophrenic client. She formulates this to stem from her lack of understanding of schizophrenia and she displays a need to want to actively do something to help her clients' mental health symptoms go away. It is interesting that this impatience is only activated with non-schizophrenic clients and further adds to the previously expressed notion that Eve's therapeutic process stems from '*trying to save*' her grandfather '*through working with other people who have mental health problems*' (194). Eve responds to a question which asks whether there are any disadvantages or advantages in the way she works differently with clients, to which she responds

*'(...) well I don't know whether they benefit from it to be honest'.* (Eve; 234)

Zoe uses a metaphor to describe how the experience with her brother's mental illness drains her resources and the negative impact it has on a client session:

*I see it as kind of having a bucket full of water and at the end of, when you experience things in a day they might be more draining than others and that takes more water out of the bucket so I feel when these clients, they might need, I feel like I don't have much left to give them, like if they need water, so like a plant you give them water to grow, my conditions I would give them, I can't give them that coz I have nothing left in the bucket so I feel like my part as the counsellor in the relationship isn't fully as present as it should be.*  
(Zoe; 134)

Zoe describes a loss in her sense of self as a counsellor and a failure in her ability to participate in a therapeutic relationship with her client. Zoe's disconnection with herself results in a disconnection with her client and as a result, she feels her client is unable to 'grow' from the therapeutic experience and this impedes the progress of the client therapy. Zoe goes on to use her psychological knowledge to make sense of her cognitive process:

*I think in that would be the attention span that's a lot less, also the, um, I think, with my empathy, I feel like there's less empathy coz I can't, um I can't reach a deeper level inside me, reaching that deeper level I feel I can engage with my client so having more effective work, you know, with my client, whereas, when I'm, I feel like I haven't got, I'm reaching burnout, I feel like I can't do that coz I'm very on the surface, I feel like I'm quite closed coz of what's going on for me. (Zoe; 134)*

Zoe's acknowledgement of her decreased attention span indicates that her experience with her brother eclipses the client which can lead to the client process being missed. Zoe previously said that she has increased empathy with a client like her brother, but when she feels burnt out as a consequence of her experience she finds that her empathy decreases. Zoe recognises a change within her cognitive process as she is unable to 'reach that deeper level' within herself in order to uncover/understand more meaningful connections for her client. Her interpretation of feeling 'very on the surface' indicates that she is unable to participate in a more meaningful therapeutic process with her client. Her lack of concentration within the therapy room results in Zoe losing concentration with the awareness around how she is feeling and her own cognitive processes, which can result in a decreased connection with her client.

*I don't think I had anyone with eating disorders or anything like that but it's, but similar things, anything could trigger off your own thoughts and you'd be like, oh my god I'm thinking about this instead of thinking about my client. (Pam; 38)*

Pam's sister eclipses her client as thoughts from her experience are more pertinent than what is going on within the therapy room. Pam also experiences a loss of

control as intrusive thoughts come into the client session if the client reminds Pam of her sister in any way. Pam goes on to say that she feels:

*(...) angry sometimes with a client coz (...) you know on a personal level I'm like, oh but you don't get it coz I know that's something my sister would say as well, oh they weren't there for me and they would say we were, we were going through the whole thing with you. So...yeh I think it did affect my client. If I had, I would never ever work with eating disorders I don't think, it's too close to home. (Pam; 285)*

Again, her sister is coming into the therapy session and Pam is experiencing counter-transference with her client in the form of displaced anger. Pam is not transparent with her sister in regards to her personal feelings and this is transferred within the client session. Pam is aware of her changing process within a session and acknowledges her limitations in working with clients whom have an eating disorder like her sister.

*(...) with this particular client, I feel slightly frustrated in a way because of my own issues really, because she so wants to be loved by this mother, um so wants desperately wants and no matter what she does this person is just not seeing her. So of course, in my head I am thinking; can't you see that there's no way? Of course I can't tell her, but I'm thinking there's no way, the best you do is moving away and protecting yourself, coz it's a similar situation. (Lea; 237)*

Like Pam, Lea also experiences her own personal thoughts about her mother coming into the session with her client as she feels 'frustration' which she acknowledges stems from her own experience with her mother.

*(...) one of the things you might feel is frustration with them [client] because you don't want to sit in that place that's there with them. And you might also feel that it's challenging your own competence and your ability to help. I think any counsellor might feel like that. I think that perhaps for me, that path is very well worn, so I'm not saying that the feeling is not about that*

*counselling situation, I'm just saying that because it's a place I've been in with my mum a lot of times and feeling frustrated or feeling useless, that it's very easy for that feeling to be activated (...) But I don't think you can work out what part of that feeling is to do with my mum and what part of that feeling is to do with, that's was it's like being with a client. (Amy; 465)*

Amy experiences a spill over of personal emotions which come into the therapy room with her client. She displays a feeling of resentment in having to sit with her client who is in a similar situation to what she felt her mum was in. Amy finds it difficult to fully understand what her own process is and what is her clients'. This could have a negative impact within the session because she may misinterpret her own process for her clients and it could leave her unaware of any client projection within the session. This could decrease the effectiveness of the therapy delivered.

### **2.13.3 Personal identification within an academic setting**

This sub-ordinate theme captures the participants' experience of their relative's mental illness and how it may be triggered or spill over within an academic setting.

*I had a very interesting lecture on attachment theory and how that relates to counselling psychology and um, it was extremely interesting to watch but slightly disturbing to me to watch videos of this strange experience for example and see a very distressed baby who has a very unresponsive mother, and of course there's always a part of me as I've been doing all this thinking, that actually that happened to me (...) and that might be the reason why I have some issues regarding this or that regarding my own life now. (...) it's good to know, to understand in order to be able to change, but it's also painful when these things come, I am a human after all [laughs]. (Lea; 144)*

This extract demonstrates Lea's personal life experience spilling over into her lecture when she is faced with psychological theory which reminds her of her personal life. This leads her to question how her mother's mental illness impacted on her own development as a child. The knowledge learnt from the course allows Lea to use the tools to change herself. This allows her adult and child parts to become further

connected, increasing her connection to her sense of self. Lea acknowledges that she is beginning to understand her thoughts and emotions more as she uncovers pain in regards to the neglected child she never dealt with within her. Lea uses laughter to deflect from the difficult feelings she experiences within the interview.

*I remember being in a lecture here about medication and they talked about Risperidone and one other, and the side effects and my mother has some of these side effects. I had to leave the lecture in the end coz I was so upset, I didn't see it coming at all, but just the fact that she's on this medication. Am I doing enough, should she be on the medication? You know is there anything else I can do and um, I suppose just feeling a bit hemmed in by the lecture. Being stuck there with this stuff going around in my head (...). (Joy; 193)*

Like Lea, Joy also experiences an emotional trigger within her university lecture which leads her to question the effectiveness of her role in her mother's care. This leads Joy to experience overwhelming feelings when her personal process comes into the lecture room and results in her feeling a loss of control over the situation which instigates her feeling physically and emotionally 'stuck'. The increased knowledge from the lecture results in a decrease of knowledge as she struggles to contemplate how to help her mother.

*(...) you're like faced with your problems, so like slapped in your face and you have to talk about them. And we do talk about them in the class, we do talk about them in the group, it's just always like talking, always analysing and thinking and sometimes it doesn't give you any room to breathe I think. So I think before you would go to personal therapy just privately, it was once a week and that's it really, but now you're like constantly thinking about it and just like [pants] you want to breathe. So I think it is a lot, it's very intense in like personally it's very intense I think. (Clare; 25)*

Lea, Joy and Clare all describe the spill over of their personal lives into an academic setting as quite a traumatic and overwhelming experience. Lea and Joy use words like 'painful' and 'stuck' to describe their experience. However, Clare uses quite violent language to explain the feeling of constantly feeling forced to face the

problems she has with her family, whom she feels all have some form of mental illness. She physically pants within the interview to demonstrate the constant analysis she feels is required from her throughout the course is suffocating. She is losing her sense of self as the experience of her relative's mental illness and the course are taking over her life.

#### ***2.13.4 Personal identification with a counselling career***

This sub-ordinate theme captures how the experience of the participants' relative/friend with a mental illness either influenced them to take up a career in psychology or influenced them to work or not work in a specialised area.

*She [Mum] would always come to me for advice (...) I always felt like I always had to take care of her (...) when I became a teenager, friends would come to me for advice and support and they would say to me, wow you're really good at giving support and I kind of thought, oh well maybe I could do this as a profession but kind of just like joke to myself. And then...I...realised when I was 15 that that was really what I wanted to do. (Sue; 159)*

*(...) it has impacted to the point of my choice of career. I don't think I ended up in this profession by chance. I'm sure my family background has played a major part in my choice of career. (Lea; 307)*

*Psychology seemed a way to do it and I think this is probably where my mother does fit in. I'd always be fascinated by how people think and why and I think my mum's depression is possibly what made me think about that. Why does she think in these ways, why does she get so anxious about things, are there different ways of thinking that might be more helpful? (Amy; 251)*

Sue, Amy and Lea are all aware that their choice of career was influenced by their experience with their relative's mental illness. Amy uses her career to try to regain some control within her life by attempting to understand her mother's depression, whereas Lea seeks the same thing by wanting to further understand herself. They both recognise that they have questions they want answers to and they both feel that

they would be able to find them within a psychology career. Sue sees her psychology career as a natural calling and Clare also shares their career motivation, displaying that through all the 'hate' she is able to find some self-acceptance through her psychology role:

*Now I think I'm fortunate. I used to hate my background, I used to hate to have had that brother, I used to hate to have these sisters but now I just feel like it really created me as a person. It took me where I am. I wouldn't be in counselling psychology. (Clare; 1651)*

Sue's, Lea's, Amy's and Clare's relatives' mental illness had developed years before they had decided to pursue a course in counselling psychology and they speak about feeling that their relative's mental illness was the reason why they decided to pursue a career in counselling psychology. Clare feels her personal experience not only impacted on her career but also on the person that she; she gained something positive from a negative experience.

The mental illnesses of Pam's and Zoe's relatives developed after they had decided they wanted to pursue a career in psychology. However, they still talk about how their relative's mental illness influenced them into working or not working with specific client groups or therapy models.

*I didn't consciously decide I wanted to go and do family and systemic work but it just kinda happened and maybe it was because of everything I've gone through (...) because of how I saw my sister and everything that she kinda went through, so it kinda just draws you to it. (Pam; 388)*

*I don't think I want to be involved with this, what my brothers got coz I don't think I understand it (...) I get too frustrated with it so I wouldn't want to go near those kinds of things. (Zoe; 438)*

Pam takes up a wounded healer role and wants to work in the same way that her family worked for her sister, whereas Zoe does the opposite and does not want to work with clients who have her brother's mental illness. Zoe appears to display

avoidance in wanting to work with clients who remind her of her relative. There is a sense of unresolved process that Zoe has not dealt with yet.

## **2.14 A space for personal development**

This super-ordinate theme shows that the course gives the participants space to be able to reflect on themselves and their relationship with their relative. This increases understanding and encourages personal growth and strength within the participants.

### ***2.14.1 Developing personal insight through a professional role***

This sub-ordinate theme explores the understanding and personal movement that the counselling psychology course has elicited in regard to the participants' understanding and perspective of their relative's mental illness.

*It's helped me make sense of things but I'm trying to think even how it's made me help me make sense of things [pause]. I don't know, I mean...it's probably had the most, the biggest impact because going to therapy I'm able to sort these issues out on my own, myself. (Sue; 662)*

Sue always had a caring role for her mother since she was a child and always put herself last. The process of personal therapy has given Sue a sense of control as she is putting herself first and looking after her own needs: '*I'm able to sort these issues out on my own, myself.*' Through this, Sue is able to develop a deeper connection and an increased understanding of her own emotions and cognitive processes. Personal therapy is a learning process for Sue as she is beginning to make sense herself. Zoe also speaks about how the course has deepened her connection with herself and how that has allowed her to have a deeper more effective connection with her brother:

*It's helped me to find out where I'm at and to pay attention to my, um, my inner processes. How I interpret things, how I respond and interact, how I make sense of things (...) find out more about me and what was too much for me and what was good for me, things that, I can't explain it, things.....I think knowing who I was gave me inner peace and that helps, helped me to work with more patience, more tolerance, acceptance. (Zoe; 194)*

During the course, Zoe has experienced extensive personal growth and she has an increased insight into her own processes in relation to how her brother's mental illness impacts on her. She has also cultivated an increased understanding into her brother's mental illness and why it may have developed.

*I remember when I was a teenager and she was quite sad, I had these kind of fantasies of being able to fix her, that I could help her (...) And that I don't feel it in the same way now but I don't quite know how I made that move (...) I have moved a lot since I've been on the course I think, the course has helped me to look at what's going on between us more clearly. (Amy; 170)*

Amy speaks of a time before and a time now where she acknowledges that she has 'moved'. This continuous movement that she experiences signifies growth and change within her that has been elicited throughout the course. Amy has also moved from her unrealistic child expectation of wanting to 'fix' her mother's mental illness to the more realistic expectation of acknowledging her own limitations. Amy has a different perspective now as she refers to seeing things 'more clearly' with her mother.

During the course, Lea has come to understand her mother's behaviours; however with that understanding, she acknowledged that she was unable to help her:

*I have an explanation for my mother's behaviour but there is not much I can do so there is a sense of being helpless really. I can only understand, but I can't change her, I can't make her seek help, all I can do is help myself. (Lea; 133)*

Like Amy, Lea was also able to let go of the unrealistic expectation she was holding on to and concentrate on the realistic goal of helping herself.

All four participants speak about making more space for themselves and seeing things more clearly. Throughout the course, they gained an increased understanding of themselves. They have all moved personally whilst being on the course.

### **2.14.2 Looking for personal support within a university setting**

This sub-ordinate theme captures the participants' expectations of the course in wanting to talk about their personal experience in an attempt to meet their clients' needs and their own.

It appears that Eve came onto the course hoping to examine her relative's mental illness. Her assumption that the reasons why other students chose this course were similar to hers, indicate that Eve wants to connect with others who have been in a similar situation:

*I actually thought, before coming on the course that we would look specifically at our experiences, mental health problems, relatives (...) I would assume that most people who come to this profession, they have reasons why they want to become therapists and I think it's often related to your family.*  
(Eve; 712)

Sue also wanted to talk to others on her course about her mother's depression:

*(...) I didn't talk about it because you weren't supposed to, I never asked but it's kind of like unsaid. And I think, I really would have loved to, I would have been absolutely ok to and it's something that nobody knows on the course.*  
(Sue; 876)

Like Eve, there is a sense that Sue wants to connect and share with others, and one of the reasons for going onto the course may have been a desire to be able to talk to others who were in a similar situation or others who would understand. However, Sue appears to experience a hidden taboo in speaking about her personal experience.

Clare questions whether individuals on the course can deal with her personal experience:

*I wonder how much of it can they really take. How much of that can they really contain? If you really say everything that is there, would they really want you to be on that degree? Would they really think that you're suitable as a psychologist to work? (...) Because I think you're supposed to voice only so much and then that's it, you can't go beyond that, you can't be this totally disorganised, traumatic traumatised person, you can have certain trauma and that's it. (Clare; 835)*

Like Sue, Clare also speaks about an unspoken taboo, an expectation that she should be a specific way and this prevents her from being open and honest on the course and she holds herself back. There is a fear of how others would perceive her. In contrast, Joy feels that she could be open and honest on the course and received continuous support from her colleagues and lecturers; which she found beneficial:

*(...) being in this training or in this field has been a huge help more than a hindrance. Much huge help. And also when I've had to talk to people such as lecturers and stuff because it's nice to have been in a field where there's no stigma. You know, you can say I'm struggling in this lecture because it's bringing up stuff for me. (Joy; 440)*

However, Eve did not experience support from her teachers like Joy did:

*I guess it's the teachers that they don't really have the experience themselves, like they would quite literally freak out if you tell oh one of my clients is schizophrenic and that you would probably need to refer them somewhere else. It does make me, um, I'd much rather have more support in ways of dealing with the client instead of saying get rid of the client. (Eve; 271)*

Lea uses personal therapy effectively to deal with her own personal processes:

*I am in therapy again because of this compulsory training. I do like it and I think it is extremely useful to me, especially with the training bringing up so*

*much stuff, it's uh quite important to be in therapy to work them out. (Lea; 452)*

Lea's phrase '*I am in therapy again because of this compulsory training*' indicates that if it was not for the course's compulsory therapy requirements, Lea would not have gone into personal therapy. Lea acknowledges the importance of personal therapy as she recognises that the course has elicited many emotional triggers and it is '*important*' to work through her process. Joy also benefits from going to personal therapy, although she like Lea was also avoidant in seeking help:

*I was really lucky because of this training I went into personal therapy (...) I really found that reaching out for help thing really difficult. And I think I needed to be pushed through the door. And I'm ever so grateful that I did and for me personally it's one of the best things I've ever done. (Joy; 262)*

Personal therapy helped Joy to deal with and prevent her own mental illness from developing further and it also helped her to work through the impact of mother's depression. Amy also used her personal therapy as a space to explore the impact of her mother's depression and the caring role she adopted:

*I think the main way in which the course has helped me to work through it has been (...) probably for the first 6 months I was on the course, I was using my personal therapy to talk about my mum and some of my struggles with juggling on the course are around this feeling that I have to be 100% there for her, but maybe I have that feeling for everyone that wants me and that's quite, that's been quite good to look at, to challenge. (Amy; 216)*

Personal therapy has been the most influential aspect of the course for Amy and it has allowed her to explore her experience with her mother's depression, resulting in her being able to experience a personal development in herself.

All participants found the space the course gave them through personal therapy or supervision was a positive space and it allowed them to explore the impact of their relative's mental illness on a personal and professional level. Through personal

therapy or supervision, they were able to grow and reflect on their personal life which allowed them to be a better therapist to their client and encouraged an increase in ethical practice.

## **2.15 Discussion**

### **2.15.1 Overview**

The aim of this research study is to gain an in-depth lived understanding of the experiences of trainee counselling psychologists who have a relative/friend with a self-reported mental health condition using a semi-structured interview within an IPA approach (Smith & Osborn, 2003; Smith, Flowers & Larkin, 2009). There are no current qualitative studies which have examined this phenomenon and an aim of this study is to contribute to the existing literature surrounding this topic. The main research question is:

The experience of having a relative/friend with a self-reported mental health condition for trainee counselling psychologists personally, professionally and academically.

In relation to the main research question the following areas are explored:

1. A trainee counselling psychologist's personal experience with a mentally ill relative/friend.
2. A trainee counselling psychologist's experience with their mentally ill relative/friend in relation to their psychology work/placement.
3. A trainee counselling psychologist's experience with their mentally ill relative/friend in relation to their counselling psychology course.
4. The experience of the counselling psychology course in relation to a relative/friend with a self-reported mental illness.

## **The experience of having a relative/friend with a self-reported mental health condition for trainee counselling psychologists personally, professionally and academically**

Within the following section, in light of the research aims above, the main findings will be discussed in relation to its evidence base and existing theory. The significance and limitations of the study, clinical implications of the results, methodological considerations and suggestions for future research will all be discussed.

### **2.15.2 A trainee counselling psychologist's personal experience with a mentally ill relative/friend**

Within this subsection, the first topic explored in relation to the interview research question was: What is your experience and interpretation of having a relative/friend with a self-reported mental health condition? Overall, the findings were that participants found that their families expected them to continue a therapy role at home because of their trainee psychology status. However, participants felt that they were unable to match up to their families' expectations because they did not know how to help their relative with their mental illness. It was also interpreted that participants tried to balance their continued therapy role with their current life demands whilst trying to also look after themselves, which resulted in the participants feeling mentally and physically exhausted. The participants also spoke about how their experience with their mentally ill relative/friend led them to question their own mental illness.

### ***2.15.3 Not knowing in an expected therapy role***

This recurrent sub-ordinate theme demonstrates that nearly all participants found that because of their trainee counselling psychology role, they either had expectations from themselves (Eve, Sue, Pam, Amy), their family (Eve, Lea, Pam, Clare) or their relative (Pam, Amy, Clare) in continuing a therapy role at home. Whereas without their psychology background there would not have been an expectation to take up a therapy role.

The Literature Review highlights that Lefley's (1987) study reports that mental health professionals were "*unwilling or unable to apply their information or expertise to successful treatment of their FM's case*" (p. 616) (FM= family member). Yet, within this study nearly all participants, whether they were aware of it or not, used their expert therapy role with their family member, however not all were successful. However, in Lefley's study they were not all therapists and so it may be interpreted that the acquisition of a therapy skill set may elicit therapists to take up a therapy role with their relative as they may feel they are better equipped to deal with it.

Some of the participants view their therapy role at home as a duty, even though the majority of participants comment that they do not know how to help their relative; however this does not stop them from trying. Sue uses the word "*starving*" to describe her mother's need for her therapy skills; otherwise she feels her mother would deteriorate. She places a huge expectation on herself to help her mother, but at the same time recognises that her continued therapy role is not working. Eve places expectations on the course, questioning why she has not been taught therapy skills to help mentally ill individuals within her placement who had the same diagnosis as her relative. She wants to help but does not know how. She too places a huge responsibility and expectation on herself.

The participants demonstrate an aspect of self-efficacy (Bandura, 1977) in believing that they are able to help their relative. The participants see their expected therapy role at home as a continuous process (Eve, Lea) and over time recognise that it is taking too much from them (explored further in sections 2.5.4; 2.12.1; 0 & 4.2.3). The participants' continued therapy role at home increase their level of responsibility and liability as they are expected by their family members to make a difference. This also causes considerable stress for the participants as they experience conflicting thoughts and emotions as they are pulled between their family role and their continued therapy role at home (as explored further in sections 2.11.4; 2.18.2).

Some of the participants within the study feel they should know how to help their relative but do not know how to, fail or give up. This results in the participants experiencing feelings of guilt and self-blame. They also experience comments from

others who judge them in their inability to fix their relative's mental illness. Truell's study also reports that participants feel judged by others and experience feelings of guilt in being unable to solve the problems of others. This is also shared with participants in this study. Participants show that even though they feel like this, they do not give up. The participants demonstrate a great deal of strength, perseverance and determination in not giving up their counselling psychology course.

Truell's (2001) study only looks at the negative experiences of the trainee counselling psychologist, whereas a fuller trainee experience is reflected within this study. It is found that alongside a negative experience there are also some positives experienced by the participants. It was found that Joy is the only participant who does not have expectations from any members of her family, which feels positive for her, and she sought to get help from other professionals as she recognised and acknowledged that she did not know how to help. On the other hand, the rest of the participants experience negative emotions from the expectations their family members have of their trainee role; this results in the participants trying to take on their relative's mental illness by themselves. This may illustrate that the expectations of family members play a significant role in the trainee's decision to carry on a continued therapy role at home. As previously highlighted within the Literature Review, UK trainee counselling psychologists report feeling stressed by being on a counselling psychology course as they feel they are viewed differently by individuals within their personal life as a consequence of the course (Truell, 2001). The participants demonstrate that the expectations from their family to take up a continued therapy role at home cause considerable stress.

The majority of findings within this sub-ordinate theme demonstrate that the existence of a relative/friend with a mental health condition impacts the trainee counselling psychologist by creating additional burden which negatively affects their personal life. The additional burden is viewed in the form of; expectations from others to continue a therapy role at home; and self-expectations to continue a therapy role at home. These two forms of burden resulted in the trainee experiencing role conflict, depletion of personal resources, stress, self-blame, guilt and not knowing how to use their therapy role to help. An interesting component in this part of the study was that Joy was the only participant who did not have expectations from

others or from herself to continue a therapy role at home, and as a result she was the only participant who did not experience any negative reactions to her continued therapy role at home. This could be taken further to recognise that the trainees' families and the trainees themselves were putting unrealistic expectations on themselves. The findings from this study demonstrate that trainees should not take on a therapy role outside of a professional setting as it can cause boundaries to be blurred, cause considerable stress for the trainee and may provide an unsafe environment for the informal client. Also if trainees do not know how to help an individual, as was voiced by the majority of participants within this study, then they should refrain from doing so or seek professional supervision. This could be detrimental to the therapeutic process with a client and can delay an informal client in getting adequate psychological care. These findings can be generalised to trainees within other disciplines and professional psychologists and psychotherapists.

#### ***2.15.4 Balancing self-care with personal and academic demands***

As the literature suggests, training in the psychology field is full of stressors and puts many demands on the trainees' economic, professional and personal lives (Millon, Millon & Antoni, 1986; Kumary & Baker, 2008; Jensen, 1995; Bor, Watts & Parker, 1997). On top of the stressors developed throughout the course, some of the participants comment on their struggle to balance their professional and academic lives in relation to the responsibilities they have with their mentally ill relative/friend. Some of the participants struggle to balance these aspects of their lives and question how they would move forward (Zoe). The participants experience a loss of control and an over-investment within their therapy role with their relative. The demands of their continued therapy role add a lot of weight to the already present balancing act which is taking place, in particular the demands of the course. This results in a decrease of personal resources which leave no time for self-care (Zoe, Sue, Pam, Joy, Clare, Joy).

As the Literature Review previously illustrated, Givelber and Simon's (1981) study found that therapists who had lost someone through death did not look after themselves very well as they did not take time off work after the loss of a loved one. This study shares similar concepts, as participants report that they are aware that they

do not look after themselves and that they put looking after their relative's needs in front of their own (Eve, Zoe, Sue, Pam, Joy, Clare). It is interpreted that some of the participants were not even aware of the huge investment they had undertaken in looking after their relative and they were not aware if they were even caring for themselves or not (Sue); the participants neglect their own needs. Givelber and Simon (1981) also claim that these stresses may be due to financial worries. Lea and Clare report feeling stressed from the financial costs of the course which are also consistent with Jensen's (1995) and Bor, Watts and Parker's (1997) studies, which found similar stresses reported by their psychology trainees.

Over time, Lea and Clare recognised that they were unable to meet the demands of the course and support their relative at the same time. They decided that they had to look after themselves and so they cut complete contact from their relatives. Throughout the course, the participants developed an increased insight into themselves and their situation. They gain an awareness of their own personal limitations and made changes in accordance. This allowed them to gain some control back into their lives and balance their lives more successfully.

This sub-ordinate theme illustrates that the trainees were at their most vulnerable at the beginning of the course as their insight and personal awareness develops with the course. To tackle this, trainees could attend extra groups on time management or address it in their personal therapy sessions. However, if students are not disclosing and a group is set up for them, there is no certainty that they would disclose within a new group. A deeper question to be addressed here would be why trainees are not disclosing and under what circumstances are they likely to disclose? Self-disclosure may increase their levels of insight and awareness and allow them to look after themselves better.

#### ***2.15.5 A depletion of mental and physical energy for counselling psychology trainees***

It has been illustrated within the literature that burnout amongst counselling trainees can have a severe impact on the trainees and their clinical practice (Shapiro, Shapiro & Schwartz, 2000). However, most of the participants within this study verbalised

the impact of their therapy role at home and the interpretation was that participants experienced a similar concept of burnout as they spoke about a depletion of mental and physical energy. According to Mashlash and Jackson (1981), increased feelings of emotional exhaustion are characteristics of burnout syndrome. When the participants spoke about their continued therapy role at home with their relative, they reported that they felt emotionally and physically drained (Eve, Sue, Pam & Amy). This is a repetitive process of which the duration is approximately between one to ten years and results in Eve, Pam, Sue and Amy feeling a loss of control over the situation as a result.

Another characteristic of burnout syndrome was an individual having a negative self-perception, especially in relation to their client work (Mashlash & Jackson, 1981). As a consequence of the participants feeling a loss of control, they experienced feelings of helplessness as they felt unable to help their relative with their mental illness. Theory suggests that the participants' inability to help their relative results in a weakening of their self-efficacy (Bandura, 1994). Pam's, Lea's and Sue's self-worth deteriorates, which results in them questioning their competency as professional therapists, as they question their inability to help their own mentally ill relative which leads them to consider how they would help their clients. It has been suggested that burnout can also result in a deterioration of the quality of care or service provided to clients (Freudenberger, 1974; 1975) (later explored in section 2.16.2).

Eve and Pam have expectations from their family to take up a therapy role at home and they find it draining and comment that it makes them feel tired. They also describe that they feel they are holding their family together which requires a considerable amount of energy. There is a sense that the participants are carrying their family through this. The participants use words like '*heavy*', '*dumping*', '*holding*', [family] '*pouring*' and '*carry*' to describe what they feel like when their families expect them to take up a therapy role at home. The participants display a sense of suffocation and a feel like a part of them is lost as the therapy role eclipses a part of them. The participants use words like '*draining*', '*tiring*', '*weaker*' and '*self-destructive*' to explain what their continued therapy role at home feels like. This portrays a depletion of energy and again, a loss of self, which also contributes to the

participants being unable to care for themselves. The implications of these concepts on a trainee can mean that the trainee will be unable to function effectively as a student and trainee psychologist (explored further in sections 2.16.2 & 2.17.1), which may impact on their client work and academic success. Many educators are aware that trainees need tools to self-care and many training courses have put services in place for this purpose (Baker, 2003; Weiss, 2004). Christopher and Maris (2010) observed counselling and psychotherapy students who had taken a mindfulness class alongside their psychology course. Students were taught to self-care and increase self-awareness. The study found that students developed an increased awareness, acceptance of their experiences, increase in self-confidence and an increase of their competence in their relationships with themselves, clients and others. The study was so successful that the course became a mandatory module within their psychology programme. It may be beneficial for trainees to be aware of the benefits of mindfulness training or any other holistic therapies to allow them to self-care. This study shows that the participants' put themselves last the majority of the time; their continued therapy role at home was always the more dominant role and this contributed to their depletion of mental and physical energy. This study highlights that trainees who have a strenuous personal life should be aware of the importance of self-care, especially at the beginning of training as studies highlight that this is when trainees struggle the most (Bischoff et al., 2002; Skinner, Elliott & Wheeler, 2010). This sub-ordinate theme gives awareness to the importance of self-care so as to reduce the risk of feeling drained and the negative consequences it can have on trainees and their clients.

#### ***2.15.6 Personal identification with a relative/friend's mental illness***

The Literature Review identified that just because therapists have knowledge and experience within the psychology field, it does not mean that they are exempt from being affected by mental illness themselves (section 2.5.2). Truell's (2001) study reports that one of the stressors of a UK counselling psychology trainee on a Diploma course was the questioning of their own mental health. This sub-ordinate theme illuminates this phenomenon further. All participants apart from Pam explored the meaning of their own mental health in comparison to their mentally ill relative/friend. Eve lost her concept of reality when she experienced her friend

hallucinating and it was interpreted that she disconnected from her sense of self into the unknown. She feared the development of her own mental illness when working with future clients who had similar mental health symptoms to her relative. Sue and Lea also shared this underlying fear that in the future they too would develop a mental illness like their relative. Lea, Joy and Amy felt that their psychological knowledge was a defence against developing a mental illness as it gave them insight, which meant that they had the awareness to get help which their relatives did not get or resisted to get. They perceived this as the difference between themselves and their relative. Zoe identified with her brother's mental illness as she felt she previously had similar mental health symptoms to her brother. Sue, Lea, Amy and Clare all refer to their own mental health symptoms as a direct consequence of their experience with their mentally ill relative/friend.

As identified in sections 2.15.4 and 2.15.5, this study illustrates that the participants' experienced a decline in their mental and physical energy levels as a result of doing too much and they did not always implement appropriate self-care. Gilroy, Carrol and Murra's (2002) study, highlighted the importance of self-care as a prevention of psychological symptoms for the therapist. This study takes their study further by illustrating that knowing someone with a mental illness may encourage trainee psychologists to question a possible existence of their own mental illness. This concept elicits fear and causes the participants' to question what is known and unknown about their own mental health. This is a situation which can escalate out of control if not properly managed. Gilroy, Carrol and Murra (2002) went on further say that they believe personal therapy should be mandatory for all trainee psychologists to addresses circumstances like these. It is important that trainees recognise this phenomenon and address it in a professional space. Throughout the course, trainees are working with clients and this can impact on the client in a negative way if not acknowledged and properly managed.

## **2.16 A trainee counselling psychologists experience with their mentally ill relative/friend in relation to their psychology work/placement**

This subsection addresses the second area explored in relation to the research question: What are your experiences, if any, that the experience with your relative/friend had at your work/placement? The findings from the experience of the participants' mentally ill relative/friend which spilt over into a professional space were uncovered and illustrated under two sub-ordinate themes: working with personal experience in a positive way within a professional environment and working with personal experience in a negative way within a professional environment.

The literature highlights countertransference as the therapist's reaction to clients which stem from the therapist's unresolved issues (Gelso & Hayes, 1998). Countertransference within a therapy session can be a negative and positive experience for the client and therapist (Gelso & Hayes, 2001a; Hayes et al., 1998; Bonny & Fussell, 1990). One of the triggers experienced between all participants was 'therapy content' (Gelso & Hayes, 2001a). This is well researched within the literature and is where the client presents material which relates to the therapist's unresolved conflict. It has been well documented within the literature that family matters can evoke strong emotional responses with therapists (Hayes et al., 1998; Hayes & Gelso, 2001b). The therapy process between the therapist and client can also trigger personal emotions which can spill over within a therapy session and out of a therapy session (Hayes et al., 1998). This spill over of thoughts and emotions within a therapy session was displayed amongst some of the participants within this study. These will be explored below.

### ***2.16.1 Working with personal experience in a positive way in a professional environment***

Hayes and Gelso (2001b) commented that “(...) *future research needs to be directed toward understanding how therapists can use their experiences of having been wounded to facilitate their work with clients*” (p. 1050). The Literature Review showed counselling psychologists facilitating positive countertransference when using their personal experience in a positive way within therapy sessions with a client (Gilroy, Carroll & Murra, 2002) (section 2.5.3). The findings of this study

contribute further to this phenomenon as participants spoke about how their personal thoughts and emotions around their relative/friends mental illness came into the therapy session with a client which had a positive impact on the client session. The participants were able to empathise with their clients as a result of their personal experience and were able to gain a deeper understanding of their client's experience. They reported that this increased empathy was attributed to clients who had a similar diagnosis to their relative or shared a similar family background to themselves (Zoe, Lea, Amy, Clare). Participants felt their use of empathy added "*another dimension to our relationship*" (Zoe; 165) and allowed them to "*really really relate*" with the client and feel "*more attuned*" (Pam; 212, 700), which they found was beneficial to the therapeutic relationship between participant and client (Givelber & Simon, 1981).

The participants also reported that they developed increased insight into the client's world which was derived from their own personal experience of having a mentally ill relative (Lea, Amy, Clare). The literature highlights the importance of insight developed through countertransference, commenting that it "*can deepen therapists' awareness of relationship dynamics and provide valuable information about the course of treatment*" (Hayes et al., 1998, p. 468). Amy comments that her experience with her mentally ill relative at times has had a positive impact as it "*does help in the therapeutic alliance*" (Amy; 310).

Within Pam's and Clare's accounts, they felt that the mental health experience with their relatives had contributed to their ability of being an effective therapist and they felt stronger within their client sessions as a result. Although no studies were found which specifically explored the experience of a trainee's personal life and the impact it may have in a client session, trainee counselling psychologists share a similar experience with professional therapists in Givelber and Simons' (1981) study. They found that the personal experiences of the professional therapists could improve the therapeutic relationship with a client as the therapist listened more and was more sensitive to their client. The participants within this study also demonstrated increased listening abilities and felt more comfortable with clients whom reminded them of their relative.

This sub-ordinate theme adds to the already existing literature within this area by showing that a negative personal experience can be a positive experience for trainees within their client sessions as they draw upon their own personal experiences to further develop their therapeutic skills. This can have a positive impact on the therapeutic relationship with a client and can aid in facilitating a richer therapeutic experience. The findings from this study demonstrate that the existence of a friend/relative with mental health issues provides a direct source of information of mental health which positively influences a client session for a trainee counselling psychologist.

### ***2.16.2 Working with personal experience in a negative way within a professional environment***

The participants also demonstrate a spill over of personal thoughts and emotions as a result of having a relative with a mental health condition as a trainee counselling psychologist, which can have a negative impact on the client session. The literature shows that this can display itself in forms of anger, sadness, boredom and feelings of inadequacy for therapists (Hayes et al., 1998). Some of the participants state that they feel that more of their unresolved emotions were coming into the therapy room with their client as a result of their personal experience (Zoe, Pam, Lea, Amy, Clare). The participants experienced a range of negative emotions in a client session: anger, frustration, helplessness and impatience. The unresolved emotions they possessed with regard to their mentally ill relative/friend were eclipsing the client as the therapist's concentration decreased. An implication of this could result as a negative experience for the client, as the client may not feel heard or seen, which can have a negative impact on the therapeutic relationship.

Gelso and Hayes (2001) recognised that a therapist who is unaware and unable to manage their own anxiety can employ negative countertransference behaviours; e.g., avoiding a client; responding to a client in a negative way. This could impact negatively on the therapeutic relationship between therapist and client and could fail to facilitate a space for personal growth (Van Wagoner et al., 1991). In Eve's case, where she previously had an increased interest with a client whom had the same mental illness as her relative; she had a decreased interest with a client whom did

not. This resulted in her experiencing impatient feelings with her client as she recognised that it was because helping the client did not serve a personal function for her. Eve had needs which she was not yet aware of which needed to be met. It appears that she did not recognise it at the time but demonstrates an awareness of it within her interview.

Gelso and Hayes (2007) identified blurred boundaries as a consequence of a negative spill over of personal emotions within a therapy session with a client. Clare had insight into her own emotional process within the interview as she commented that at times she felt unsafe working with clients as she recognised that she was unaware of boundaries which were being blurred by her own personal process. Blurred boundaries within a therapeutic relationship can result in situations escalating out of control. It is important for the trainee to confide to a supervisor in an effort to gain awareness and control over the situation. However this study illustrates that some trainees purposely do not confide to anyone as they didn't want to be viewed as an 'incompetent therapist'. In reference to that particular situation, where would the trainees take their process? A further study could be carried out to further explore this phenomenon so that a framework can be constructed to try and address this issue. It could follow on from Mehr, Ladany and Caskie's (2010) quantitative study, which focused on identifying what counselling and psychotherapy trainees were not disclosing within supervision. The study did not explore avenues in which changes could be made and so an informal focus group could be constructed to ask trainees what they were not disclosing, the reasons why and under which circumstances were they most likely to disclose in the aim of encouraging disclosure within a professional space.

As previously discussed in section 2.15.5 (a depletion of mental and physical energy for counselling psychology trainees); the majority of participants reported that they felt emotionally and physically drained from coping with their relative's mental illness. This sub-ordinate theme takes these findings further by reflecting that the participants recognised that this was impacting on their client sessions. Some participants recognised an increase in frustration and anger (Zoe, Pam, Amy) whilst others felt a decrease of empathy for their client (Zoe) and felt uncomfortable working with a client whom reminded them of their relative (Amy). O'Conner

(2001) recognises that it is a hard job for psychologists to contain their emotional feelings and responses in intense sessions with a client. This can result in psychologists feeling emotionally drained which can impact on their quality of work with a client (Gelso & Carter, 1994; Gorkin, 1978). Eve reported that she was unsure if clients who reminded her of her relative benefited from her different way of working with them. Zoe also did not feel as she was able to be fully present as a counsellor in a counselling session with a client when she felt emotionally drained as a consequence of her relative's mental illness. In contrast, Joy did not experience any negative transference within the therapy room with a client. These reflections leave the researcher to question what projective identification the participants were left with and how it may impact the client. This could be addressed by implementing a study which explores the client's experience. A similar study was carried out by Stephano, Mann-Feder and Gazzola (2010) which explored clients' experiences when working with novice counsellors. The study found that the participants felt their positive counselling experience was a result of the counsellor's interpersonal qualities and skills. As the findings of this sub-ordinate theme illustrated, at times, trainees engage in therapeutic work with a client when the client's best interest is not foremost. Further research can be carried out within this area to ascertain what clients may experience within this phenomenon. However, the research topic may result in a difficult recruitment process.

## **2.17 A trainee counselling psychologists experience with a relative/friend in relation to their counselling psychology course**

This subsection addresses the third area of exploration in relation to the research question: How do you make sense of your relative/friend with a self-reported mental illness in relation to your psychology course/trainee role? It reflects the participants' experience with their mentally ill relative/friend and the spill-over onto a counselling psychology course. It also highlights the participants' use of a professional space within the course.

### ***2.17.1 Personal identification within an academic setting***

The Literature Review identifies that psychology training is a difficult journey which can alter an individual's identity (Skinner et al., 2010) and their interpersonal

relationships (Seashore, 1975; Owen, 1993). This can be a very stressful and negative time for the trainee (Cushway & Tyler, 1996). This sub-ordinate theme illuminates what it is like for trainee psychologists whom have a relative/friend with a mental illness and how this impacts on them within the course. The study found that participants identify with material learnt on the course as it activates thoughts and emotions which they were not always aware of which is elicited through their experience of their mentally ill relative. Lea uses the knowledge learnt within the lecture to understand some of her own behaviours which she recognises are a result of her relative's mental illness. As a result of a lecture, Joy finds herself questioning whether she is doing enough for her mother which results in increasing her feelings of helplessness and loss of control. This then causes Joy to leave her lecture. Clare also experiences a loss of control over the constant reflection she feels is asked of her during the course, and through this Clare disconnects from her sense of self. This results in her questioning her own identity as she tries to make sense of the different roles she takes up (explored further in section 2.18.2). The spill-over of the participants' personal lives onto the course is interpreted as a traumatic and overwhelming experience, with Lea and Joy using words such as "*painful*" and "*stuck*" to describe it. In addition, Clare uses quite violent language to explain how she continuously feels like the course forces her to face her own problems. Again, there is a loss of control.

The Literature Review also showed that the interpersonal relationships of individuals who go into training as psychologists are likely to change (Seashore, 1975; Owen, 1993) which can result in trainees decreasing their circle of friends and socialising less during their counselling career (Faber, 1983). The findings of this study corroborate this. As previously mentioned, both Clare and Lea cut complete contact with their relatives as a result of the course. Throughout the course, they recognise that they are unable to help their relative and they are unable to cope with being on the course and supporting their mentally ill relative at the same time.

This sub-ordinate theme shows that the participant's personal experience impacts negatively on the course by causing the trainee to lose focus. It also demonstrates the trainees using the material learnt on the course to increase their understanding and make decisions in regards to their relative and their mental illness. There is an

interactional relationship between their personal experience and the course and it may be beneficial for trainees to have an awareness of that; moreover, this research study encourages participants to explore their process further in a professional space.

### ***2.17.2 Looking for personal support within a university setting***

Some of the participants disclosed that they would not have gone into personal therapy if it had not been for the course requirements and that it was the best thing they ever did (Lea, Joy, Amy). The participants benefited from being able to talk about how their relative/friend's mental illness impacted on them. Personal therapy and supervision aided in each trainee's personal development. This process goes back to Abraham Maslow and Carl Roger's work of self-actualisation (1957; 1961). The journey of self-actualisation allows the individual to become more self-aware and theory shows that this is beneficial not only for the counselling psychologist but for the complete counselling process (Malikiosi-Loizoz, 2013). The participants demonstrate that through personal therapy and supervision, they do show evidence of self-actualisation as they become more self-aware of their own personal processes. As established within the Introduction (section 2.4.3), Target's (2007) study concluded that through personal therapy, participants felt they were able to "*establish authentic emotional contact with themselves*" (p. 46) and felt personal therapy should remain mandatory on counselling psychology training programmes. Within this study, personal therapy was found to be beneficial for the participants. Participants used personal therapy to explore their experience with their mentally ill relative/friend and re-establish an authentic emotional connection with themselves. The participants found personal therapy very helpful as they were able to talk about their relative's mental illness, their own identity in relation to that and the emotions elicited from the course as a result. The participants also used supervision to explore how their experience impacted in and out of their client sessions. However, they stated that at times, they did not fully confide about their personal experience in the early stages of the course for fear of appearing as an incompetent therapist. This was similar to some of Barnet and Hillard's (2001) findings, as discussed within the Literature Review (2.5.3). The therapists in their study also chose not to disclose their personal process for fear of being judged by others. It appears that this theme is not exclusive to trainees, but extends to professional therapists too.

Studies show that for supervisors to develop a trainee's clinical competence and professional development, trainees need to be transparent in their supervision sessions (Ladany et al., 1996; Wallace & Alonso, 1994; Mehr, Ladany & Caskie, 2010). Nondisclosure by trainees can contribute to a decline in significant learning experiences and decreased clinical effectiveness (Wallace & Alonso, 1994). Mehr, Ladany and Caskie's (2010) study report that trainees do not disclose because they are concerned how supervisors would view them in personal and professional contexts. This fear is also replicated within this study, as some trainees fear how others would view them and, as a result, do not share their experiences with others.

The consequences of nondisclosure can also impact on the trainee's clients, as unresolved issues can result in conscious and unconscious countertransference. The consequences of this unawareness can cause unresolved personal issues to come out within a therapy session with a client. It has been previously illustrated that acting out countertransference with a client can be harmful, and as Gelso and Hayes (2001a) state, it is important to use countertransference management to be able to increase understanding and maintain healthy boundaries. This can be achieved through personal therapy and supervision which is a requirement of the course. Gelso and Hayes (2001b) say that "*Research from the past 50 years has underscored the necessity for therapists to attend to their own unresolved conflicts to minimize the likelihood of having countertherapeutic reactions to clients*" (p. 1050). This study found that participants experienced a spill over of personal emotions as a result of their relative/friends mental health problems within their therapy sessions with their clients and trainees did not disclose all to their supervisors and to others in their lives.

The participants also share findings in Truell's (2001) study of trainee counselling psychologists. Both studies report that the expectations of the trainees were not met on the course as they were unable to talk about their personal experience within an educational and social context. Eve reports that, when applying for the counselling psychology course, she expected to be able to examine her relative's mental illness as she would be able to talk about her own feelings and learn how to help others who had the same mental illness as her relative. This is associated with the 'wounded

healer' literature, as it is recognised that some individuals embark on a psychology career as a consequence of earlier emotional pain (Menninger, 1975; Sedgwick, 1994; Strupp, 1973). The wounded healer literature findings have also been replicated within this study; evidently, some of the trainees specifically embarked on a counselling psychology career as a consequence of their relative's mental illness (explored further in section 2.17.3).

It was also interpreted that Eve wanted to connect with other students who had chosen the course for similar reasons. This was also shared by Sue, however she reported that it was unspoken, arguing that "*I didn't talk about it because you weren't supposed to*" (876). Clare also wanted to share her personal experience with others on the course; however she questioned whether they would be able to contain her trauma. She also shared Eve's view that she wasn't supposed to voice her personal experience. It was interpreted that the participants were looking for a space to be themselves; a space where they could talk about their experiences. It is acknowledged that the counselling psychology courses have a strong tradition of providing support to students; nonetheless, the majority of participants within this study demonstrate that they do not confide to others about what is going on for them. It appears that the resources are there but the students are not accessing them effectively. It seems as if trainees want to talk about it but are not. A way of addressing this issue may be to set up an informal group outside of university hours which would allow students to come in and talk about any personal experiences they may have which may impact on their counselling psychology role. This study also highlights that the majority of participants within the study do not communicate with their family members to tell them that they do not know how to help their mentally ill relative. The participants keep a lot of their experience to themselves and this study illustrates that trainees may need more support in this area. It raises awareness for supervisors and personal therapists who have students who may be in a similar situation and it also raises awareness for students, encouraging them to gain support so that they are able to talk about what may be going on for them. This may decrease their feelings of responsibility, role conflict, unrealistic expectations and guilt.

Joy was the only participant who felt she could be open and honest on the course about her experiences, which she benefited from. For her, the course held no mental

health stigma; whereas other participants felt that even though it was a counselling psychology course, it still held mental health stigma and they felt that the academic professionals did not know how to deal with mental illness (Eve). A counselling psychology course would seem an unlikely place that an individual would encounter mental health stigma; however, this study encountered mental health stigma within an academic setting. A further search of the literature did not encounter any studies on this phenomenon. Research could be carried out within this area to further understand a trainee's experience of this and to identify ways in which to minimise mental health stigma and encourage individuals to seek professional support if they do experience it.

### ***2.17.3 Personal identification with a counselling career***

Sue, Amy and Lea indicate that they chose the counselling psychology course because of their experience with their mentally ill relative. As discussed within the Literature Review (2.5.5), Walter et al., (2003) commented that trainee psychiatrists chose the course as a result of their experience with a mentally ill relative; however, it was a quantitative study and he did not explain why. This study contributes to the literature by describing that participants used the course to try to gain some control within their lives by trying to understand their relative's mental illness. Participants also wanted to understand how their mental illness developed and ways in which they could help them with their mental health symptoms. Participants also used the course to understand themselves as a result of their relative's mental illness in terms of their own behaviours, emotions and cognitive processes. Eve went on to say that she felt she was saving her relative through other clients and that was one of the reasons why she enrolled on the counselling psychology course. This supports the wounded healer theory (previously referred to in section 2.5.5), which illustrates that some individuals embark on a psychology career as a consequence of earlier emotional pain (Menninger, 1975; Sedgwick, 1994; Strupp, 1973).

The participants whose relative's mental illness had developed after they had decided to pursue a career in psychology (Pam, Zoe) also show that their relative's mental illness did influence their future career decisions. Some of the participants felt drawn to specific areas in psychology with clients whom had the same diagnosis as their

relative. They said it was because they wanted to make a difference with other clients who were similar to their relative. Other participants recognised that they did not want to work with clients whom had the same diagnosis as their relative as it brought up too many emotions and they did not feel they were ready to deal with it; avoidance was used as a coping mechanism. The literature also shows that a therapist's personal traumatic experience can influence their career decisions (Menninger, 1975; Strupp, 1973; Walter et al., 2003). The study illustrates that some participants are influenced to work within a specific model because that is how they worked for their relatives at home. Pam and Clare both decide they want to work within a systemic therapy model as they liked the way they worked together as a family to help their relative. Howard, Inman and Altman's (2006) study reported that participants personally identified with their counselling role and incorporated this within their counselling role identity. Within this study, the participants identify with their personal experience of their mentally ill relative/friend and incorporate it into their counselling role identity; which is evidenced by their choice of career. It is important that trainees utilise their personal therapy and supervision sessions properly so they can gain an insight into themselves and have an awareness of their own personal process. As previously discussed, this may aid in facilitating a healthy therapy session with a client, as it would have been likely that any emotional process would have been uncovered. This study illustrates the importance of having a professional space to take personal process and demonstrates the importance of having mandatory personal therapy within a psychology course.

### **2.18 The experience of the counselling psychology course in relation to a relative/friend with a self-reported mental illness**

This subsection addresses the final area of exploration in relation to the research question: What is your experience with the course in relation to your relative/friend with a self-reported mental illness? This section presents how the course impacts on the participants' experience with their mentally ill relative/friend. It highlights the knowledge gathered by participants from the course which has allowed them to gain a deeper insight of their mentally ill relative/friend. It also highlights the therapy role which was cultivated during the course and how the participants have continued the therapy role at home and the struggles they have experienced in doing so.

### ***2.18.1 Developing personal insight through a professional role***

As already highlighted through the lectures, supervision and personal therapy delivered during the course, the participants show they have developed a deeper insight and understanding into themselves and their relative/friend's mental illness and behaviours (Sue, Zoe, Eve, Lea, Amy, Joy). This sub-ordinate theme further highlights the insight the participants gained throughout the course and how it impacted on their perspectives and relationship with their mentally ill relative/friend. It supports the literature by Hamilton and Mackenzie (2007a), who found trainee counselling psychologists had deepened their own understanding about themselves through the course and learnt to prioritise different areas within their lives. Hamilton and Mackenzie's (2007a) study was a quantitative study and this study further illuminates this theme in more detail.

Throughout the course, the participants developed a deeper understanding of their relative/friend's mental illness and tried to make sense of it (Eve, Zoe, Lea, Joy, Amy, Clare). This deeper understanding allowed Amy, Clare and Lea to recognise that they were unable to help their mentally ill relative which resulted in letting go of their unrealistic self-expectations. The course also assisted by encouraging the participants to self-care. Some of the participants had an awareness of how the course helped them to develop (Eve, Sue, Zoe, Lea, Joy, Clare) and some participants were aware that they had developed during the course but were unsure how (Amy). All of the participants developed personally during the course, which resulted in them gaining a deeper connection with themselves and understanding themselves more. The course facilitated a significant amount of personal insight which was used to make sense of their mentally ill relative. This insight facilitated movement for all participants as the personal change within themselves had an impact on their relationship with their relative. This implies that understanding is empowering and the counselling psychology course can facilitate this change for the participants. This sub-ordinate theme shares previous findings in the present literature which demonstrate that individuals go through many personal changes when training as a psychologist (Skinner et al., 2010; Seashore, 1975; Owen, 1993). However, unique findings also emerge from this study as it demonstrates that trainee

counselling psychologists use the personal changes facilitated through the course, to evaluate their relationship with their relative/friend and the investment of their continued therapy role.

### ***2.18.2 Negotiating identity: Family versus therapy role***

This sub-ordinate theme illuminates the struggle experienced between the participants' family role and their continued therapy role at home. It does not look at the expectations of others but at the participants' own feelings regarding which role they should take up. No previous findings were discovered which support this particular theme; however, the prevalence of this theme across the majority of participants made it stand out as a sub-ordinate theme. Truell's (2001) study commented that trainee counselling psychologists experienced role conflict as they did not know how to be themselves and how to be a counsellor. Lefley's (1987) quantitative study goes further than Truell's (2001) study, as it shares findings with this study regarding the confusion that participants felt with regard to being a mental health professional and having a family member with a mental health condition. This research study takes Lefley's findings even further as it sheds light on the participants' lived experience of the role conflict. Barnett and Baruch (1987) hypothesised that the more roles an individual has, the more role strain they are likely to experience. Pam, Lea and Sue consciously struggle with which role to take: their therapy role at home or their family role. They actively battle between both roles and this cause's personal conflict. The participants experience a difficulty integrating the two roles and coming to terms with a new identity. It is interpreted that Eve, Sue, Zoe, Lea and Clare all see their continued therapy role at home as the more dominant role in comparison to their family role. The participants experience confusion, questioning, conflict and ambivalence between the two roles. The participants disconnect from their sense of self and boundaries are blurred, which increase feelings of helplessness and result in participants experiencing a loss of control. It was also interpreted that some of the participants had a conscious awareness that they were struggling between the two roles, whereas some of the participants were unaware of the battle they were in. This study also demonstrates that participants experience a sense of separation from their families when taking up a continued therapy role at home (Sue, Zoe, Pam & Lea). It appears that there are

themes of alienation and isolation felt by participants as they do not view themselves to be in the same role as their family members but in a whole role of their own.

There were no questions within the interview schedule which asked about role conflict; however, all participants, excluding Amy, spoke about it in their interview. Amy held a predominantly caring role with her mother, rather than a therapy role. It was not apparent that she utilised any of her therapy skills with her mother and she did not view herself as being in a therapy role.

This sub-ordinate theme is a unique finding as no literature was found which reports the role conflict experienced by a trainee psychologist when continuing a therapy role at home. This sub-ordinate theme displays this role conflict as a negative experience for the trainees. The role strain experienced contributes to a decline in emotional and physical energy, which impacts negatively on the trainee and their client work. This has implications on the effectiveness of the therapeutic work, as previously discussed in section, where there was a negative impact on client sessions. It is important that trainees utilise their available support services adequately, as it has been demonstrated that it can help a trainee work through their process, potentially facilitating healthy therapeutic process within a client session and also resulting in trainees experiencing an increased connection with themselves.

## **2.19 Significance of the study**

This study provides an understanding into the phenomenon of a trainee counselling psychologist's experience of having a mentally ill relative/friend and how that impacts on them personally, professionally and academically. The existence of a trainee's relative/friend with a mental health condition creates additional burden which negatively affects the trainee's course, place of work and the trainee themselves. Additionally, the existence of a trainee's relative/friend with a mental health condition provides a direct source of information of mental health which positively influences the trainee's course, place of work and the trainee themselves. This appears to be the first study which has been conducted within this subject area and it also appears to be the only qualitative study that looks at a trainee psychologist's experience of having a mentally ill relative/friend. The only

quantitative studies found within this research area were by Lefley (1985; 1987); where coping strategies and family burden were explored for mental health professionals who had a relative with a chronic mental illness. No studies were found which looked at a psychologist in training and their experience of having a mentally ill relative/friend. The findings within this study provide an introduction in gaining an understanding of a trainee counselling psychologist's experience of having a mentally ill relative/friend whilst on a counselling psychology course. The idiographic nature of IPA allowed for an in-depth description of the participants' experience to be portrayed and allowed the voices of individual participants to be heard.

## **2.20 Clinical implications**

The current research highlights the difficulties experienced by participants when caring for a relative with a mental illness. Families and mental health professionals also reflect the difficulties experienced by the different roles they felt they were in and the positive and negative consequences experienced when supporting a relative with a mental illness. Trainees reflect positive and negative changes by being on a psychology course in the form of burden, relationship changes, change of personal identity, balancing professional with personal and increased self-awareness.

IPA studies have small samples and the findings should not be generalised without caution. As explored within the Discussion (section 2.15), some of the findings are consistent with previous research and theory, whilst others further illuminate previous research and theory; furthermore, some findings appear to contribute new information to the counselling psychology field.

Firstly, the results have implications for trainee psychologists and training institution educators in raising awareness regarding the trainees' continued therapy role outside of their course or place of work. The results highlight that the trainees' continued therapy role has a considerable impact on their personal and professional lives. The study demonstrates that participants need more support in this area and it may be beneficial for trainees to seek extra support from their universities and for educators to gain awareness of the demands placed on a trainee who may be in a similar

situation so that additional support may be offered. However, counselling psychology courses offer a considerable amount of support; therefore, why are trainees not accessing these services effectively? As previously addressed, trainees may not always disclose in a professional space. Therefore, trainees are encouraged to seek support in other forms, or for training courses to re-educate trainees of the benefits of disclosing in personal therapy and supervision.

Secondly, the study also demonstrates that participants experience a spill over of personal emotions in relation to their relative/friends mental health problems which have been shown to have a negative and positive impact within a therapy session with a client. This was supported by studies consisting of mental health professionals (Givelber & Simon, 1981; Pappas, 1989) who found personal experience to be manifested through countertransference within a client session. All participants within this study commented that they used personal therapy and supervision to reflect and make sense of their relative/friends mental illness and the impact it had on them personally and professionally. As presented within the Introduction, the literature reflects that counselling psychology trainees felt personal therapy was very important for trainee psychologists (Target, 2007; Rizq & Target, 2007; Kumari, 2011). This study and the existing literature suggest that personal therapy should be mandatory for all trainees in a psychology field; however, this is an active debate within the psychology field which has still not been concluded. As Freud (1964) once said: *“But where and how is the poor wretch to acquire the ideal qualification which he will need in this profession? The answer is in an analysis of himself, with which his preparation for his future activity begins”* (p. 246).

Participants in these studies disclosed very personal information and the Introduction spoke about Deutsch’s (1985) study, in which participants reflect a sense of relief in being able to share their secret. This study highlights that the majority of participants want to talk about their experience but fail to do so as they feel it is not meant to be spoken about or that others would view them to be an incompetent therapist. The study also reflects that participants take on a continued therapy role at home and do not communicate to their families about the negative experience they have being in that role. Extra consideration should be taken with first-year students, as the study highlights that these feelings are more apparent within the first year. This is because

as the trainees develop during the course, their perceptions change and they feel more able to be honest about their feelings without believing they will be judged. The participants also refer to the interview as a space where they can bring their personal and professional together, whereas they feel that personal therapy is for personal process and supervision is for client process. A future consideration could be a new space which incorporates all. As previously addressed, another consideration could be that trainees are not accessing their support services efficiently. Trainees have an allocated space to take their process, and as this study illustrates, many do not. Further exploration could be carried out to find out why trainees consciously refrain from disclosing significant process in personal therapy and supervision and what can be done to change it. Trainees could be further educated about what supervision and personal therapy is used for. It appears that some trainees need reassurance that making mistakes as a trainee is normal and not to worry what others may think of them and that it is all part of their personal process and development of their counselling psychology identity. One suggestion could be that training courses could set up a buddy system or a third year mentor for first year trainees. First year trainees would be able to informally contact their mentor for advice and the mentor may be able to share some of their own experiences as a first year student.

### **2.21 Methodological considerations**

The in-depth exploration of the participants' experience was one of the methodological strengths of the study. Every interview was individually analysed in a detailed and thorough process. It was taken into account that this detailed analysis would assist in capturing the participants' experience and facilitate the significant level of interpretative engagement of the text. The small sample size of the study may be seen by others as a weakness; however, it appeared as a strength of the study. This is because it helped facilitate the aims of the study as it allowed time for an in-depth analysis of the transcripts to be carried out and ensured that all participants' voices were heard. These all met with the idiographic commitment of IPA (Smith, Flowers & Larkin, 2009).

This was the first time I had used IPA or any qualitative methodology. As a result, I wanted to ensure that the quality of the research was to a good standard. To achieve this, I made certain I undertook a lot of reading about IPA and read studies which had used IPA as a methodology to gain a better understanding of the methodology and how it worked. This was in addition to qualitative lectures I received as part of my doctoral training. I also had supervision with an experienced IPA research supervisor throughout the process of my research. I spoke with peers who were also using IPA as a methodology so that I could gain a more in-depth understanding by participating in invigorating discussions.

Member-checking was also not carried out for this study due to the time constraints on the research and due to the sensitive nature of the topic. It was a sensitive topic and I wanted to refrain from the participants going through any further emotional distress.

A criticism of this methodology was the small sampling pool used. Participants were only selected if they were on the BPS Professional Doctorate in Counselling Psychology course because of the compulsory personal therapy which was a requirement of the course (explained within the Introduction). However, in hindsight, it has been recognised that other counselling courses could have been included which also consist of compulsory personal therapy. This would have widened the sampling pool and the findings would have contributed to a larger area within the counselling psychology and psychology field. A bigger sampling pool may have made the recruitment process easier and less time-consuming as the second recruitment stage would not have been implemented. A bigger sampling pool may also have afforded the opportunity to recruit a more homogenous sample as participants from a particular year could have been selected, as the analysis reflected that participants' cognitive process and personal development changed during the progression of the course. However, a strength of the current sampling pool was that all of the participants who were recruited were from the same course, which made it a more homogenous sample, as different courses teach different methodologies and the participants would have developed different skill sets throughout their course.

Another criticism of this study which may have impacted on the recruitment process was the original research title. The research title asked for trainee counselling psychologists whom had a 'loved one with a mental illness'. In her interview, Clare questioned why I had used the word 'loved one', as she didn't feel like she loved her relative anymore. This only came to my attention when she brought it up in the interview, and at that point, I had already recruited all participants and it was my final participant interview. In hindsight, this may have impacted on the recruitment process as it may have excluded potential participants from the study. Also, in relation to the original research title within the recruitment process, I used the word 'mental illness' instead of 'self-reported mental illness'. Participants may have not received a clinical diagnosis for their participant, but it did not mean their relative did not have a mental illness. This came to my attention when one of the participants emailed me about the requirements of the study and asked me if their relative had to be clinically diagnosed. I realised I had not made it clear and rectified the research title in both instances to better represent the sampling pool. This was not reflected within the interview questions as it was amended before any interviews had commenced.

It was acknowledged that the interview questions would impact the themes interpreted within the analysis. Efforts were made to try and abstain from using any leading questions and to utilise the interview schedule in a flexible way, thereby enabling the participants to talk about what they felt was relevant. Additionally, the question 'Is there anything else you would you like to talk about with regard to your experience?' was posed at the end of the interview so that participants could comment upon things which may not have been asked of them.

It was recognised that all participants had been or were in personal therapy and had regular supervision at the time of the interviews. It is acknowledged that this would have made an impact on how the participants interpreted their experience. During the analysis of the transcripts, I interpreted the participants to be quite insightful about their experience and how it had impacted upon them. They were also insightful in trying to understand how their relative's mental illness had developed. At times, the participants had already analysed parts of their cognitive process through personal therapy and supervision and this was reflected within their interviews. A sense of

avoidance in regards to dealing with emotional process as a result of the participant's personal experience, was also interpreted from the transcripts. As a result, it was likely that the participants were unable to fully reflect their thoughts and emotions; therefore, it may not have been possible to access some parts of their experience.

## **2.22 Suggestions for future research**

The findings of the current study have illuminated the lived experience of eight trainee counselling psychologists whom have a mentally ill relative/friend and how that impacted on them personally, professionally and academically. The study demonstrates a strong link between the trainee's personal experience and a spill over of their personal emotions into a therapy session with a client. This has shown to have a negative and positive impact within the client session. It would be informative for this study to be repeated, focusing more on this process within the therapy session and finding out how to better support the trainee. The same study could also explore the amount of personal emotional spill over experienced and if, how and why it changes as the trainee develops throughout the course. Some of the participants touched upon this concept within the study; however, it was not fully explored as it veered away from the research aims of the study. A repeated study could further explore and illuminate this phenomenon.

The interview accounts may not accurately represent the experience of the individual participants and a way to address that may have been to allocate more time for the study so that member checking could have been carried out. This would have given the participants an opportunity to correct any errors and challenge any perceived or inaccurate interpretations. This would have increased the credibility of the study as it would have highlighted any false information being presented as faithful research.

A longitudinal study could have also been carried out with a much longer time frame. This would have been expensive and difficult to organise; nevertheless, it would have allowed a study to be carried out which looked at the correlation between the participant's continued therapy role at home and the development of learnt factors from the course. This could have been explored and monitored to see how the participants' change in relation to their continued therapy role over time. Even

though this concept came up a few times within the transcripts, it was not used as a sub-theme as it was not a properly developed theme. The longitudinal study may allow for a thorough exploration of this theme.

A future area of research suggested by this study would be to use a quantitative methodology to find out how many trainees who go onto a psychology course have experienced a relative/friend with a mental illness. The study could use the findings from this study to devise a questionnaire and recruit from different courses and universities around the country to get a better idea of the statistics of this phenomenon.

### **2.23 Conclusions**

The aim of this study was to gain an in-depth understanding of a trainee counselling psychologist's experience of having a mentally ill relative/friend. In relation to this research question, the following more specific areas were also explored: How they personally made sense of their experience; how they made sense of the experience in relation to the psychology course; how they made sense of their experience in relation to their counselling psychology role; how the experience may have impacted on their work/placement; what has their experience allowed them to do; and what has it not allowed them to do. In selecting the IPA methodology for this study, it allowed for an in-depth idiographic investigation of the participants' lived experience to be explored, which resulted in four master themes:

1. Negotiating roles: Personal identity versus therapy identity
2. Continuing a therapy role within a personal space: Personal impact
3. Personal influence within a professional role
4. A space for personal development

Some of the themes were found to support existing theory and literature, which were discussed as countertransference, emotion spill over within a client session, demands of the course and wounded healer theory. However, this study also contributes new findings to these concepts as it gives a more in-depth interpretation of what the participants experienced, which was not found in other quantitative or qualitative

studies. The rest of the results were new findings in the literature which were not supported by any existing theory: Expectations of others to take up a therapy role; conflicting therapy and family roles; identification with a relative's mental illness; looking for personal support within a university setting; and insight into a trainee counselling psychologist's experience of having a mentally ill relative/friend.

Overall, this study produces an in-depth and idiographic approach to the experience of a trainee counselling psychologist's experience of having a mentally ill relative/friend and how that impacts on them personally, professionally and academically. This was the only qualitative study found within this research area. Findings generated from this study have contributed to the foundations of this evidence base.

#### **2.24 Final comments on reflexivity**

The close of this research brings to the end my thoughts on reflexivity. As I neared the end of my research I understood even more how my personal experience of the subject area could have impacted on the research process and myself in both a negative and positive way. The use of my research diary, the process of bracketing and the use of personal therapy helped me to gain a deeper insight into my own processes and refrain from imposing myself onto the research, which may have resulted in an unfaithful interpretation of the findings. Coming to the conclusion of my research, I am aware that the deliberation with regard to my own epistemological positioning has resulted in a personal advancement where I feel I have a firmer grip on my sense of self, my personal and professional identity and the way I view and interpret the world.

During the analysis and discussion stage of the study, I contemplated the hermeneutic circle and the movement between the part and the whole, as suggested by Smith, Flowers and Larkin (2009). One difficulty during the analysis stage was the process of clustering the themes together to create its sub-ordinate theme. I found myself, at times, getting swept away by all the data and getting lost within the vast amount of information. However, I took some time out and found it useful to come back to it with a clear mind. I reminded myself to stay true to the research question

and select themes which helped to illustrate the research aims of the study. This helped me to remain focused.

My desire to be a perfectionist is highlighted within the Client Study in the next part of this portfolio. I also found my perfectionist traits coming into the analytical process of this study. I know that IPA is not about obtaining 'accurate' answers; however, I was constantly trying to 'get things right'. It was difficult to not have a structured way of doing things. I was aware of this ambivalent process within me and, at times, I had to reflect and change the way I was thinking. I explored it in personal therapy, which increased my awareness of it and allowed me to manage it better. I found I was able to use my creative side within the analysis process; indeed, as Smith, Flowers and Larkin (2009) argued, there was no right or wrong way to conduct IPA, and they creatively encouraged researchers to find innovative ways to carry out the analysis. I found this creative part of the analysis to be more engaging as it allowed me to think of my own ideas within the analysis process. I used colour-coded transcripts which helped me to identify which participant themes were for whom and assisted me with the analytical process.

Before and during the research process, I contemplated whether my personal connection to the research study would be positive or negative in relation to the research process. Through personal reflection within my own personal time, personal therapy and speaking to others, I felt that the positives would outweigh the negatives. I felt that because of my personal experience, I was passionate in carrying out this research study. I found that my personal connection to the data contributed in a positive way to the research process. After interviewing each participant, I experienced an increased feeling of motivation and excitement in carrying out the research. The participants breathed life into the research and me, as I felt honoured and privileged to listen to their stories. I could resonate with how hard it was for them to be sharing their story as it was such a personal experience and it felt good to be able to give the participants a voice within that phenomenon. Particularly when I felt that I did not have anyone to talk to when I was going through it, it felt nice that I could be that someone that the participants could talk to in a safe environment. At the end of the interviews, most of the participants also commented how nice it was that they were able to take part in the study and talk about their experiences.

My own personal experience allowed me to see concepts within the analysis theme process as I was able to make links and fill in the blanks because of my own experience. The theme '*balancing self-care with personal and academic demands*' is a theme which I also experienced. Trying to balance the demands of the course, placement and dealing with what was going on at home with my brother was very difficult and at times I really found myself struggling. This caused me to feel mentally and physically drained and there was not as much space to take time out and look after myself. There were many times when the course and placement felt too much. My personal familiarity with this phenomenon meant that I was able to identify with some of the participants who also struggled with a very similar concept. They also found it hard to balance the course, their own life and the impact and responsibilities of their relative/friend's mental health condition. Reflexive theory comments that when a researcher is close to the research topic (Smith, Flowers, & Larkin, 2009), specific processes can help aid a subjective data analysis. One of the processes used within the research process was the hermeneutic circle spoken about by Smith (2007). The process of the hermeneutic circle allowed me to be aware of my own experience but also allowed me to stay as close to the data as possible.

During the research process, if I found a theme which I felt I could relate too, I would look at the opposite end of the scale to uncover what may not be present by using Smith, Flowers, and Larkin's (2009) polarisation method. This allowed me to look beyond my own experience which helped me to see things which I may not have originally seen, as some of the participant experiences and themes identified were ones which I personally did not identify with. My own personal experience aided me in seeing what wasn't being seen. Within the theme '*personal identification with a counselling career*', some of the participants wanted to work with clients that reminded them of their relative/friend and they sought a career in a related domain. Whereas, within my personal experience, I found it was more of a challenge to work with a client that reminded me of my brother and I would try to stay away from it, as at times, it felt too much to deal with. Smith, Flowers, and Larkin's (2009) analytical tools helped me, as a researcher, to see what was not originally seen and helped me to remain subjective within the data analysis as much as possible.

I wanted to raise awareness about what trainees experienced within this phenomenon. An illustrated theme within the study was that the participants did not always disclose their experience to others and if they knew others had gone through something similar they may have felt more able to confide to others about their experience and gain some support. I also felt that because of my personal connection to the research, I had an increase in motivation to carry out this study.

I recognise that what I have learnt through the research process has impacted on my therapeutic work. I find that with clients and others in my personal life, I pay more attention to the linguistics of their language. I find that this increases my listening skills. I recall that, previously, I would sometimes only observe the whole of a sentence; however, like the hermeneutic circle, I find myself observing not only the whole but the part too, more intensely than before. I find I am able to get a much deeper connection and insight with a client, which I feel deepens the therapeutic relationship and facilitates personal growth and change for the client. I also find I am more observant with individuals within my personal life, which I feel increases the personal connection between us. I always listen to others; however, I feel my observation skills have increased as a result of the research, which means I now see things I may not have seen before.

Reflexivity theory speaks about researchers reflecting upon their own personal and epistemological reflexivity in regards to the phenomenon they are researching. As researchers we should be able to reflect and identify ways in which we may have influenced the research process and its findings (Willig, 2008). The process of reflexivity means that as a researcher I am able to reflect on how my own personal experience means that I react in a particular way to the data which helps to make specific connections and can encourage certain insights. I was able to reflect on how my own personal experience may mean that I do not look further to see other explanations or understandings as it fits in with my own perceptions.

During this research process, as a researcher I embedded myself into the data analysis and tried to make sense of it. Phenomenology allowed me to recognise that the interpretations that I made of the data were partly from my own subjective judgement and that there was no such view of a correct or true interpretation (Lyon,

2007). As I can never fully understand the meaning of how the world and everything in it is constructed, understanding it will always be incomplete. My preconceptions and life experiences are unable to be pushed aside so that I may look at the phenomena for the first time, even more so as I have a close connection to the research topic. The qualitative methodology allowed me as a researcher to employ reflexive processes so that I could try to understand how my own processes around the research data may have contributed to the interpretation of the data and the documented findings (Willig, 2008).

During the research process, I recognised that at times I had assumptions which were a result of my own personal experience. When Clare asked me why I had used the word 'loved one' in my original research question, I recognised that I was making an assumption that just because I loved my brother it must mean that the other participants will love their relative/friend. However, I was filling in the blanks because of my own personal experience. It did not allow me to look at other alternatives; that not all individuals may love their relative/friend with a mental health condition. This realisation allowed me to be more self-aware within the research process and I became more self-aware that I sometimes automatically fill in the blanks.

Eve brought to my attention that I had used the word "mental health condition" whilst recruiting participants. Eve explained that her mother had not been clinically diagnosed by a doctor and questioned if she was able to take part in the study. This led me to realise that just because an individual had not been clinically diagnosed with a mental health condition, it did not mean they did not have one. It was part of my own personal view and the epistemological position of this study is one where the participant is the expert in their own experience. There was no right or wrong and if the participant believes that their relative/friend has a mental health condition than that is sufficient with the study. However, taking this further, if a participant believed that their relative/friend had a mental health condition because they for example always cried at sad movies, then the participant and I would have a conflict of perception. At that particular time in my research process I did not think about what I may do in a situation of conflict. However in hindsight, if it did come up, I would have taken it to my research supervisor to explore and decide how I could resolve the

differences of opinion by either explaining my opinion to the participant or reviewing my recruitment material.

When writing up the research study, it became apparent that I was automatically taking up a psychodynamic perspective when describing the interpretation of the data as I found I was using words like ‘countertransference’, ‘burnout’ and ‘the unconscious’, which are all psychodynamic terms. This reflects that, at times, I was interpreting the data using a psychodynamic lens. In concordance with this, I also believed that the phrases would be easily understood by the reader as, to me, they were generic terms. I recognise that by looking through a psychodynamic lens and by using generic concepts within the research project, I was not entirely capturing the individual participant content within the research study. Instead, the reader was left to make sense of what the researcher meant when using the word ‘countertransference’, without any specification regarding the individual participant’s meaning. I was also portraying the data from a psychodynamic perspective. This meant that the detailed individual meaning of what the participant was portraying was not coming across clearly to the reader. It was a bit of a struggle for me to try and take my psychodynamic hat off in this instance and refrain from using psychodynamic terms. I was able to recognise that I was not being fully transparent with the generated themes, which meant that some of the descriptive commentary was being lost within the research write up. Instead, within my thesis, I explained what the participant was saying for each individual concept, which added to the in-depth interpretative phenomenological analysis of the data and took the researcher and reader away from looking at things through a psychodynamic lens.

One thing I may do differently in the future, if I was to do another research study, is to trust myself more. During the analysis process, I had some difficulty in interpretively analysing the data. My feelings around it were that I did not want to get it ‘wrong’, which I know goes against the epistemological positioning of IPA as there is no right or wrong. I knew that if I analysed the data or another researcher analysed the data, different themes could emerge as we would both be bringing ourselves into the analysis. Once I had analysed all of the data and I had taken it to my supervisor, we both came to the conclusion that my data was not interpretive enough. I had the option of using the analysed data and writing up my research using

Thematic Analysis (TA). However, I decided to re-analyse the data using IPA. I first spoke to my supervisor about why I was not letting myself go which I also explored further within personal therapy. I recognised that I did not trust myself to give a true representation of the participants' experience and I was worried that I would get it 'wrong'. However, by talking about it and re-reading the IPA literature, I recognised that I could be interpretative; I could bring myself into the data whilst at the same time staying close to what the participants were saying. This shift and understanding within me meant that I was able to get an IPA of the data, I built up trust within myself and I gained confidence as a researcher which I will take with me in future studies and throughout life.

Another aspect which I may change in future studies, with regards to reflexivity, is to be more reflexive in the recruitment and participant information process. Looking back, I feel that at the time I did feel I was being reflexive, however there were some areas where I could have been more reflexive, as previously spoken about when making assumptions by using phrases like 'loved one' and 'mental health condition'. This whole research process has been a momentous learning experience and the mistakes I have made have opened my eyes and taught me very valuable lessons. My awareness has been raised and these are all things which I will use within future research studies and take with me in my career as a Counselling Psychologist and myself as an individual.

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### **3 Professional case study**

#### **Working with Perfectionism and Self-blame Within the Cognitive Behavioural Therapy Model**

### **3.1 Introduction**

The decision which influenced me to present this as my advanced client study was for practical, personal and theoretical reasons. I personally chose this case because I found it interesting to explore what my client activated within me and the effectiveness of the Cognitive Behavioural Therapy model (CBT) within a short space of time.

On a theoretical level, the CBT model worked well with my client Sophia. It drew out her core belief and allowed Sophia and I to discover that her core belief was a prevalent theme running throughout many different areas of her life. Once these were identified, the CBT techniques came into effect. Sophia and I really struggled to challenge her Negative Automatic Thoughts (NATs) as they had informed her life from the age of 11 and, to Sophia, it meant admitting that the way she had been thinking was unhelpful. Sophia strived to be perfect and admitting that her view was distorted went against her own self-perceptions. I learnt a lot from this process with Sophia and empathised with her struggles as my personal concepts of perfectionism were activated during this process. I chose to share this experience with others as clients often activate a lot in us as therapists and it can be beneficial to explore the parallels at work (Givelbar & Simon, 1981; Pappas, 1989). This can be enhanced for trainee counselling psychologists, as the participation in their own personal therapy may facilitate personal change, which can spill into a therapy session with a client (Kumari, 2011). The therapist's personal issues which came into the therapy session in response to the client's issues proved to be a positive and negative experience for both client and therapist (Givelbar & Simon, 1981; Hayes et al., 1998). Adequate professional support for the therapist can help to facilitate healthy transference.

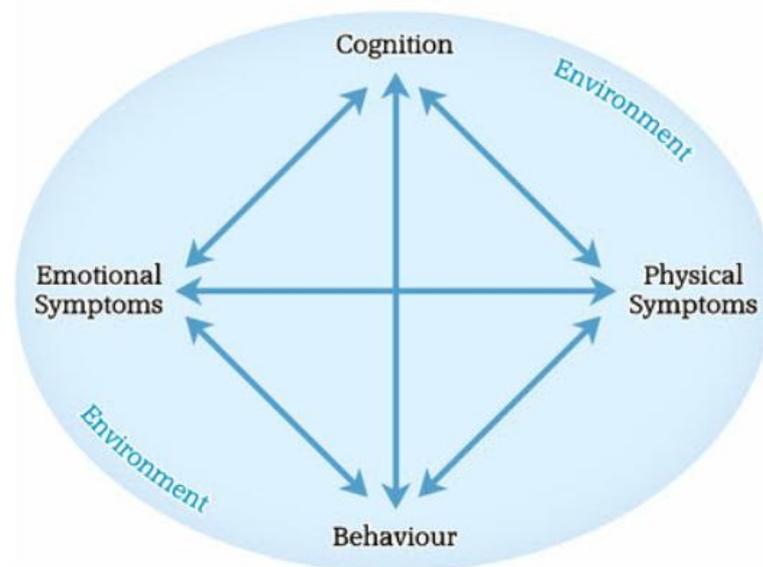
Throughout this client study, and with the assistance of supervision and personal therapy, the therapeutic journey taken by Sophia and I is illustrated. This client study explores the concept of perfectionism using the CBT approach and there is limited literature on this within the counselling psychology field. The client study illustrates the effectiveness of CBT when working with perfectionism and self-blame theory. It also illustrates the possibility that by working on particular concepts (symptoms of depression and anxiety), perfectionism can decrease. Correlations are made on a practical level and connections found in other aspects of this Doctoral portfolio

within the themes of mental health and personal emotional spill over within a therapeutic relationship. This client study will explore the process reflections of the therapist and an evaluation of the therapy sessions. This decision is borne out of the substance of therapy at these instances and pivotal moments of the work.

### 3.1.1 Theoretical orientation

There are two main influences of CBT. The first is behavioural therapy developed by Wolpe and others from the 1950s (Wolpe, 1958). The second is the cognitive therapy approach pioneered by Aaron Beck in the 1960s. CBT is seen as a broad movement which is continuously developing. The approach reflected within this client study is the model founded by Beck. CBT is a directive approach where the client and counsellor work in close collaboration (Gilbert & Leahy, 2007). It is where the client's emotional reactions, physical reactions and behaviour are influenced by their thoughts, beliefs and interpretations in specific situations (Gilbert & Leahy, 2007).

Figure 1 illustrates the CBT process.



**Figure 1. Padesky's CBT Model (1986)**

CBT is based on the information where the problems that individuals experience are caused and maintained by negative or maladaptive core beliefs. Past experiences with relationships and specific events are usually the cause of underlying

assumptions and core beliefs. CBT is a mix of cognitive therapy, where the client is helped to identify distorted patterns of thinking, and behavioural therapy, where the client identifies any dysfunctional behaviour they may have as a result of their thoughts (Padesky, 2004). At the time of the individual's experience, it is crucial that they learn what their own beliefs and underlying assumptions are within their experience. This helps the individual to cope with the difficult situation (Alfred & Beck, 1997).

My practice as a trainee counselling psychologist has been influenced by the directness that CBT encourages from a client as it helps to facilitate change within the client at an accelerated rate compared to other approaches I had worked within. It is acknowledged that with the limited amount of sessions a service may offer using other therapeutic models, the client may not be able to work with all they wanted to therapeutically address. However, the CBT approach works well to complete a considerable amount of work within a limited amount of time. Within the CBT approach, collaborative empiricism between the client and counsellor is very important as it calls for an equal relationship. The client is encouraged to become their own therapist so that when they leave the counselling room they are able to work independently on their own problems with the skills learnt from their therapy sessions (Westbrook, Kennerley, & Kirk, 2007).

### **3.1.2 Perfectionism theory**

Perfectionism is seen as an individual's need to achieve the highest performance, which is accompanied by a strict evaluation of the particular performance (Frost, Marten & Lahart, 1990). Perfectionism has both functional and dysfunctional elements for an individual (Papadomarkaki & Portinou, 2012).

Over the last 30 years, perfectionism has been recognised as an important characteristic in defining personal differences when an individual is in psychological distress (Hewitt & Flett, 1991; Shafran & Mansell, 2001) and it has been recognised as a maintaining factor in depression (Chang & Sanna, 2001; Hewitt, Flett & Ediger, 1996), anxiety (Frost, Novara & Rheume, 2002) and eating disorders (Fairburn, 1997; Fairburn, Cooper & Shafran, 2003; Ehan & Hine, 2008).

Perfectionism appears as a co-morbid factor within multiple mental health disorders, and as a result of this, various researchers agree that perfectionism is most useful when used within a multidimensional construct (Hewitt & Flett, 1991; Frost, Marten, Lahart & Rosenblathe, 1990). However, some researchers disagree that perfectionism is simply a variable which correlates with co-morbidity (Bieling et al., 2004). They view the construct of perfectionism as mainly coming from a developmental perspective. There is some research that highlights a valid relationship between parenting and perfectionism (Blatt, 1995; Enns, Cox & Clara, 2002). Some researchers view the development of perfectionism originating from early experiences with parents, which suggests that perfectionism is partly constructed from early learning and experiences (Frost, Marten, Lahart & Rosenblathe, 1990).

Bieling et al. (2004) suggested that “*if perfectionism were treated directly, it is possible that the individual would experience symptomatic relief across a number of domains*” (p. 199). They also argued that it may be more beneficial to treat perfectionism in individuals with co-morbid disorders than more traditional interventions which treat maintaining factors of each disorder. This view was also supported by diagnostic theories of disorders which claim that for clients with co-morbidity, it is possible that interventions which focus directly on perfectionism may have an advantage over other approaches that treat certain disorders or symptoms in a sequential way (Bieling et al., 2004; Fairburn et al., 2003).

### **3.1.3 Self-blame theory**

Self-blame can be seen as one of the most toxic forms of emotional abuse an individual can put on themselves. It highlights perceived inadequacies, real or imagined, and can prevent an individual from moving forward. Janoff-Bulman (1979) stated that there were two types of self-blame: blame directed at an individual’s character (e.g., *it went wrong because I’m the sort of person that bad things happen to*) and blame directed at an individual’s behaviour (e.g., *it went wrong because I did something wrong*). It is hypothesised that characterological blame can cause increased depressive symptoms and feelings of helplessness

compared to behavioural blame (Janoff-Bulman, 1979; Seligman, 1975). Working within this hypothesis within the CBT framework, there would be an increased difficulty to implement change if an individual had characterological self-blame, as theory suggests that characters are more fixed than behaviours. However, if self-blame were directed by an individual's behaviour, then it would be more manageable to work on an individual's behaviour within short-term CBT therapy, which may be able to decrease the depressive symptoms and feelings of helplessness (Bulman & Wortman, 1977).

## **3.2 Context and referral**

### **3.2.1 Summary of biographical details**

At the time of therapy, Sophia is a 46-year-old Italian female who lives with her husband in their own home. She presents as an attractive, tall woman in a smart work outfit with good eye contact and a generous smile. Sophia explained that she had her first miscarriage four years ago and her second miscarriage three years ago. She reported that there was no known cause for the miscarriages and Sophia blamed herself for them. Sophia wants to have a child but feels that the window for having a child is very small now as she is getting older. Her anxieties are increasing because of this.

A significant event in Sophia's life was the verbal bullying experienced in school between the ages of 11 and 16 from a female peer on a weekly basis. In childhood and adulthood, Sophia had not spoken to anyone about the bullying apart from briefly telling her husband. Sophia still experiences distress from the bullying she suffered as a child as it was not addressed or spoken about.

Sophia has a full-time job where she works as an estate agent with her husband. At work she has been verbally bullied by her manager for the past 4 years on a weekly basis. She reports that he often comments on her marriage, saying that he feels they will get a divorce soon. She also said that he has given her huge amounts of work which are impossible to finish in a day. This has caused a disruption in her daily functioning as she feels she has no one to talk to, making her feel tearful and low in mood. Its negative impact resulted in her being signed off work by her General

Practitioner (GP) for five weeks as she felt she could not cope. Since being back at work, nothing has changed and Sophia's low mood and anxiety is increasing (further biographical details can be viewed in Appendix 1).

### **3.2.2 The referral and context for the work**

Sophia was first treated by her GP with Diazepam for anxiety and Citalopram for depression one year ago; however, it did not appear to be helping. After her five weeks' sick leave, her GP referred her to the NHS Counselling Service. In the service, Sophia was referred to me as she had come to the top of our CBT waiting list and I had an available appointment slot. The service provided me with weekly supervision with a qualified clinical psychologist who was trained in CBT.

The counselling measures Patient Health Questionnaire (PHQ-9) (Appendix 2) measuring depression and the Generalised Anxiety Disorder (GAD) (Appendix 2) questionnaire measuring anxiety were required by the service to be completed at the beginning of each session. I found these informed the work with Sophia as it fit in with the short-term CBT therapy framework and allowed Sophia and I to address how she was feeling at the beginning of each session.

### **3.2.3 Client and theoretical orientation**

The CBT model was selected because theory suggests that parts of the model help to alleviate worries and symptoms caused by GAD and depression, which was considered important for Sophia's therapy. The National Institute for Health and Care Excellence (NICE) (2010) guidelines recommend using CBT as an intervention for GAD and depression. The counselling service has a limit of 6-12 sessions per client and CBT appeared an effective choice as the NICE (2010) guidelines recommend that 6-8 sessions over 10-12 weeks should be considered for individuals with mild to moderate depression or anxiety. It was formulated between my supervisor and I that 12 sessions would be enough to facilitate therapeutic change within the client as the presenting problem was one in the 'here and now', which is possible to work through in short-term therapy using the CBT approach.

The CBT approach appeared to fit in with Sophia’s personality as she said she liked the sound of the CBT model and the directness of the approach. She said she was willing to work collaboratively with me and agreed to complete the homework. At this point, the CBT approach appeared to be an effective framework for Sophia and I to work therapeutically.

### 3.2.4 Contract and plan for psychological counselling

In the assessment session, I invited Sophia to negotiate a contract; a procedure that the NHS service has for all its clients. This also fit in with the CBT therapy framework as it allowed the client to have an understanding of the framework they would be working within. The framework consisted of an assessment session which formulates the client’s presenting problem and therapeutic goals. Once these are established, a treatment plan is constructed collaboratively and treatment begins, consisting of homework exercises and monitoring specific concepts associated with the client. This framework is illustrated in Figure 2.

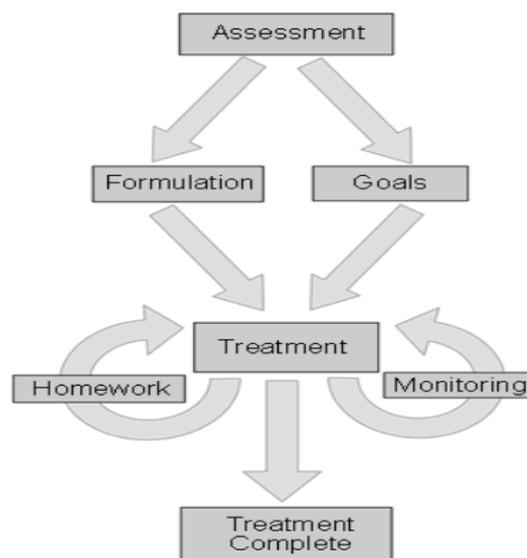


Figure 2. Structure of therapeutic process (Simons, 2012)

### **3.2.5 Presenting problem and therapeutic goals**

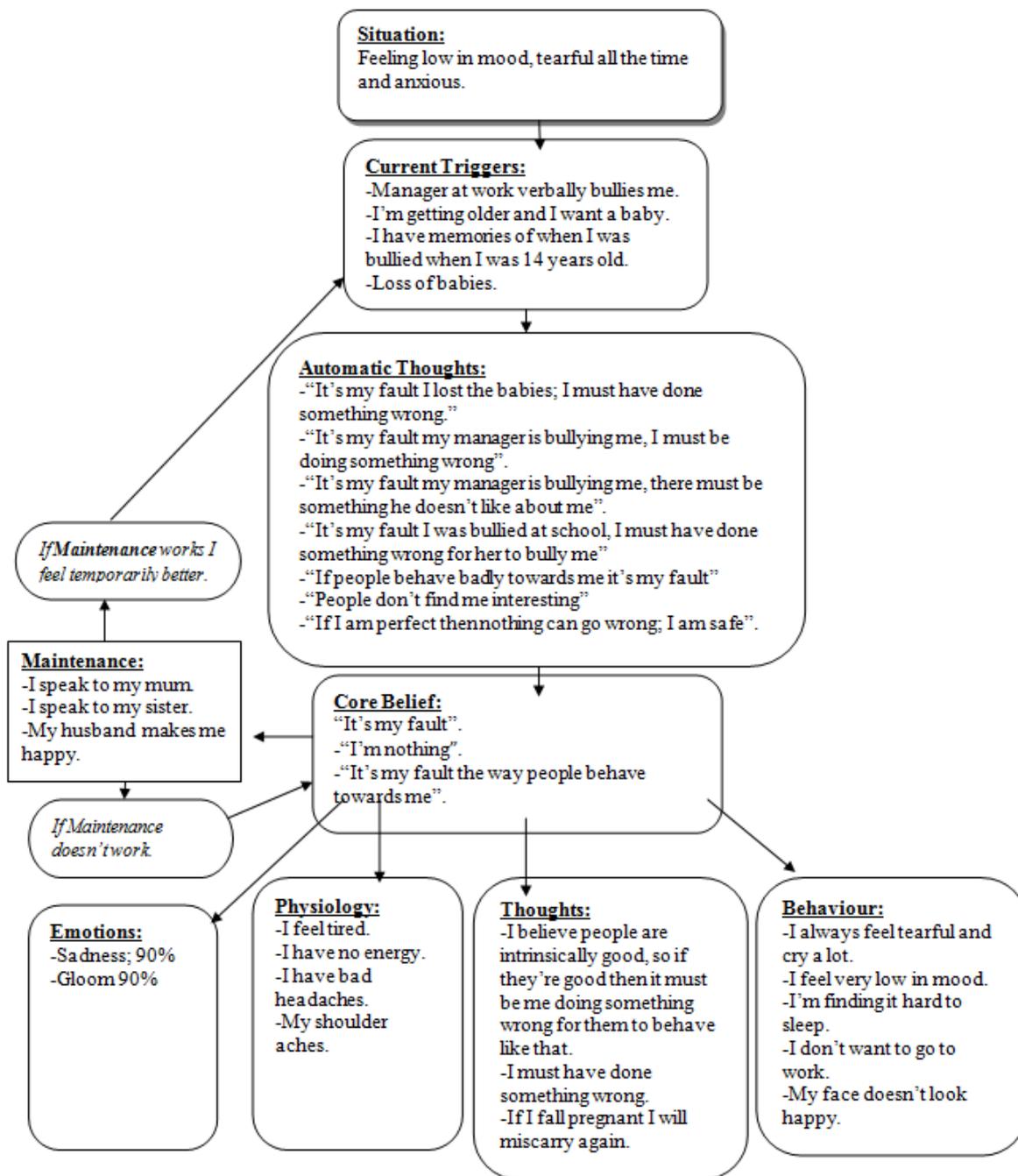
Sophia was referred by her GP with an acute onset of anxiety and depression. In the assessment session, Sophia explained that she had been back to work for 3 months; however, her manager was still giving her too much work and verbally bullying her, which was causing her to feel depressed and anxious. Sophia's therapeutic aims for the sessions were that she did not want to feel tearful and low in mood most of the time. Sophia said she would like to explore and talk about this in her sessions to try and see how she could manage and cope with it in a more effective way.

### **3.3 Key content and process issues in formulation and early sessions**

This section addresses the development of Sophia's formulation session, the key themes uncovered from it and her collaboratively agreed treatment plan.

#### ***3.3.1 Formulation session***

Some theorists view formulation as a bridge between the client's experience and CBT theories (Kennerley & Westbrook, 2007). It is seen as the connection between practice and theory (Butler, 1998). However, other theorists do not agree (Rogers, 1951). They believe that the therapist's hypotheses about the client's presentation can contribute to inequality in the power dynamic between the therapist and client. However, it is hoped that the collaborative approach that CBT encourages between client and therapist would help to decrease this problem. Sophia and I collaboratively worked on her formulation within the sessions, which was mapped out on paper (Figure 3).



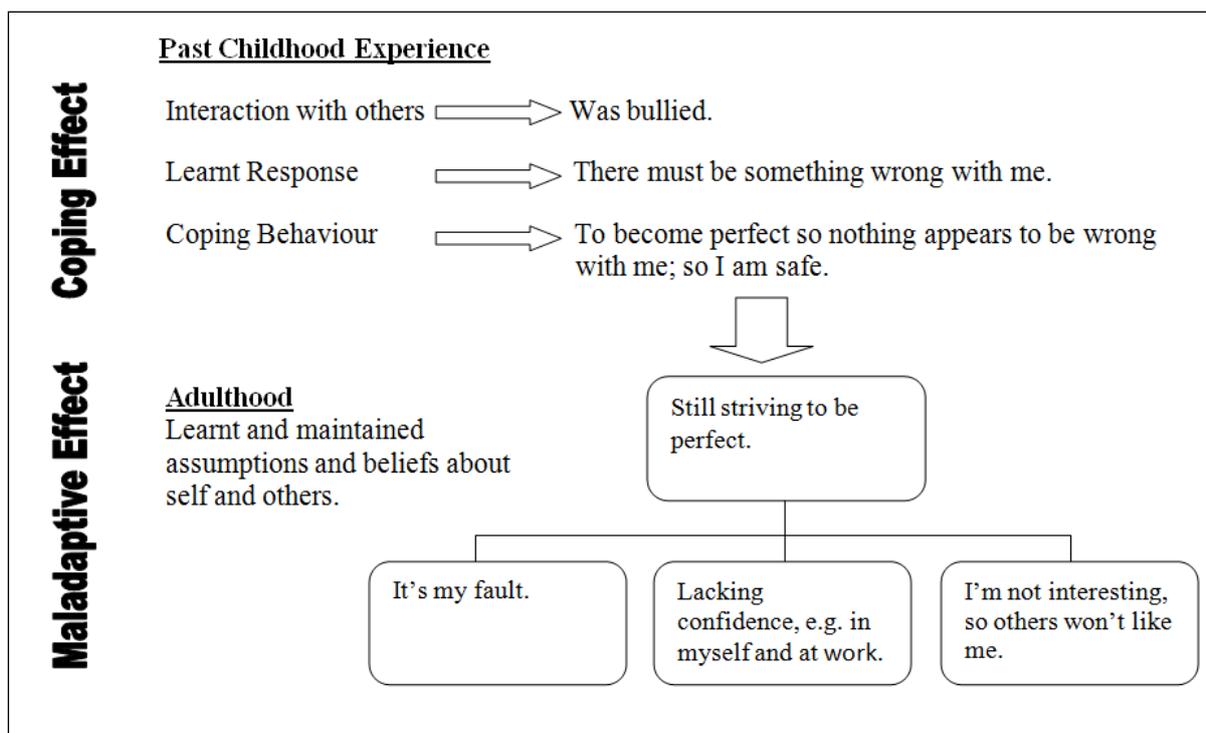
**Figure 3: Formulation (Vivyan, 2009)**

As the formulation session developed, Sophia identified that as a result of being bullied as a child, she had developed the assumption that “*if people behave badly towards me then it’s my fault*”. Sophia identified her core beliefs to be “*it’s my fault*” and “*I’m nothing*”. Sophia personalised everything as she believed that she was solely responsible for the negative events in her life and the way others behaved towards her. These thoughts then remained dormant until she miscarried her two

babies twenty-five years later, which resulted in a re-activation of the core beliefs “*it’s my fault*” and “*I’m nothing*”, which led to negative and critical self-appraisals. Her negative thoughts maintained the depression and anxiety she experienced. It was then reinforced further when her manager started bullying her at work. Mawn and Simons (2010) found that bullying in the workplace was associated with negative health and job satisfaction. Sophia’s work situation also contributed to her feeling stressed and she was not enjoying work like she used to. Olweus (1993) found that adults who had been bullied in childhood had significantly higher levels of depression and lower levels of self-esteem than individuals who had not been bullied. Sophia responded to the workplace bullying with anxiety and depression. Sophia said she felt “*crippled and helpless*”. She was experiencing a lot of negative thoughts, such as “*it’s my fault my manager is bullying me, I must be doing something wrong*” and “*if people behave badly towards me then it’s my fault*”. As previously addressed, according to Janoff-Bulman (1979), individuals who blame the way they have behaved for things that have gone wrong and do not blame their character should not suffer much from helplessness and depression. However, according to Sophia, she was experiencing helplessness and depressive symptoms, whilst blaming her own behaviour for things going on in her life. This did not support Janoff-Bulman’s (1979) theory. Nonetheless, it did suggest that it would be easier to work within a CBT framework as it would be possible to work directly on Sophia’s behaviours to change the way she thought and felt, which would in turn decrease her psychological symptoms.

To cope with all the bullying, Sophia made sense of it by believing that she had to be perfect. When she was bullied at school, she concentrated on her studies and excelled academically. This worked as a coping mechanism for her. She believed that people would not bully her if she was perfect and things could not go wrong.

Figure 4 shows Sophia’s underlying assumptions which were necessary at first but then gradually manifested into a maladaptive assumption as it was continuously used.



**Figure 4: Sophia's learnt underlying core beliefs and assumptions (Westbrook, Kennerly, & Kirk, 2007)**

From looking at the formulation, Sophia and I identified what was relevant for her and we collaboratively came up with some mutually agreed goals (Figure 5). We both felt these goals would help to structure the therapy sessions and maintain focus.

- Goals:**
- 1) To challenge negative thoughts with cognitive techniques.
  - 2) To challenge negative core beliefs with cognitive techniques and an experiential process.
  - 3) To reinforce learning by practising cognitive and behavioural techniques.
  - 4) To learn how to relax more and control the worrying in an experiential process and psycho-education.

**Figure 5: Treatment plan**

Sophia and I spoke about some of the interventions we could use to try and reach her goals. Figure 6 shows the agreement we came to; however, we both acknowledged that this was likely to change as the therapy progressed.

**Interventions:**

- 1) To construct a timeline to see where her anxieties began/pattern, so that we can get a better understanding of her problem.
- 2) Mood diary (Vivyan, 2009).
- 3) Relaxation skills with guided imagery and progressive muscle relaxation.
- 4) Psycho-education; assertiveness training, relaxation, what is anxiety, what is self-esteem, and what is depression information sheets.
- 5) Behavioural activation; in this intervention Sophia will use what she learnt in the assertiveness training to role play in the therapy session.
- 6) Using coping self-statements.
- 7) Relapse prevention; to recognise the signs and to know what to do.

**Figure 6: Interventions**

Sophia and I then identified which obstacles may come up to hinder development in and out of the therapy sessions (Figure 7).

**Obstacles ahead:**

- 1) Manager still bullying me at work.
- 2) Negative thoughts about myself and bullying may help to maintain my low mood and anxiety.
- 3) Negative core beliefs may help to maintain my low mood.

**Figure 7: Obstacles ahead**

**3.3.2 Progression of early therapy sessions**

In the sessions, role play was used as it has been used to evoke key feelings and cognitions (Westbrook, Kennerley, & Kirk, 2007). Through this intervention, Sophia was able to identify her thoughts, which helped to move some of her unhelpful cognitions. Sophia was also able to produce various assertive reactions, which she felt more confident to use in future situations with her manager. When this was applied to her manager at work, she found her manager reacting the same way he always did. This upset Sophia as she felt she had changed her behaviour but was still being bullied. It was hard for Sophia to understand that her manager was responsible for his own behaviour and the way he treated her. By talking this through in the sessions, Sophia was beginning to understand that it may not be her fault.

On reflection, I identified and disclosed to Sophia that we may have prepared better for this intervention by identifying alternative ways that her manager may have responded.

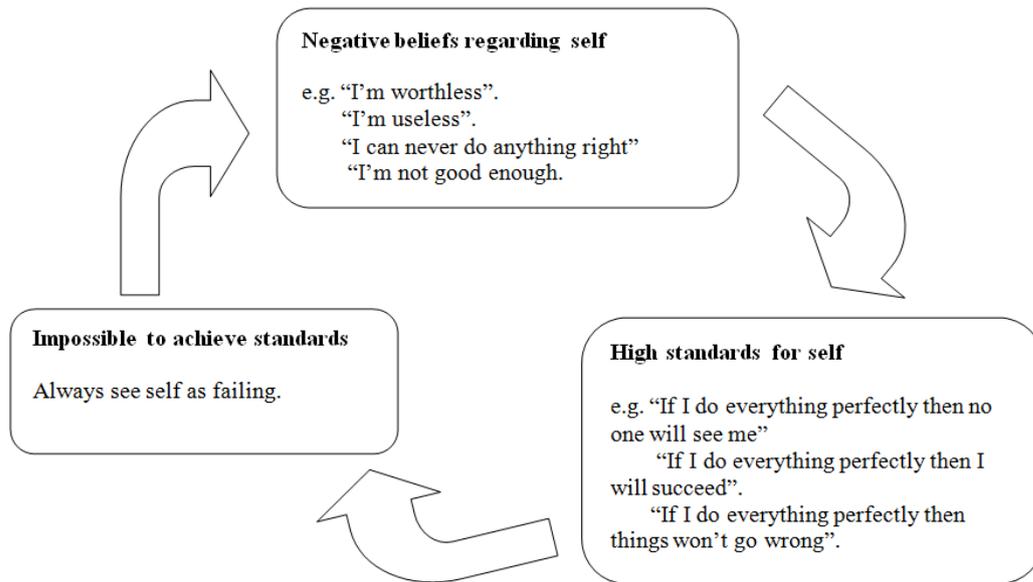
Beck characterised cognitions in depression as the negative cognitive triad. This is where the individual viewed themselves, the world and the future in a negatively biased way (Westbrook, Kennerley, & Kirk, 2007). One cognitive strategy in depression is to help the client with symptom relief by reducing the impact of NATs using an Automatic Thought Record (ATR) (Stephens, 2001) (Appendix 3). This can then be developed to combine “*ongoing dysfunctional and underlying cognitions in the form of Assumptions and Core beliefs*” (Stephens, 2001, p. 1). To reality test Sophia’s dysfunctional thoughts, ATRs were completed addressing situations at work and challenging her NATs. This facilitated a meta-cognitive shift, which allowed the process of reality testing to take place. Through this, Sophia was able to identify the core belief of “*it’s my fault*” and came up with the alternative balanced thought of “*it’s not always my fault*”. We were also able to identify and challenge habitual patterns of thinking in terms of catastrophic thinking, mind-reading and black-and-white thinking by referring to the Unhelpful Thinking Habit therapy sheet (Appendix 4).

As we delved deeper into Sophia’s thought processes during the sessions and built a stronger therapeutic relationship, Sophia uncovered the belief “*I should be perfect*”. We identified that this belief spilled out into all areas of her life. Frost et al. (1990) conceptualised that “*perfectionism highlights two cognitive inaccuracies on the part of the individual*”; the client “*sets the standards excessively high*”; and their “*self-evaluation is overly critical*”. Therefore, one of the goals within the sessions was to work on Sophia’s perfectionism, which was hypothesised would relieve some of the symptoms she was experiencing (Bieling et al., 2004; Fairburn et al., 2003). This method fit within the CBT framework as we were able to establish a core belief and collaboratively incorporate goals into our sessions which we were able to work with.

To further explore Sophia’s perfectionism processes, an ATR (Appendix 3) was used. Sophia was asked to focus on a situation where she had strived to be perfect.

Sophia selected a situation at work where she set herself many targets for the day. The ATR was clearly showing that Sophia set herself very high goals and this stemmed from her desire to prove to herself that she was not worthless and incapable of doing things. However, because Sophia always set herself unattainable goals, she was continuously reinforcing her feelings of worthlessness, thus directly contributing to her depressive symptoms on a daily basis. A Positive Qualities sheet (Appendix 5) was used as an intervention, which involved keeping a weekly diary of all the positive things Sophia had achieved each week. The reason this intervention was chosen was because it was hypothesised that it would build up Sophia's self-esteem by showing her the amount of work she was actually doing on a daily basis. It was hypothesised that Sophia would see the unrealistic goals she set for herself and recognise that she blamed herself when unable to achieve the unrealistic goals. This would result in her feelings of worthlessness and self-blame being maintained instead of reduced. These thoughts and unattainable tasks maintained her low confidence, low self-esteem and low mood.

In light of Sophia's new perfectionism core belief, the original formulation was revisited and revised. Westbrook, Kennerley, and Kirk (2007, p. 51) had a perfectionism cycle template, which was adopted and used as part of the initial formulation to further explore Sophia's perfectionism (Figure 8).



**Figure 8: Sophia's perfectionism cycle (Westbrook, Kennerley, & Kirk, 2007; p.51)**

From the perfectionism cycle, Sophia and I hypothesised that her core belief was “*I’m not good enough*” and her perfectionism was her overcompensation of that. Diagram 8 shows Sophia’s desire to prove to herself that she was not completely worthless or incapable; this resulted in such high standards that she could never meet them consistently and, therefore, her sense of worthlessness was maintained rather than reduced. Egan and Hine (2008) stated that perfectionism is higher in individuals with psychological disorders. This indicates that Sophia’s sense of worthlessness was cultivated by her high standard of perfectionism and is a maintaining factor in the anxiety and depression.

### **3.3.3 Session eight: A pivotal moment in therapy**

This particular session was selected to be explored within this study as it showed a turning point Sophia had within her therapy session. In Sophia’s therapy session, she was given educational sheets on bullying. One particular section explained how it was not the individual’s fault that they were bullied when young. Sophia brought this up in the session and said it was hard for her to believe. I presented my own analogies to Sophia, which looked at things from another perspective. I asked Sophia

*“if a child is abused by an adult, is it the child’s fault?”*; and *“if you saw a girl at school being bullied, is it the girl’s fault?”* To all the questions Sophia responded with a “no”. I then asked her *“so in your situation, is it your fault you were and are being bullied”*, to which she paused and replied “no”. I then reiterated to Sophia that it was not her fault that she was bullied when she was 14 and it was not her fault she was being bullied now. She paused, nodded her head in agreement and started to cry. This was a pivotal moment within our therapy session. I had elicited an understanding with her that, at 14 years old, it was not her fault that she was bullied and it was not her fault now. It is from that core belief all those years ago which triggered the same feelings and allowed them to resurface within her current situation where she was experiencing bullying at work.

Sophia was really beginning to challenge her core belief and believe it was not her fault. This also demonstrates an aspect of phenomenology. The phenomenon (the bullying) was seen in two different ways by Sophia and I. My interpretation of how I perceived the phenomenon was an eye-opener to Sophia. It gave her another perception of the bullying which made sense to her. Reflecting back to Sophia my interpretation of the bullying facilitated therapeutic change within Sophia in a positive way. Sophia gained strength and insight from this and decided that she wanted to put in a formal complaint against her manager, which she subsequently did.

#### **3.3.4 Session 12: *Final therapy session***

In the final session, Sophia came in with a letter, which she handed to me to read. It read that her grievance had been accepted. Sophia was elated because she had been recognised and it validated that the bullying at work was not her fault.

Sophia also spoke for the first time since her formulation session that she blamed herself for the miscarriage of her two babies. Sophia said that she felt ready for the therapy to end. She thanked me for helping her and said that I had changed the way she now viewed counselling psychology because I had helped change her life.

### **3.4 Evaluation of the therapy**

This section addresses the difficulties experienced whilst working with Sophia and how I experienced my own personal emotions coming into the sessions with her. This was all taken to supervision to explore. The work carried out with Sophia is evaluated and the changes made in the formulation and treatment plan are illustrated. The client study closes with the ethical procedures used.

#### ***3.4.1 Difficulties in the work and use of supervision***

My client's belief that she has to be perfect activated my own schema and belief that I also try to be perfect. My belief is that if I appear perfect, then I will come up against no conflict. I recognise this is an avoidance mechanism for me. Sophia was trying to be the perfect client and I found myself feeling anxious that I had to be the perfect counsellor for her. I believe my anxiety was coming from the feeling that if I failed to be the perfect counsellor Sophia expected me to be, then conflict between us may arise. I was mirroring her feelings and my own core belief was also coming into it. The feeling of anxiety that I felt, especially just before a session with Sophia, made me sometimes wish Sophia would call in sick or not turn up. I wanted to avoid the situation all together. Sophia and I were both bringing expectations of perfectionism into the session. I took this to supervision and personal therapy for further exploration. In personal therapy, it opened up a new avenue for my therapist and I to explore, which was beneficial for me personally and professionally. I was able to explore my own perfectionism and see where it had originated from, just like Sophia had.

In supervision, I found that I was able to sort through my own anxieties and see what my processes were and what were Sophia's. I recognised that I had to be careful not to let Sophia see how much I wanted her to succeed in therapy because, as a result of Sophia's perfectionism, there was a real danger that she would try to meet my needs in being a perfect client. I wanted Sophia to be honest in the sessions and not something that I wanted. This would have been detrimental to the therapeutic work.

Gilbert (2000) suggests that the microskills of "*monitoring internal feelings and cognitions*" and "*increasing awareness of the relationship amongst thoughts, feelings*

*and social behaviour*” (p. 158) have a major impact on the outcome of therapy. I felt I was able to achieve this through personal therapy and supervision, which made our relationship a more equal and collaborative one. It strengthened our therapeutic relationship.

In supervision, I spoke about the intervention where I reiterated bullying examples to Sophia in session eight. I explored my reasons behind this and identified that I went with my instinct in the session as I felt a new perspective may have been useful for Sophia to hear. I could understand why she blamed herself for what she went through and I could see her journey in the development of her core belief, but a part of me felt frustrated and angry with her and just wanted to say, “*can't you see it's not your fault?*” On reflection, part of my ‘want’ here was because I could see the pain that she was going through, which resulted from her trauma of being bullied. By being able to talk about this in supervision, it allowed me to let go of my own instinctual reactions and focus on her process. I do not recall Sophia showing any anger in the therapy sessions and I am now wondering if I may have been picking up on her own repressed anger. I spoke about this in supervision after I had finished therapy with Sophia and my supervisor and I both agreed that this may have been something worth exploring. If Sophia came back for a follow up session, it is something I feel I would mention to her.

#### **3.4.2 *The therapeutic process***

The therapeutic process between client and therapist is seen as a central level of analysis (Bor et al., 2010). Westbrook, Kennerley, and Kirk (2007) said that within CBT, the relationship between client and therapist is seen as an important foundation for therapeutic change. This was demonstrated in the therapeutic relationship that I felt Sophia and I had which became richer and stronger as the sessions developed. Once Sophia had established a good relationship and trusted me, we were able go deeper into her process by working with her core beliefs and exploring her perfectionism. It felt nice that Sophia and I had a good therapeutic relationship and I believe the honesty we both displayed in the sessions helped to lift a lot of underlying anxieties. It helped to facilitate therapeutic change in Sophia, which was evident at the end of our therapy together.

The pace of the session process was very fast as we identified goals which we wanted to reach and Sophia worked hard to reach these goals. Her core belief of wanting to be perfect pushed her to work hard in the sessions; however, her goals were realistic and within reach, and when Sophia reached them, it lifted her mood and increased her confidence. This allowed her to relax a little more and it allowed us to at times come out of the rigidity of the structured sessions. In these instances, Sophia spoke about day-to-day experiences and various childhood memories. We were able to laugh at times and this strengthened our relationship, which increased the trust and allowed us to connect a little more each time.

### ***3.4.3 Evaluation of the work***

I felt that Sophia's core belief of "*I have to be perfect*" played a big part in the counselling sessions with me. Sophia always turned up to the sessions on time, she never called in sick and she would always do her homework. To me, she really felt like a perfect client and definitely presented herself in this way. In her work, she would not tell her manager if he did something wrong or upset her and she did not tell anyone when she was bullied as a child. I wondered how much of this was mirrored in the counselling room with me. I took it to supervision and decided that I felt comfortable enough to do what Gilbert (2000) referred to as increasing awareness of the relationship amongst thoughts and feelings by linking this parallel together. I voiced this to Sophia in the session and it really seemed to resonate with her. With this intervention, Sophia gained a deeper insight and was able to recognise the different patterns which ran through her life.

I am aware that the CBT model works mainly in the 'here and now' and does not delve much into the client's past; however, the CBT model does allow for some flexibility depending on the individual case (Gilbert & Leahy, 2007). I believe this client study was a complex case because although trauma had not been officially diagnosed for Sophia, she did experience trauma in the past when she miscarried her two babies and when she was bullied as a child. In Sophia's case, it would be inappropriate to ignore this history because her history contributes to the severity of her current distress. These traumas were included in the initial formulation; however,

they were not included in the treatment plan as Sophia said she did not want to focus on it in the therapy sessions. This is something that could have been worked on if the service permitted for longer term therapy.

The acceptance of the formal complaint helped lift Sophia's mood and she felt ready to end therapy on Session 12. She felt the problem was now solved and as it was the last session, I was unable to offer her any more. However, it is well known within the literature that a depressed client is often negative in their thinking (Westbrook, Kennerley, & Kirk 2007) and I wonder how Sophia would have responded if the grievance outcome had gone against her. This makes me question how much and for how long the CBT therapy would have helped Sophia. It seemed to have helped her in her situation of the 'here and now'; however, I wonder how long her positive situation and the remnants of the therapy would remain with her before her core belief started to trigger her negative thoughts again. Core beliefs rarely change overnight, and as the service only offers short-term therapy, we were unable to work on cognitive restructuring by focusing on schema therapy (Raraeli, Bernstein & Young, 2001). Sophia showed that she displayed early maladaptive schemas which were generated from her childhood bullying and had been elaborated throughout her lifetime. It is dysfunctional and the schema drives the behaviour. This was explained to Sophia and counselling telephone numbers were given to her on our last session in case she decided she wanted longer term therapy. Sophia and I went through relapse prevention together; as such, it was hoped that she would be able to be her own therapist and identify the signs herself.

In the initial formulation, it was hypothesised that by focusing on Sophia's anxieties, her depressive symptoms would decrease. This hypothesis was correct and it is evident in Sophia's PHQ-9 score, which was 17/27 at the beginning of the therapy sessions and went down to 0/27 by her last session. Sophia's GAD score was also 18/21 at the beginning of therapy and went down to 0/21 by the end of therapy. This demonstrates that Sophia's response to treatment was effective.

#### **3.4.4 Changes in the formulation and the therapeutic plan**

Towards the end of the therapy, it started to become more apparent that Sophia may have been suffering from a traumatic stress reaction to the miscarriage of her two babies. The continued belief in her negative thoughts (“*it’s my fault I lost the babies; I must have done something wrong*”) may have contributed and helped to maintain Sophia’s anxiety, tearfulness and low mood. This was not one of Sophia’s original goals of therapy; however, it did play an important part in the sessions and in Sophia’s life and Sophia found these thoughts start to resurface when she began to deal with the bullying.

One of our original therapy goals was to reinforce learning by practising behavioural techniques. However, in one of the sessions, Sophia became very upset in her behavioural exercise. We re-visited this and eventually decided to work with the cognitive side of the model as Sophia felt she was getting more out of it and felt more comfortable to explore her vulnerabilities in a safer way. The cognitive techniques had proved to be very beneficial to Sophia; as such, I felt comfortable with this decision. However, on reflection, this could have been explored a little further to see why Sophia felt so uncomfortable.

As the therapy progressed, it became evident that Sophia’s perfectionism may be maintaining some of her symptoms. As a result of this, the theoretical orientation for her therapy was slightly altered from just focusing on her anxiety and depression and included a focus on her perfectionism too. The literature shows that there is a considerable amount of research which explores the use of CBT on various psychological disorders; nevertheless, there is limited literature which looks at the effect of CBT on perfectionism. By using CBT to specifically target perfectionism, some studies found a decrease in perfectionism (Egan & Hine, 2008; Ferguson & Rodway, 1994; Glover et al., 2007; Pleva & Wade, 2007; Shaffer, Lee & Fairburn, 2004). A reduction was also found in anxiety (DiBartolo et al., 2001; Hirsch & Hayward, 1998; Pleva & Wade, 2007), depression (Hirsch & Hayward, 1998; Pleva & Wade, 2007; Shaffer, Lee & Fairburn, 2004) and bulimic symptoms (Shaffer, Lee & Fairburn, 2004; Steele & Wade, 2008). The results found within these studies are encouraging as it suggests that working on perfectionism may result in a reduction of

anxiety and depressive symptoms and the outcome of the therapy sessions appear to support the literature.

#### ***3.4.5 Psychotherapeutic practice, theory and reflections on myself as a therapist***

This client study demonstrated how effective the CBT techniques are in a short-term counselling centre. Due to time constraints, every session was crucial. CBT's immediate identification of the goals of therapy allowed us to get to work on the core concepts straight away, which helped achieve the result obtained within the small amount of time.

This case study has also demonstrated to me that even though I was working within the CBT model and looking at the 'here and now', it did not mean that I had to ignore the history. I learnt how useful it was to follow the core belief back to where it originated and to then bring it forward to the 'here and now' so that Sophia's behaviours and thoughts could be further understood and explained.

Even though elements of this case were a challenge in terms of what it brought up for me, I really enjoyed working with Sophia. I was able to understand the developments in therapeutic CBT interventions a little more and matured in my understanding of applying them. I feel that if I could have more sessions with Sophia, I would broaden out and use elements of schema therapy as it is still under the CBT umbrella and it would have further developed the work with Sophia. My relationship with Sophia made my learning a rich and experiential learning experience.

Working with Sophia also showed me that by working on the constructs of perfectionism and self-blame, anxiety and depressive symptoms decreased as they were not the problem, just merely a symptom of the deeper rooted construct. This is something I will take with me when working with clients in the future.

As spoken about throughout this study, there is limited research which looks at the effect CBT has on perfectionism, especially for counselling psychologists. However, this study shows the effectiveness of this relationship under the counselling psychology philosophy. By using CBT with the perfectionism construct, as already

mentioned, some studies suggest that there would be a reduction in anxiety and depression. A reduction in anxiety and depression was found with Sophia when perfectionism was worked on as one of the major concepts. This contributes to the counselling psychology literature as it demonstrates that using CBT techniques on perfectionism within a counselling psychology ethos can help reduce psychological symptoms within the client. This client study also shows a detailed insight into this phenomenon, more so than in quantitative studies. It would be favourable for other trainee counselling psychologists to read a detailed account of such a phenomenon as they may be able to resonate and learn from parts of it in a valuable way.

This client study also demonstrates to trainee counselling psychologists how things can be activated personally for the therapist within a client session and the importance of personal therapy and supervision in being able to explore and work with any therapist-client countertransference.

On reflection of the final session with Sophia, I am amazed at the end of our session. It was really odd, because throughout Sophia's life, she had always strived to be perfect. This was paralleled within the sessions as it even activated my own belief of wanting to be perfect. The way the session ended with her grievance being accepted was the perfect end to our therapy together. I could not have timed it better myself even if I had tried. However, I did feel sad that the therapy had ended as I had come to really enjoy working with Sophia, but I was glad we had finished on such a good note. I was happy that Sophia was happy and had made positive therapeutic progress. It felt like she had made a turning point in her life.

The sessions with Sophia provided me with a rich learning experience, which I feel has further developed my CBT skills and my learning of the concepts of perfectionism and self-blame and how these concepts are connected together psychologically and physiologically. I have a greater awareness of how trauma, even if not really spoken about, plays a big part in the therapy sessions. I feel more confident as a counsellor within the CBT model and I feel able to apply the skills and knowledge that I have learnt to future clients.

### **3.5 Ethics**

Informed and written consent was obtained for the recording and write-up of this client study. Sophia understood that she could withdraw her consent at any time with no questions asked. All names and specific biographical and personal details have been anonymised throughout to preserve confidentiality.

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#### **4 Publishable paper**

**A continued therapy role for a trainee counselling psychologist**

## **A continued therapy role for a trainee counselling psychologist**

Niki Phrydas

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**Background/Aims/Objectives:** This research study reflects the lived experience of trainee counselling psychologists who have a mentally ill relative/friend. It focuses on expectations from their families, role conflict and a decline in emotional and physical energy as a result of the continued therapy role outside of a professional environment.

**Methods/Methodology:** The study was conducted using semi-structured interviews and the findings were analysed using an Interpretative Phenomenological Analysis (IPA) methodology. The sample consists of eight individuals who are on a UK, BPS accredited Professional Doctorate in Counselling Psychology course.

**Results/Findings:** Three sub-ordinate themes from the original research study are explored within this paper: 1. Not knowing in an expected therapy role; 2. Negotiating identity: Family versus therapy role; and 3. A depletion of emotional and physical energy for trainee counselling psychologists'.

**Discussion/Conclusions:** This study provides an insight into the lived experience of the participants and raises awareness for psychologists and training institution educators on the experience of a trainees' continued therapy role outside of their course and place of work.

**Keywords:** *Trainee counselling psychologist, mentally ill relative, IPA, identity, role conflict.*

There is a body of evidence which suggests that training as a counsellor, psychiatrist or psychotherapist can be a very difficult process for trainees (Rosenberg & Pace, 2006; Halewood & Tribe, 2003; Kumary & Baker, 2008; Cushway & Tyler, 1996). The literature shows that trainees experience symptoms of burnout (Rosenberg & Pace, 2006), stress (Zemirah, 2000), loss of personal relationships (Seashore, 1975) and a loss of self (Millon, Millon & Antoni, 1986). However, trainees also experience positive changes in the form of improved personal relationships and a deeper understanding of themselves (Hamilton & Mackenzie, 2007).

No studies exploring the lived experience of trainee psychologists who have a relative/friend with a self-reported mental health condition were identified within the

literature and so a wider search of the literature was executed. This revealed that although there are many studies which explore the experience families (Greenberg, Greenly & Benedict, 1994; Herz et al., 1976) and therapists (Lefley, 1985; Lefley, 1987) have with a relative with a mental health condition, it does not offer a deeper insight into the individual's experience of having a relative with a mental health condition. The majority of studies found were quantitative studies. This paper presents the experience of trainee counselling psychologist's who have a relative/friend with a self reported mental health condition. It illustrates the role conflict experienced by the trainee and their family members' expectations that they should know how to help their relative because of their trainee psychology role. It also illustrates decline in emotional and physical energy experienced by the trainees as a consequence. There are no current qualitative studies which examine this phenomenon and findings generated from this study contribute to the foundations of this evidence base.

#### **4.1 Methodology**

This study employed an IPA methodology as it focused on the individual experiences of the participants and their understanding of a particular phenomenon. Smith, Flowers and Larkin's (2009) procedure for analysing qualitative data was used within this study. The data was collected through the process of a semi-structured interview and the captured data was filtered through the researcher's own interpretation of the meaning of the data and presented within the study.

The explored phenomenon were trainee counselling psychologists who had a mentally ill relative/friend and their experience of that in regards to the continued therapy role they took up with their relative/friend. An inclusion criterion was that all participants were on a British Psychological Society (BPS), UK Professional Doctorate in Counselling Psychology course. One of the reasons for the small sampling pool was that personal therapy was compulsory for trainees on the Doctorate in Counselling Psychology course. It was considered that by selecting a particular course, all participants would have a similar training and skill set which, would result in a more homogenous sample. A purposive sampling of participants

was used for the data collection as the research question would be significant within a well-defined group sample.

#### **4.1.1 Data collection**

An email was sent out to the programme directors of the course with information about the study. Eight participants were recruited on a first come, first served basis on the condition that they met the inclusion criteria. Semi-structured interviews were conducted on a one-to-one basis in a confidential space at the participant's university. They were audio recorded and ranged between 40 and 127 minutes long.

#### **4.1.2 Data analysis**

The audio recordings were transcribed verbatim as faithfully as possible. Each transcript was analysed using parts of the IPA procedure outlined by Smith, Flowers and Larkin (2009). The aim was not to find one true meaning but to obtain an interpretation of the participant's lived experience. The emerging data was clustered into themes and patterns were sought for across cases. The analysis resulted in overall super-ordinate and sub-ordinate themes for the participant group. The write-up of the super-ordinate and sub-ordinate themes resulted in a further re-evaluation of the findings, and it was only at this stage that a final consideration of what would be included within the write-up was made.

#### **4.1.3 Ethical considerations**

The research complied with the basic ethical guidelines (Elmes et al., 1995). Ethics approval for the study was sought from the Ethics committee and submitted to City University London. It followed the guidelines for minimum standards of ethical approval in psychological research from the BPS (2009).

The participants were asked to sign an informed consent form if they understood and agreed to take part in the study. It was made clear to each participant that they were able to withdraw from the study with no questions asked at any point during the research. In an attempt to safeguard the participants further, a counselling service was offered to them after the interview for those who needed additional support.

The participants were aware that their names would be converted into a pseudonym for anonymity and all identifying characteristics would be removed or altered within the transcript and research write-up.

Due to the sensitive context of the research and the close personal relationship with the research topic, the researcher thought it best to stay in personal therapy throughout the entire research process. This allowed the researcher to explore personal reflexivity with regard to the study.

## **4.2 Findings**

This section presents the findings of the sub-ordinate themes with related participant quotes.

### ***4.2.1 Not knowing in an expected therapy role***

All participants comment on their continued therapy role at home and the expectations from their families, relative and selves. They also explain that in the midst of everyone's expectations, they themselves do not know how to use their therapy knowledge to help their relative with their mental illness. Eve's family have unrealistic continuous expectations of her and are unable to view her as separate from her therapy role:

*My family think I'm a therapist so I like listening to people's problems, so listen to my problems like 24/7. (Eve; 638)*

The phrase '*my family think I'm a therapist*' implies that Eve doesn't feel like a therapist even though she is seen as one by others. Sue uses a powerful metaphor to describe the expectations she has of herself and the reason why she uses her therapy techniques with her mother:

*Because I knew the tools, it's kinda like you have food and there's your starving mum (...) It's like well, what do you do? Do you not give it to her? (...) I want to help her. (Sue; 683)*

The selection of the word '*starving*' indicates that Sue feels she has the tools to help her mother, and like Eve, she puts an expectation on herself to take up a therapy role. The metaphor implies that if Sue does not give her mum food, then she would physically deteriorate; if she did not give her mum the tools to help her, then her mental health would deteriorate. Like Eve, Sue has placed a huge expectation on herself.

*I'm also expected from my parents and from everyone else to be the one who understands psychologically what's going on for her, to ask the right questions to the doctor, what therapeutic support is she going to get (...) How am I supposed to know, you know. (...) she [sister] would say that to me, you should understand, you should understand what I'm going through. (Pam; 121)*

Others expect Pam to use her psychological knowledge to help her sister, but she does not know how to help. There is a sense of separation from her family because of her expected role. The question '*how am I supposed to know*' is expressed within the interview but not to her family. Pam hides her true feelings and takes up a therapy role as expected, which further separates her from her family.

#### **4.2.2 *Negotiating identity: Family versus therapy role***

This sub-ordinate theme reflects the trainee's experience of their continued therapy role at home and the internal push and pull experienced between their family and therapy role. Some of the participants have a conscious awareness of their internal struggle in taking up two roles, whereas others do not. Most of the participants display a struggle in developing or accepting an altered identity.

*I think unfortunately I do try to fix them. I have definitely changed the way I listen to them...and....I still try to keep the balance and remember that I'm still their daughter or brother or sister or whatever, but I feel that its um....yeh I do put my needs aside quite often, I think. (Eve; 505)*

Eve is aware of the therapy role she adopts within her home environment. The use of the word 'change' indicates two different ways of listening; one which she recognises was before the course and one since the course. Eve employs skills learnt from the course to try and communicate with her family; her role at home has changed. Her use of the word 'unfortunately' indicates that her therapy role at home is not a positive experience, as she finds that by continuing her therapy role at home, it takes away from her. Eve speaks about actively trying to keep a balance between both her family and therapy role, and her use of the phrase 'quite often' indicates that her therapy role is the more dominant role within her home environment.

*I know CBT and I know ways to help her, which I have used. (...) I just felt that this wasn't my place, I just felt really like resentful. In one way I wanted to help her but then at the same time I was like I shouldn't be doing this.*  
(Sue; 682)

Sue takes on a therapy role at home as she feels she is able to help her mother as a result of her trainee counselling psychology role. Sue's comment; 'this wasn't my place'; and 'I shouldn't be doing this'; show the dissonance felt between her natural family role and her forced therapy role. She struggles to accept the new identity she is taking up at home. She demonstrates insight into the ambivalent thoughts she is feeling. Like Eve, the therapy role is the more dominant role here. Pam also talks about the conscious struggle she has in trying to work out which role she should take up:

*(...) I'm like her sister but I also want to be her therapist, and so when I talk to her, I start doing CBT and I'm like, no I'm her sister, so it's really hard to be like what position am I taking up, I don't know, who am I to her, who am I trying to be. And I felt like oh, I should be the therapist because that's who I am, that's what I'm doing, so I should be the one who's like no come on think about this and do like crisis plans around helping her.(...) I felt pressured, I felt like split, like a split person.* (Pam; 80)

Pam is actively moving between two different roles: a therapy role at home and her natural family role. This active force comes from Pam's own expectations and from

the expectations of others. Pam questions her own identity and struggles to combine the two roles as they currently exist as separate identities within her. In order to combine the two roles, Pam has to alter and develop a new identity. Pam's comment about feeling like a *'split person'* reveal just how separate the two roles are for her. Pam's use of language conveys the notion that she is in an identity battle.

#### ***4.2.3 A depletion of emotional and physical energy for counselling psychology trainees***

This sub-ordinate theme explores the participants deriving a feeling of self-worth from their continued therapy role at home. Whilst this conveys feelings of happiness and, at times, a sense of achievement, it also causes participants to feel drained and weak.

*I go back home and stay with my brother now who is drunk every single day and in and out of hospital every couple of months. It would definitely make me much weaker and feel helpless. (...) I can only support someone if I am strong myself. If I bring myself back there it will kind of drain all my energy and it would be no good. (Eve; 632)*

Eve uses the words *'weaker'* and *'drain'* to describe the physical and emotional experience of supporting her brother. Her use of the word *'helpless'* demonstrates her experiencing a loss of control and a decrease in her own self-worth as she is unable to help her brother. She describes her experience as *'every single day'* and major events taking place *'every couple of months'*, which shows that she sees her experience as a repetitive cycle which doesn't change, one which she has limited control over. Each event takes away from her resources. Eve goes on to further describe her experience:

*I guess my family has a tendency of dumping problems on me. Also coz they think I'm a therapist so I like listening to people's problems, so listen to my problems like 24/7. (637)*

The use of the word ‘*dumping*’ demonstrates a heaviness that her family put on her. She describes the ‘*dumping*’ as a ‘24/7’ process, indicating that she feels her family give her no space to be herself and, again, her depletion of resources feels like a constant process.

*I thought, why don't I use the CBT to look at this (...) after the 3 hours you could see that there definitely like was a change (...) and I was happy for her but it was just kind of like self-destructive in a way because I knew I was helping her but in doing that I felt like it was kind of, it sucked a lot out of me.*  
(Sue; 326)

Sue’s therapy session and duration immediately show her over-investment in her mother’s problems. This over-investment causes Sue to feel emotionally and physically drained as she is only giving and not putting back into herself. Sue describes her experience as ‘*self-destructive*’, which conveys that she feels she is losing her sense of self. When her mother relapses after their therapy session, Sue explains how much it took away from her physically and emotionally:

*I saw that she'd drunk a bottle and a half in one night and it's just so demoralising (...) Especially when you put in all that work. So it's not just like seeing a client and you know, it's disappointing. (...) It's your mum so there's that connection, especially when you spent three hours talking about it, three and a half hours, so draining, and then on top of it that happens.*  
(338)

Sue describes her failed therapy session as ‘*demoralising*’. This is a really powerful word and instantly conveys Sue’s loss of spirit and confidence within her therapy role and herself, which contribute to her decrease of self-worth.

*(...) because of that attached to me I had to be the one, no I can hold the whole family and get through this, I'm the one that will you know, sort things out, understand everyone's feelings. Everyone's pouring stuff into me and I was left holding it, you know, and you kind of have to be that person, it's tiring. I don't want to be that person who's listening, I do it in my job, I don't*

*need to like come home. It's like, but then the whole thing comes under self care, if you are a therapist and you do have someone, a loved one, there's a lot of self care involved, more than usual. (Pam; 614)*

Pam uses the phrases ‘*attached to me*’, ‘*pouring*’ and ‘*holding*’, which describe a sense of heaviness associated to her therapy role at home. All of this makes Pam feel ‘*tired*’, emphasising a depletion of her personal resources. Pam experiences a loss of control over the situation and feels she is responsible for keeping her family together, indicating that, perhaps, if she didn’t ‘*hold*’ her family together, then it may fall apart. This is a process that requires a considerable amount of energy and demonstrates just how much effort Pam is putting into the process. Pam has insight into her sense of self as she recognises that the process is taking from her own personal resources and she acknowledges that she has to look after herself.

### **4.3 Discussion**

Within the following section, the main findings of the sub-ordinate themes will be discussed in relation to its evidence base and existing theory. The significance and limitations of the study, clinical implications of the results, methodological considerations and suggestions for future research will all be explored.

#### **4.3.1 *Not knowing in an expected therapy role***

The majority of findings within this sub-ordinate theme demonstrate that the existence of a relative/friend with a mental health condition, impact a trainee counselling psychologist by creating additional burden which negatively affects their personal life. The additional burden is viewed in the form of; expectations from others to continue a therapy role at home; and personal expectations to continue a therapy role at home. These two forms of burden result in the trainee experiencing role conflict, depletion of personal resources, feeling disconnected from personal emotions and cognitive processes, stress, self-blame, guilt and not knowing how to use their therapy role to help.

Various studies within the literature only look at the negative experiences of the trainee counselling psychologist (Truell, 2001), whereas a fuller trainee experience

was reflected within this study. It was found that alongside a negative experience, there were also some positives experienced by the participants. Joy was the only participant who didn't have expectations from others or from herself to continue a therapy role at home, and as a result she was the only participant who did not experience any negative reactions to her continued therapy role at home. This could be taken further to recognise that the trainees' families and the trainees themselves put unrealistic expectations on themselves. The findings from this study demonstrate that trainees should not take on a therapy role outside of a professional setting as it can cause boundaries to be blurred, cause considerable stress for the trainee and may provide an unsafe environment for the informal client. Also if trainees do not know how to help an individual, as was voiced by the majority of participants within this study, then they should refrain from doing so or seek professional supervision. This can be detrimental to the therapeutic process with a client and can delay an informal client in getting adequate psychological care. These findings can be generalised to trainees within other disciplines, and professional psychologists and psychotherapists.

#### ***4.3.2 Negotiating identity: Family versus therapy role***

This sub-ordinate theme illuminates the struggle experienced between the participants' family role and their continued therapy role at home. It does not look at the expectations of others but at the participants' own feelings regarding which role they should take up. No previous findings were discovered which support this particular theme; however, the prevalence of this theme across the majority of participants make it stand out as a sub-ordinate theme.

Lefley (1987) and Truell's (2001) study, both illustrate psychologists' experiencing role conflict as they do not know how to be themselves and how to be a counsellor. This research study takes their findings even further as it sheds light on the participants' lived experience of the role conflict. The findings show that the participants' consciously struggle with which role to take: their therapy role at home or their family role. They actively battle between both roles and this creates personal conflict. The participants experience difficulty integrating the two roles and coming to terms with a new identity.

This sub-ordinate theme is a unique finding as no literature was found which reports the role conflict experienced by a trainee psychologist when continuing a therapy role at home. This sub-ordinate theme displays role conflict as a negative experience for trainees. The role strain experienced causes the trainees to feel tired and drained, which impacts negatively on the trainee and their client work. This can have implications on the effectiveness of the therapeutic work, as it can have a negative impact on client sessions. It is important that trainees utilise their available support services adequately, as it has been demonstrated that it can help a trainee work through their process, potentially facilitating healthy emotional process for the therapist within a client session and also resulting in trainees experiencing an increased personal connection with themselves.

#### ***4.3.3 A depletion of emotional and physical energy for counselling psychology trainees***

The literature does not identify the concept of burnout for any mental health professional/trainee whilst continuing a therapy role at home with a mentally ill relative. It has been illustrated within the literature that burnout amongst counselling trainees can have a severe impact on the trainees and their clinical practice (Shapiro, Shapiro & Schwartz, 2000). However, most of the participants within this study verbalised the impact of their therapy role at home and the interpretation was that participants experienced feelings of tiredness and a decline in self-care. According to Mashlash and Jackson (1981), increased feelings of emotional exhaustion are characteristics of burnout syndrome. When the participants speak about their continued therapy role at home with their relative, they report that they feel emotionally and physically drained (Eve, Sue, Pam & Amy). This is a repetitive process which takes place between approximately one to ten years and results in Eve, Pam, Sue and Amy feeling a loss of control over the situation as a result.

Another consequence of emotional and physical exhaustion were participants experiencing a negative self-perception, especially in relation to their client work (Mashlash & Jackson, 1981). As a consequence of the participants feeling a loss of control, they experienced feelings of helplessness as they felt unable to help their

relative with their mental illness. Theory suggests that a participants' inability to help their relative results in a weakening of their self-efficiency (Bandura, 1994). Pam's, Lea's and Sue's self-worth deteriorates, which results in them questioning their competency as professional therapists, as they question their inability to help their own mentally ill relative which leads them to consider how they would help their clients. It has been suggested that the participants burnout symptoms of tiredness and a depletion of energy can also result in a deterioration of the quality of care or service provided to clients (Freudenberger, 1974; 1975).

A decline in emotional and physical energy for a trainee can mean that the trainee will be unable to function effectively as a student and trainee psychologist. This may impact on their client work and academic success. Many educators are aware that trainees need tools to self-care and many training courses have put services in place for this purpose (Baker, 2003; Weiss, 2004). Christopher and Maris (2010) observed counselling and psychotherapy students who had taken a mindfulness class alongside their psychology course. Students were taught to self-care and increase self-awareness. The study found that students developed an increased awareness, acceptance of their experiences, increase in self-confidence and an increase of their competence in their relationships with themselves, clients and others. It may be beneficial for trainees to be aware of the benefits of mindfulness training or any other holistic therapies to allow them to improve their concept of self-care. This study shows that the participants' put themselves last the majority of the time; their continued therapy role at home was always the more dominant role and this contributed to their decline of emotional and physical energy. This study highlights that trainees who have a strenuous personal life should be aware of the importance of self-care, especially at the beginning of training as studies highlight that this is when trainees struggle the most (Bischoff et al., 2002; Skinner, Elliott & Wheeler, 2010). This sub-ordinate theme gives awareness to the importance of self-care so as to reduce the risk of depleting emotional and physical resources as it can have negative consequences on trainees and their clients.

#### **4.3.4 Methodological considerations**

A criticism of this methodology was the small sampling pool used. Participants were only selected if they were on the BPS Professional Doctorate in Counselling Psychology course because of the compulsory personal therapy which was a requirement of the course. In hindsight, it has been recognised that other counselling courses could have been included which also consist of compulsory personal therapy. This would have widened the sampling pool and the findings would have contributed to a larger area within the counselling psychology field. A bigger sampling pool may have made the recruitment process easier and less time-consuming as the second recruitment stage would not have been implemented. A bigger sampling pool may also have afforded the opportunity to recruit a more homogenous sample as participants from a particular year could have been selected, as the analysis showed that participants' cognitive process and personal development changed during the progression of the course. However, a strength of the current sampling pool was that all participants were recruited from the same course, which increased the homogeneity of the sample as different courses taught different methodologies and the participants would have developed different skill sets through their course.

#### **4.4 Conclusion**

The findings of this study contribute to the literature as it reflects the unique findings of the lived experience of trainee counselling psychologists who have a relative/friend with a self-reported mental health condition. The results have implications for trainee psychologists and training institution educators in raising awareness of the trainees' continued therapy role outside of their course or place of work. The results highlight that the trainees' continued therapy role has a considerable impact on their personal and professional lives. The study has demonstrated that the participants need more support within this area, and it may be beneficial for trainees to seek extra support from their universities and for educators to gain awareness of the demands placed on a trainee who may be in a similar position so that additional support may be offered.

A future area of research suggested by this study would be to use a quantitative methodology to find out how many trainees who embark on a psychology career have experienced a relative with a mental illness. The study could use the findings

from this study to devise a questionnaire and recruit from different courses and universities around the country to get a better idea of the statistics of this phenomenon.

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## **Appendices**

### **Appendix 1: Bibliographical details of client**

At home Sophia had an uneventful childhood and recollects happy memories with her family. However, Sophia's father, to whom she was close to, died from a heart attack four years ago. She has a mother and two sisters. Her mother and older sister live close by and she is close to them. Her younger sister moved to Italy ten years ago where she lives with her family, although Sophia does not speak to her as much as she would like because of the distance between them. Sophia has few family members within the UK and does not see her aunts and uncles regularly. Sophia has two close friends whom she also does not see very often.

Sophia has been with her husband for twenty-one years, married for sixteen years and their daughter is seven years old. Sophia says that she and her husband do not communicate well when things get difficult. He knows that she gets bullied at work but does not say anything as it is his manager too. Sophia does not talk to him about what is going on with her and it is not spoken about at home. Sophia says she and her husband have a perfect relationship and she has no complaints about him. She said they both do not talk about the miscarriage of their babies or that she suffers from anxiety and depression. They had spoken about this all very briefly and quite a long time ago. Sophia has a good relationship with her seven year old daughter. She has worked at the estate agents for ten years and her husband has worked there for three years. Sophia used to enjoy her job but does not any more.

Sophia was first verbally bullied in primary school at the age of eleven by a girl in her class who would make fun of her appearance and whisper and laugh with the other girls about her. They would laugh at her long brown hair and say she was ugly. When Sophia went on to secondary school, the girl also went to the same school and the bullying continued. Sophia became distressed to the point that she would hide in the toilets at lunchtime and have her lunch in a cubicle because she did not want to see the other students laughing and pointing at her. Sophia believes that it was because of this that she did not have any friends during this period at school. Sophia concentrated on her studies instead, which resulted in her becoming a grade-A student. Sophia did not tell anyone what was going on and it only stopped when the

particular girl had moved area and therefore left the school. Sophia said that she had cried a lot during those five years and would often have nightmares related to the bullying. Sophia says the bullying has left her feeling sad that it happened. She feels confused as to why it happened and why the girl would pick on her. Sophia feels it may have been because the bully was jealous. Sophia believes that a reason for the bully's jealousy may have been because Sophia viewed herself as a nice person who did well academically and she believed that maybe the girl did not like that. Sophia said she sometimes thinks about the bully and also tries to see what she may have done wrong to make the bully pick on her. Sophia explained that she was a nice person who just wants to be liked.

Sophia feels she has been verbally bullied at work for the past four years from her department manager. She reports that he often comments on her marriage, saying that he feels they will get a divorce soon. She also said that he has given her huge amounts of work which are impossible to finish in one day. He uses his presence to stand by her office door, staring at her and making her feel uncomfortable and also making inappropriate comments regarding work and her personal life. She said that he ignores her when she gives him her opinion or advice about the business and would also, at times, take credit for her ideas. Sophia reported that other colleagues had seen his behaviour towards her and commented on it to Sophia, also confirming that they felt it was wrong and his behaviour was out of line.

## Appendix 2: PHQ-9 and GAD questionnaire

P2 – Local Patient/Identifier

### PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1 Little interest or pleasure in doing things	0	1	2	3
2 Feeling down, depressed, or hopeless	0	1	2	3
3 Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4 Feeling tired or having little energy	0	1	2	3
5 Poor appetite or overeating	0	1	2	3
6 Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7 Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8 Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9 Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
A11 – PHQ9 total score				<input type="text"/>

### GAD-7

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1 Feeling nervous, anxious or on edge	0	1	2	3
2 Not being able to stop or control worrying	0	1	2	3
3 Worrying too much about different things	0	1	2	3
4 Trouble relaxing	0	1	2	3
5 Being so restless that it is hard to sit still	0	1	2	3
6 Becoming easily annoyed or irritable	0	1	2	3
7 Feeling afraid as if something awful might happen	0	1	2	3
A12 – GAD7 total score				<input type="text"/>

### Appendix 3: Thought record therapy worksheet (Vivyan, 2009)

Thought Record Sheet – 7 column

Situation / Trigger	Feelings Emotions – (Rate 0 – 100%) Body sensations	Unhelpful Thoughts / Images	Facts that <u>support</u> the unhelpful thought	Facts that provide evidence <u>against</u> the unhelpful thought	Alternative, more realistic and balanced perspective	Outcome Re-rate emotion
<p>What happened? Where? When? Who with? How?</p>	<p>What emotion did I feel at that time? What else? How intense was it?</p> <p>What did I notice in my body? Where did I feel it?</p>	<p>What went through my mind? What disturbed me? What did those thoughts/images/memories mean to me, or say about me or the situation? What am I responding to? What "button" is this pressing for me? What would be the worst thing about that, or that could happen?</p>	<p>What are the facts? What facts do I have that the unhelpful thoughts are totally true?</p>	<p>What facts do I have that the unhelpful thoughts are NOT totally true? Is it possible that this is opinion, rather than fact? What have others said about this?</p>	<p>STOPPP! Take a breath....</p> <p>What would someone else say about this situation? What's the bigger picture? Is there another way of seeing it? What advice would I give someone else? Is my reaction in proportion to the actual event? Is this really as important as it seems?</p>	<p>What am I feeling now? (0-100%)</p> <p>What could I do differently? What would be more effective?</p> <p>Do what works! Act wisely. What will be most helpful for me or the situation? What will the consequences be?</p>

## Appendix 4: Unhelpful thinking habit therapy worksheet (Vivyan, 2009)

### Unhelpful Thinking Habits

Over the years, we tend to get into unhelpful thinking habits such as those described below. We might favour some over others, and there might be some that seem far too familiar. Once you can identify your unhelpful thinking styles, you can start to notice them – they very often occur just before and during distressing situations. Once you can notice them, then that can help you to challenge or distance yourself from those thoughts, and see the situation in a different and more helpful way. *Blue text (italics) helps us find alternative, more realistic thoughts.*

 <p><b>Mental Filter</b> - When we notice only what the filter allows or wants us to notice, and we dismiss anything that doesn't 'fit'. Like looking through dark blinkers or 'gloomy specs', or only catching the negative stuff in our 'kitchen strainers' whilst anything more positive or realistic is dismissed. <i>Am I only noticing the bad stuff? Am I filtering out the positives? Am I wearing those 'gloomy specs'? What would be more realistic?</i></p>	 <p><b>Judgements</b> - Making evaluations or judgements about events, ourselves, others, or the world, rather than describing what we actually see and have evidence for. <i>I'm making an evaluation about the situation or person. It's how I make sense of the world, but that doesn't mean my judgements are always right or helpful. Is there another perspective?</i></p>
<p><b>Prediction</b> - Believing we know what's going to happen in the future. <i>Am I thinking that I can predict the future? How likely is it that that might really happen?</i></p> 	<p><b>Emotional Reasoning</b> - I feel bad so it must be bad! I feel anxious, so I must be in danger. <i>Just because it feels bad, doesn't necessary mean it is bad. My feelings are just a reaction to my thoughts – and thoughts are just automatic brain reflexes</i></p> 
<p><b>Mind-Reading</b> - Assuming we know what others are thinking (usually about us). <i>Am I assuming I know what others are thinking? What's the evidence? Those are my own thoughts, not theirs. Is there another, more balanced way of looking at it?</i></p> 	<p><b>Mountains and Molehills</b> Exaggerating the risk of danger, or the negatives. Minimising the odds of how things are most likely to turn out, or minimising positives <i>Am I exaggerating the bad stuff? How would someone else see it? What's the bigger picture?</i></p> 
<p><b>Compare and despair</b> Seeing only the good and positive aspects in others, and getting upset when comparing ourselves negatively against them. <i>Am I doing that 'compare and despair' thing? What would be a more balanced and helpful way of looking at it?</i></p> 	<p><b>Catastrophising</b> - Imagining and believing that the worst possible thing will happen <i>OK, thinking that the worst possible thing will definitely happen isn't really helpful right now. What's most likely to happen?</i></p> 
<p><b>Critical self</b> Putting ourselves down, self-criticism, blaming ourselves for events or situations that are not (totally) our responsibility <i>There I go, that internal bully's at it again. Would most people who really know me say that about me? Is this something that I am totally responsible for?</i></p> 	<p><b>Black and white thinking</b> - Believing that something or someone can be only good or bad, right or wrong, rather than anything in-between or 'shades of grey'. <i>Things aren't either totally white or totally black – there are shades of grey. Where is this on the spectrum?</i></p> 
<p><b>Shoulds and musts</b> - Thinking or saying 'I should' (or shouldn't) and 'I must' puts pressure on ourselves, and sets up unrealistic expectations. <i>Am I putting more pressure on myself, setting up expectations of myself that are almost impossible? What would be more realistic?</i></p> 	<p><b>Memories</b> - Current situations and events can trigger upsetting memories, leading us to believe that the danger is here and now, rather than in the past, causing us distress right now. <i>This is just a reminder of the past. That was then, and this is now. Even though this memory makes me feel upset, it's not <u>actually</u> happening again right now.</i></p> 

## Appendix 5: Diary of positive personal qualities therapy worksheet (Vivyan, 2010)

### Diary of Positive Personal Qualities

Keep a daily log of activities which suggest or confirm your personal positive qualities (personality traits, characteristics, strengths), or times when you've shown or felt a personal positive quality. Write them down! It's easy to dismiss or minimise positives, as we tend to filter out the positives and only notice the negatives. Notice that your mind does that, then write what actually happened.

Examples of personal positive qualities: *kind, gentle, strong, resilient, caring, assertive, hard-working, reliable, honest, practical, responsible, loyal, mature, creative, consistent, appreciative, capable, quick, sensitive, perceptive, patient, thoughtful, fit, trustworthy, shows initiative, motivated, versatile, educated, willing, experienced, efficient, open-minded, logical, serious, supportive, resourceful, realistic, funny, punctual, friendly, humane – and many others!*

Day / Date	What I did	Positive Personal Quality or Qualities What positive quality did I show or feel?

## Appendix 6: Ethical approval

### Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.**

**Section A: To be completed by the student**

Please indicate the degree that the proposed research project pertains to:

Professional Doctorate in Counselling Psychology

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

An Interpretative Analysis of How Having a Close Family Member/Friend with a Mental Health Disorder May Affect Work and Personal Environment for Trainee Counselling Psychologists.

2. Name of student researcher (please include contact address and telephone number)

Niki Phrydas

Address: Department of Psychology, City University, London, EC1V 0HB

Telephone number: 07947580866

3. Name of research supervisor

Dr Don Rawson

4. Is a research proposal appended to this ethics release form? **Yes**

5. Does the research involve the use of human subjects/participants? **Yes**

If yes,

a. Approximately how many are planned to be involved?

Eight

b. How will you recruit them?

Participants will be recruited through Universities who offer the Professional Doctorate in Counselling Psychology training programme accredited by the British Psychological Society. The course administrators will be contacted by email to ask permission to send an email to the trainees. This email will have information about the research inviting them to take part.

c. What are your recruitment criteria?

Participants will be:

- 1) Trainees who are currently on the Professional Doctorate in Counselling Psychology Programme which is accredited by the British Psychological Society.
- 2) Individuals who have had the experience of having a close family member/friend with a mental health condition.
- 3) The individuals have to be able to give personal consent.
- 4) To be able to read and write in English.

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent? **No**

d1. If yes, will signed parental/carer consent be obtained?

d2. If yes, has a CRB check been obtained?

*(Please append a copy of your CRB check)*

6. What will be required of each subject/participant (e.g., time commitment, task/activity)? *(If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).*

- 1) The participants will be asked to take part in a semi-structured interview which will last approximately 60-90 minutes. This will be done in a confidential and safe space for both participant and researcher.
- 2) There will be a 15-20 minute de-brief session afterwards.
- 3) Times and dates will be arranged beforehand and at the most convenient time for the participant. The participants will also have the researchers' email and contact number if they need to get in contact for any reason.

7. Is there any risk of physical or psychological harm to the subjects/participants?

**Yes**

If yes,

a. Please detail the possible harm?

The participants may find the topic to be distressing or uncomfortable for them as the study is quite a sensitive subject area psychologically.

There is no risk of physical harm.

b. How can this be justified?

- 1) The participant may benefit in talking to someone else about their experience and may learn something new.
- 2) They will be directly contributing to this area of psychology.
- 3) Support will be available to the participants. It will be suggested that they speak to their personal therapist for support and they will be given counselling information they can contact should they need to.
- 4) It will be made clear to the participants that they do not have to answer any questions or share anything that they do not want to.

c. What precautions are you taking to address the risks posed?

- 1) The participant will be transparent about any possible risks to the participant due to taking part in this study.
- 2) The information and consent form both clearly explain the participants' right to withdraw from the study at any time with no questions asked.
- 3) The research will allow time for the participants to be able to reflect back on their interviews and the researcher will be able to provide support and address any questions posed.
- 4) The participants will also be offered a list of counsellors if they feel they need further support after the study.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

**Yes**

*(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)*

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

**No**

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

**Yes**

If no, please justify

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g., research notes, computer records, tape/video recordings)?

- 1) Digital audio recordings will be kept of each interview conducted.
- 2) Notes will be kept on a computer of each interaction and the researchers' notes.
- 3) A transcript of the audio recordings will also be on word format.
- 4) Paper copies of the consent forms and demographic information will also be kept.

12. What provision will there be for the safe-keeping of these records?

- 1) All audio recordings will be kept on a password protected laptop and will be encrypted to ensure anonymity. The laptop will belong only to the researcher and will be locked when not in use.
- 2) The word document with contact details will be encrypted and stored in a password protected folder on the password protected computer stored in a locked cabinet when not in use.
- 3) All paper copies will be stored in a locked cabinet.
- 4) All of the data collected will be handled by the researcher only and if it is shared with the appointed supervisor then they will also be bound by confidentiality. All transcripts shared with the supervisor will be encrypted.

13. What will happen to the records at the end of the project?

When the research has come to an end and the researcher has completed the Doctorate in Counselling Psychology course, all the raw data of the study will be destroyed.

14. How will you protect the anonymity of the subjects/participants?

All names will be stored on a password protected database on a password protected laptop only accessible by the researcher.

The participants' names will be converted to a code number and only the researcher will have access to the participants' personal data.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

Each participant will then be de-briefed and thanked for participating in the study. This will take around 15-20 minutes. In this time the participants will be invited to ask any questions and to reflect on the interview conducted. Each participant will be given an information pack they can take home with them. This will include a copy of their consent form, an information sheet which will include the researcher, supervisor and counselling option contact details for the participant to contact anytime after the study or if they feel they need to.

If you have circled an item in **underlined bold** print or wish to provide additional details of the research please provide further explanation here:

Signature of student researcher ---Niki Phrydas----- Date 22/06/2011

**CHECKLIST:** the following forms should be appended unless justified otherwise

Research Proposal

Recruitment Material

Information Sheet

Consent Form

De-brief Information

## Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself? Yes

If yes,

a. Please detail possible harm?

As the topic area is personal to me, I may feel emotionally affected by the subject material the participant may present with.

b. How can this be justified?

I am aware of this and feel emotionally stable to carry out this study. I will take the necessary precautions to take care of myself psychologically.

c. What precautions are to be taken to address the risks posed?

I have already spoken with my personal therapist and explored any issues that have come up in how I feel about the research. I will continue to speak to my personal therapist about my process during and after the research.

I am able to speak to my research supervisor about any concerns I have about the research.

I am also able to speak to my placement supervisor about anything that may come up for me in my placement as a result of the research study.

I am also able to speak to my placement mentor about anything that may come up for me in the research that is related to my placement.

I am also able to speak to my university tutor about any concerns around university work, including my research.



## Appendix 7: Email to university programme director



To the Programme Director,

My name is Niki Phrydas and I am a 2<sup>nd</sup> year student from City University currently on the Professional Doctorate in Counselling Psychology programme. I am writing to you as I am planning to carry out a study and would like to ask permission to invite trainee counselling psychologists from your institution to take part in my study.

For my doctoral thesis I am conducting a study entitled “An interpretative analysis of how having a close family member/friend with a mental health disorder may affect work and personal experiences for trainee counselling psychologists”.

My research aims:

- 1) How the participants make sense of their experiences of having a close family member/friend diagnosed with a mental health condition and their experiences of it personally, professionally and academically. The researcher will observe how the participants make sense of their experiences with their loved-one.
- 2) What does this phenomenon mean to them?

The participants will be given a written description of the study and will be asked to sign a consent form prior to the interview. This research will comply with the basic ethical guidelines (Elmes et al, 1995). Participants will be able to withdraw from the study with no questions asked.

It is estimated that each interview will last approximately 60-90 minutes. A flexi-interview schedule will be adopted to guide the topics of discussion. The interviews will be audio taped and then transcribed verbatim.

An analysis of the transcripts will later be performed using the Interpretive Phenomenological Analysis procedure outlined by Smith (2003). A summary of each transcript will be completed and it will outline the main themes that come out of each participant's interview. Each transcript summary will be offered to each participant to ensure testimonial validity (Stiles, 1993).

Time will be set aside at the end of each interview to allow the participants the opportunity to be debriefed, and to see whether the interview brings up any difficult feelings. Contact information will be provided if the participants feel they need someone to speak to after the study.

The research will be carried out at a time and place that suits the participant.

The research is supervised by Dr Don Rawson, a lecturer at City University. He can be contacted at: don.rawson.1@city.ac.uk.

If you have any further questions please feel free to contact the researcher anytime.

Email: niki.phrydas.1@city.ac.uk

Mobile: 07947580866

I look forward to hearing from you,

Warm regards,

Niki Phrydas

Counselling Psychologist in Training

Department of Psychology

City University

London

EC1V 0HB

## Appendix 8: Email to trainee counselling psychologists



To trainee counselling psychologist,

I am on the Professional Doctorate in Counselling Psychology programme at City University, London. For my Doctoral thesis I am conducting a study entitled “An interpretative analysis of how having a close family member/friend with a mental health disorder may affect work and personal experiences for trainee counselling psychologists”.

I am currently looking for trainee post-graduate counselling psychologists who are willing to discuss their experiences of how having a close family member/friend diagnosed with a mental health disorder is personally and professionally interpreted.

The research is supervised by Dr Don Rawson (City University, academic lecturer), who is contactable on: don.rawson.1@city.ac.uk.

It will be an in-depth semi-structured interview which will be audio taped and will last approximately 60-90 minutes.

The location and time will be held at a time and place convenient to you.

If you are interested in participating or have any further questions, then please contact:

**Researcher:** Niki Phrydas: 07947580866/ niki.phrydas.1@city.ac.uk

Thank you for your consideration in participating.

Yours sincerely,

Niki Phrydas

Counselling Psychologist in Training

Department of Psychology

City University

London

EC1V 0HB

## Appendix 9: Information sheet



### Information Sheet

#### Purpose:

The purpose of this study is to look at the experiences that a loved one diagnosed with a mental health condition has on a trainee counselling psychologist, personally and professionally.

The study is under the supervision of Dr Don Rawson.

#### Procedure:

If you agree to be a part of this study, you will be asked to do the following:

- 1) Fill out a Demographic Details form and ask any questions you may have (approximately 5-10 minutes).
- 2) Sign a consent form to say you agree to take part in this study (approximately 5 minutes).
- 3) Have an in-depth semi-structured interview with the student researcher (Niki Phrydas) on your experiences of having a loved one diagnosed with a mental health condition. The in-depth semi-structured interview will be audio taped with a small voice recorder and the will last around 60-90 minutes.
- 4) You will then be involved in a de-brief session with the researcher which will last approximately 15 minutes.

#### Benefits/risks to the participant:

The participant may benefit in talking to someone else about their experiences and may learn something new. They will be directly contributing to this area in psychology.

The participant may find the topic to be distressing or uncomfortable for them as the study is quite a sensitive subject area.

**Voluntary nature of the study and confidentiality:**

Your participation in this study is completely voluntary and at any point you have the right to withdraw from the study with no questions asked. You also have the right to refuse to answer certain questions. You may stop at any time to ask the researcher any questions you may have.

All your data from the research remains confidential and all data is published anonymously. Your name will be converted to a code number and only individuals who are associated with this research will see your name and responses. If you are feeling uncomfortable with any part of the study after the study, you still have the right to withdraw your data from the sample.

**Contacts and questions:**

At this time you may ask the researcher any questions you have. If you still have any questions or concerns after the study please feel free to contact:

**Researcher:** Niki Phrydas: 07947580866/ niki.phrydas.1@city.ac.uk

**Research Supervisor:** Dr Don Rawson: don.rawson.1@city.ac.uk

# Calling All Trainee Counselling Psychologists

Do you have a FAMILY member or FRIEND  
diagnosed with a MENTAL HEALTH  
CONDITION?

Would you like to participate in a study  
exploring your experiences?



-You will be involved in a discussion which will last approximately 60 minutes; with a 15 minute information session and de-brief.

-You can take the opportunity to share your experience.

-I am recruiting 8 participants on a first come first served basis.

You may wish to RESPOND using a PSEUDONYM to make sure your anonymity is totally protected and you can speak freely without any professional risk

Call/email: Niki Phrydas (Research and Counselling Psychologist Trainee) on: [07947580866](tel:07947580866)/[niki.phrydas.1@city.ac.uk](mailto:niki.phrydas.1@city.ac.uk)

Research supervisor: don rawson. Email: [don.rawson.1@city.ac.uk](mailto:don.rawson.1@city.ac.uk)

## Appendix 11: De-brief sheet



CITY UNIVERSITY  
LONDON

### DEBRIEF

**Research title:** An interpretative analysis of how having a loved one with a mental health disorder may affect work and personal experiences for trainee counselling psychologists.

Thank you for taking part as a research participant in the present study. The aim of this study is to look at the experiences that having a loved one with a mental health condition may have on a trainee counselling psychologist. This study explores the interpersonal relationship between you and your loved one and looks at the experiences you may have had personally and professionally.

It is acknowledged that it may be difficult to explore your personal experience and your generosity and willingness to participate in this research is greatly appreciated. It is understood that you may find the subject matter of this research uncomfortable to speak about. Your input will help to contribute to the advancement of this field. If at any time after this study you feel distressed and would like to speak to someone about your thoughts or you just have some general questions, please feel free to contact one of the following:

**Researcher:** Niki Phrydas: 07947580866/ niki.phrydas.1@city.ac.uk

**Research Supervisor:** Dr Don Rawson: don.rawson.1@city.ac.uk

If you need to express any concern about the study, then you are free to contact:

**Director of Counselling Psychology Doctorate Programme:** Pavlos Filippopoulos (City University): 0207 040 4557/ pavlos.filippopoulos.1@city.ac.uk.

All your data from the research remains confidential and all data is published anonymously. Your name will be converted to a code number and only individuals who are associated with this research will see your name and your responses. If you are feeling uncomfortable with any part of the study, you have the right to withdraw your data from the sample at any time.

If you would like any information about the results of the research once it has been completed, then feel free to contact the researcher or the research supervisor on the details above or let them know and they will contact you once the study is completed.

Thank you very much for participating in this study.

Niki Phrydas

Counselling Psychologist in Training  
Department of Psychology  
City University  
London  
EC1V 0HB

## Appendix 12: Demographic information sheet



### PARTICIPANT DEMOGRAPHIC INFORMATION

<b>Name:</b>	
Gender:	
<u>D.O.B:</u>	
<u>Contact information:</u>	<u>Telephone number:</u>  <u>Email:</u>  <u>Preferred method of communication:</u>
<u>Would you like to be contacted with the outcome of the research?</u>	<u>Please Circle:</u> Yes  No

## Appendix 13: Consent form



### CONSENT FORM

**Name of participant:** \_\_\_\_\_

**Project Title:** An interpretative analysis of how having a loved one with a mental health disorder may affect work and personal experiences for trainee counselling psychologists.

**Name of researcher:** Niki Phrydas

**Name of Supervisor:** Dr Don Rawson

1. I consent to participate in the above project, the particulars of which have been explained to me.
2. I authorise the researcher to use with me the procedures referred to under (1) above.
3. I acknowledge that:
  - (a) The possible effects of the procedures have been explained to me to my satisfaction.
  - (b) I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied.
  - (c) The project is for the purpose of research and not for treatment.
  - (d) I have been informed that the confidentiality of the information I provide will be safeguarded, subject to any legal requirements.

**Statement of consent:**

I fully understand the purpose, procedure and possible risks of this research. I consent to participate in this study.

Signature: \_\_\_\_\_

*(Participant)*

Date: \_\_\_\_\_

## Appendix 14: Counselling information



### **FURTHER SUPPORT: COUNSELLING INFORMATION**

- **SAMARITANS:** *volunteers here offer support by responding to phone calls, emails and letters. Alternatively you can often drop into a branch to have a face to face meeting.*

-Telephone Number: In the UK and Northern Ireland: 08457 90 90 90

-If you live outside of the UK or Republic of Ireland, or wish to use another language other than English, you can visit [www.befrienders.org](http://www.befrienders.org) to find your nearest helpline.

- You can also get a number and information for a Psychologist/Psychotherapist from these following websites:

-British Psychological Society: [www.bps.org.uk](http://www.bps.org.uk)

-The United Kingdom Council for Psychotherapy:  
[www.psychotherapy.org.uk](http://www.psychotherapy.org.uk)

- The British Association for Counselling and Psychotherapy:  
[www.bacp.co.uk](http://www.bacp.co.uk)

-If you have any further questions or need further support then feel free to contact the researcher or research supervisor.

**Appendix 15: Super-ordinate and sub-ordinate theme table with participant quotes**

<u>Super-ordinate theme with its sub-ordinate themes</u>	<u>Quote/key words</u>	<u>Line Num</u>	<u>Participant</u>
<p><b><u>Super-ordinate theme 1:</u></b> <b><u>Negotiating roles; personal identity versus therapy identity</u></b></p> <p><b><u>Not knowing in an expected therapy role</u></b></p>	<p>My family think I'm a therapist so I like listening to people's problems, so listen to my problems like 24/7. I don't feel like they have space for me.</p> <p>One thing that annoys me is that my parents say, you're supposed to be a therapist because I don't feel like I'm a therapist at all, like in that setting,</p> <p>I think people are looking for a device, thinking that you know better because you are doing something like that. This happens in general with friends. People are like, you know better, you must have a better coping strategy. It mustn't hurt you as much as it hurts us.</p>	<p>638</p> <p>84</p> <p>503</p>	<p>Eve</p> <p>Zoe</p> <p>Lea</p>

<p><u>Negotiating identity; family versus therapy role</u></p>	<p>since I've been doing it, she would say to me, well you're a Psychologist, why don't you fix me. That's really difficult. Really, really difficult</p>	596	Amy
	<p>a lot of people in my family would be like, yeh lets ask Clare, she's the psychologist like I'm this universal power, god that has all the answers. And I'm like, I don't know, and they're like, how can you not know, don't you learn this and I'm like, no I don't, what do you think and they like, I don't know.</p>	1934	Clare
	<p>I do try to fix them, I try to remember that I'm their daughter or sister, but I do put my needs aside quite often.</p>	505	Eve
	<p>I just felt that this wasn't my place, I just felt really like resentful. In one way I wanted to help her, but then at the same time I was like I shouldn't be doing this. Because I knew the tools, it's kinda like you have food and there's your starving mum. It's like well, what do you do? Do you not give it to her? And I want to see her better, I want to see her, I don't wana see her like that so, I want, I want to help her. But then it's kind of, you know, it's not helping me because it's, it's not fair on me in a way</p> <p>Self awareness, I think when I speak to him, it comes into play. If he breaks something or starts speaking about the devil I recognise I feel annoyed that I don't understand it</p>	682	Sue
		263	Zoe

	<p>coz it's not real, but my self-awareness has made me realise how I feel and how that affects coz he immediately shuts down and he gets upset and angry, but coz it's not a professional relationship, I let my emotional feelings kind of override.</p> <p>I'm her sister but I also want to be her therapist, I start doing CBT and I'm like no I'm her sister, it's hard to be like what position to take up, I don't know who am I to her, who am I trying to be.</p> <p>Of course there are parts of me that even though I have this understanding, that I can be forgiving and empathic, there is still the child that was not cared for properly, I'm still human as well. I can only understand why she couldn't do it, it doesn't mean that because I understand it doesn't hurt.</p> <p>I suppose I look at it as something right now as best left well alone. I think I'm being hard on myself when I say that maybe I'm a bit gutless around it coz whenever there's been a problem I've never ran away. I've faced it and if I thought things were getting worse I would drag her to the psychiatrist myself.</p> <p>I didn't want to be the strong one for anyone; I just wanted to be the strong one for myself. I wanted to have my own role, I didn't feel like I had a role, I was like someone's Clare, I wasn't my Clare. I was my sisters Clare, I was my brothers Clare, I</p>	<p>80</p> <p>388</p> <p>402</p> <p>265</p>	<p>Pam</p> <p>Lea</p> <p>Joy</p> <p>Clare</p>
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<p><b><u>Balancing self-care with personal and academic demands</u></b></p>	<p>had a lot of responsibility, there was a lot of guilt, there still is but not in the same sense and I think I wanted to regain that role</p>		
	<p>I stopped speaking with my sister and I was actually going through a very very difficult loss, feeling of loss, feeling of grief, of having lost my sister coz that's what I feel and I really don't think we will ever be in contact in the same way. And I was also mourning the loss of my role as a mother for her and I was also trying, you know no matter how good a role is, you still mourn the loss of some role and you try to adjust to the new role. So I was still trying to adjust to the role of me being the sister and me actually caring for myself</p>	732	Clare
	<p>For me really it's where it leaves me now, how am I going to continue with work and studies with this kinda running alongside me.</p>	406	Zoe
<p>when I went back to travel and visit her, to see her, coz I would, I was now here in England at University and I'd go back during the holidays, and she'd be at home for most the days, she'd not be leaving or going out of the house, she wasn't having any communication with anybody. I stayed with mum anywhere from 2 weeks to the longest is 2 months, so it really depended on what holiday it was. If it was the summer it was 2 months, if it was a little holiday it was 2 weeks.</p>	101	Sue	

	<p>Yeh, happened in my first year, in terms of her, its every now and then, she's a lot better now, but in terms of me and my training, I've noticed its always like..</p>	450	Pam
	<p>I was on the phone to my stepdad getting him to make a doctor's appointment and I said when I've finished my exam on Friday I'll come home and pick her up and we'll go. I went and did my abnormal psychology exam, it was ridiculous, I got the worst result, it's not a surprise, the subject area and what was going on at home.</p>	141	Joy
	<p>I was using my personal therapy to talk about my mum and some of my struggles with juggling on the course are around this feeling that I have to be 100% there for her, but maybe I have that feeling for everyone that wants me and that's quite, that's been quite good to look at, to challenge.</p>	218	Amy
	<p>It was really, really hard to talk with him and instead of him accepting that and trying to tell us that he would try to get away from it and just be textbook. So there was a lot, a lot, a lot on my mind and often I would just start crying and not be able to take it. And at the same time I was trying to make sense of my course, I was trying to get the grades, I was trying to deal with the economical fact that living here is really expensive, I have to save on this and this and that.</p>	547	Clare

<p><b><u>Super-ordinate theme 2:</u></b>  <b><u>Continuing a therapy role</u></b>  <b><u>within a personal space;</u></b>  <b><u>impact on self</u></b></p> <p><i><u>A depletion of mental and</u></i>  <i><u>physical energy for counselling</u></i>  <i><u>psychology trainees</u></i></p>	<p>I go home and stay with my brother who is drunk and in and out of hospital; it would make me weaker and helpless. By being away, it would do more good. I can only support someone if I am strong. If I go back it will drain all my energy.</p> <p>it was emotionally draining as well because nights that I was there I felt like I was policing her because she'd agreed that she'd have two glasses of wine and that was it, so it was that, I started feeling extremely anxious because I was continuously trying to monitor how much she was drinking and watching how much was in the bottle, um and then it was extremely disappointing because I would go out you know a few nights with my friends and I'd come back and see, I'd check the bottle and see that it had been finished and I'd confront her and she'd be like, oh it's ok, I just had, and I saw that she'd drank a bottle and a half in one night and it's just so demoralising.</p>	<p>632</p> <p>338</p>	<p>Eve</p> <p>Sue</p>

	<p>I'm able to put my needs to the side and listen to what my parents have to say, if they need to offload, listen to my brother. I know it takes a lot out of me, I've got a lot more control over myself. So I'm able to use the skills, techniques, training that I've learnt, even to just communicate with somebody to help understand them. I still get angry but I notice I'm more tolerant, I put my feelings to the side and I've been trained to do that.</p>	315	Zoe
	<p>Because of this attached to me I had to be the one; no I can hold the whole family and get through this. Everyone's pouring stuff into me and I was left holding it, its tiring, I don't want to be that person who's listening, I do it in my job, I don't need to come home. If you are a therapist and you do have someone, there's a lot of self care involved, more than usual.</p>	614	Pam
	<p>It's a coping mechanism, having to fight for my own survival here and phoning home every week and listening to something more disturbing, it was all sucking my energy. After half an hour of a phone call I felt so depressed I wanted to do nothing, close the curtains and go to sleep and not leave the room for the rest of the day.</p>	623	Lea
	<p>The course meant I could stay with mum and talk to her reasonably and calmly. It was taking a lot of energy underneath to hold it all together, but I did.</p>	426	Joy
	<p>So she tells me she wakes up every morning and her first thought is will I see Amy</p>	44	Amy

<p><b><u>Personal identification with relatives mental illness</u></b></p>	<p>today. And I find that quite a heavy thing to carry.</p> <p>so I guess talking about things in the terms of coping and how my family's dealing with it, it's really hard coz I think they all have something in some sense, and I think the hard bit for me was I think all of it, I was there in the middle and I think somehow I was the strongest of all of them and I still am and I think that was really hard coz I had to always show the face of being strong, the face of going forward, the face of keeping everything together, and I think when I moved to London, the whole idea was I wanted to escape, I didn't want to keep that. It was my idea, it was initially fleeing.</p>	246	Clare
	<p>A friend of mine was hallucinating; I started challenging my own sanity.</p> <p>because I was afraid of repeating her pattern and I think that kinda brought a lot of anxiety to me coz I put so much pressure on not breaking up with the person, having a good relationship, because if I didn't, I'd probably end up like my mum. Um, but yeh I've been able to work through it in therapy and I feel a lot more kind of relaxed in that area.</p>	312	Eve
	<p>I'm quite similar to my brother, when I was in a similar place as my brother, I was in</p>	534	Sue
		371	Zoe

	<p>this circle, in this bubble that he's in now, but I never went on medication and he did. I don't know if that makes a difference but I just went out set things up for myself and got myself out of it.</p> <p>Lots of placements in one go, I think I would have gone mad, I would have taken time out.</p> <p>Interestingly enough my grandmother was hospitalised because of a mental illness, so it's in the family. My mum's sister has suffered from depression for many years. There is something about that running through my life. Both my sisters have been diagnosed with depressions in the past, so it has had a massive impact. I haven't been clinically diagnosed with depression but I have felt really low. I've always considered myself highly anxious but I've improved.</p> <p>One of the things I became quite concerned about was my own mental health, coz I've got a history of my own personal addiction. It was nice to have a safe space to explore that. And I suppose in some way it was reassuring to know I was dealing with my neurosis already, so the chances of it escalating won't be anything like my mums. There's no reason that's going to happen to me, in fact I feel quite the opposite, because of the self awareness I have I can see myself coming and I know when I'm sort of behaving in way that's not healthy. Whereas my mum has no insight.</p>	<p>491</p> <p>440</p> <p>279</p>	<p>Pam</p> <p>Lea</p> <p>Joy</p>
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	<p>Always had the feeling as a child, and actually still do as an adult, it's as though she's going around policing that I don't go bad coz I've come from her side so I must be bad. And I think being able to recognise that's what's going on and that the impact that has on me is that I've kind of all my life had that negative voice and understanding where that's come from has been really helpful.</p> <p>I'm trying to get away, yeh it's not going away from a physical point of view coz it was overwhelming, now it's trying to get away from that life, wanting another script for myself, not wanting to end up like them, not wanting to not be close to anyone, not wanting to end up being pre-occupied with only myself or always lying or deceiving or manipulating, there's a lot of that when you live with someone who has this kind of mental health problems.</p>	487	Amy
		309	Clare
<p><b><u>Super-ordinate theme 3:</u></b> <b><u>Personal influence within a professional role</u></b></p> <p><b><u>Working with personal experience in a positive way in</u></b></p>	<p>With clients like relative, I become patient.</p>	202	Eve

<u><i>a professional environment</i></u>	coz I think it could be empowering to clients of ours to know that you can go through these things and completely come out of it and actually come out and be on the other side in helping others.	864	Sue
	When I have a client that's like my brother, I feel like I can empathise with him a lot more.	162	Zoe
	I have a greater understanding of all the family members positions in systemic work coz I've gone through such a systemic kind of work with my own family and I can deal with the complex personality coz I can understand it from my perspective. Having something like that happen to you, it changes, you have a different understanding then someone who hasn't ever experienced it.	351	Pam
	I can show more empathy, more understanding coz I've been there myself.	225	Lea
	it's just give me sort of an assurance that I can sit with people like that. I wonder if my experience with mum has made me more comfortable in that setting, because if you can deal with your own mother then surely you can deal with anyone.	536	Joy
	I think in working with clients, actually I've noticed that a lot of clients have had parents with mental health difficulties themselves. And I think that my own experience	276	Amy

<p><u><i>Working with personal experience in a negative way in</i></u></p>	<p>with my mother does help me to have an insight into what that is like and in a way, perhaps that makes me play it down. I've got an insight into that fact that living with a parent with mental health problems feels normal at the time, because it is normal. I think maybe if I hadn't been in that experience myself I'd be much more, I wouldn't understand that.</p> <p>I had two clients who had personality disorders and they were very destructive and complex clients and I actually had a very amazing therapeutic relationship with them. I think it was because I did accept that part of them, I did accept that they were self harming, I did accept that what they've been through, because they were not voicing. A lot of people with severe mental health problems don't voice always their problems because sometimes they're not aware of it, sometimes they don't want to say it, but I just felt like I could understand. Sitting in a room with them I just felt that you know, coming from the background that I come and seeing my brother the way he is, seeing my sisters and knowing what they've been through and why they are like that. I didn't just see their label, I just saw them as a person.</p> <p>With some clients I get inpatient.</p>	<p>1193</p> <p>202</p>	<p>Clare</p> <p>Eve</p>
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<u><i>a professional environment</i></u>	I think it is possible if I was to see a client, maybe that was doing that [alcoholic like mum], I'd probably think, snap out of it.	470	Sue
	I feel my attention span is a lot less than it is normally and I find it hard to deeply empathise I think with clients because I feel like my brain is still processing a lot of what is going on for me. And I know I am less tolerant I get frustrated a lot more.	115	Zoe
	With a client I suddenly realise how I feel and I'm angry sometimes with a client, coz I'm like oh you don't get it, coz that's something my sister would say as well. So yeh I think it did affect my client.	285	Lea
	With this client, I feel frustrated in a way because of my own issues, because she so wants to be loved by this mother, no matter what she does this person is just not seeing her. So in my head I'm thinking, can't you see there's no way? The best you do is moving away and protecting yourself, coz it's a similar situation. It's really painful to hear because I have tried as much as I could to help my mother and I couldn't. I feel my client's pain.	237	Joy
	you might also feel that it's challenging your own competence and your ability to help. I think any counsellor might feel like that. I think that perhaps for me, that path is very well worn, so I'm not saying that the feeling is not about that counselling situation, I'm	465	Amy

<p><b><u>Personal identification within an academic setting</u></b></p>	<p>just saying that because it's a place I've been in with my mum a lot of times, and feeling frustrated or feeling useless, that it's very easy for that feeling to be activated _____. And I think probably the training has helped me to recognise that. But I don't think you can work out what part of that feeling is to do with my mum and what part of that feeling is to do with, that's was it's like being with a client.</p>		
	<p>sometimes I think looking back at it, it was quite unsafe coz I didn't really understand boundaries as much. It wasn't like I was throwing myself at a client and telling them about my personal life. My brother has schizophrenia, I wasn't doing this things, I think there was a lot of me coming in.</p>	1103	Clare
	<p>one of my class mates just happened to be talking about their client and they said that they were domestically abused, and as soon as she said that they had been hit with a belt, which I know that happened with my mum and just hearing that, I mean if I had heard that perhaps a month before it would have been fine, but because that door had been opened that was really difficult</p>	427	Sue
<p>I had a lecture on attachment theory and it was extremely interesting to watch but slightly disturbing, of a distressed baby and an unresponsive mother, and there's always</p>	144	Lea	

	<p>a part of me as I've been doing all this thinking, that actually that happened to me. It's good to understand to be able to change but it's also painful when these things come, I am human after all, it is hurtful. I left the lecture feeling quite reflective, ambivalent feelings really.</p> <p>I remember being in a lecture here about medication and they talked about Resperidone and the side effects and my mother has some of these side effects. I had to leave the lecture in the end coz I was so upset, I didn't see it coming at all. But just the fact that she is on this medication, am I doing enough, should she be on the medication? You know is there anything else I can do and um, I suppose just feeling a bit hemmed in by the lecture. Being stuck there with this stuff going around in my head.</p> <p>And I suppose in so many ways thinking when we were doing attachment theory and that sort of thing, it's led me to question, oh I wonder what my attachment was like with my mother coz she was very depressed after I was born</p> <p>you do group therapy, you do the experiential, the fact that you do personal therapy and the fact that you do so much supervision, then somehow you're like faced with your problems, so like slapped in your faced and you have to talk about them. And we do talk about them in the class, we do talk about them in the group, it's just always like talking talking, always analysing and thinking and sometimes it doesn't give you any</p>	<p>193</p> <p>548</p> <p>25</p>	<p>Joy</p> <p>Amy</p> <p>Clare</p>
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<u><i>Personal identification with a counselling career</i></u>	room to breathe I think		
	Chose course because I thought it's good to talk about feelings, something never done in our family, you do stuff but you don't talk about how you do it	168	Eve
	She would always come to me for advice and even I remember one time, she asked me when I was about 8 years old whether she should marry her husband or, or well her boyfriend at the time and me telling her no, and giving her all the reasons why, because he was horrible and.. Umm, and so I always felt like I always had to take care of her, and um, it was yeh, it was really hard, and um, when....when I became a teenager, friends would come to me for advice and support, and they would say to me, wow you're really good at giving support and I kind of thought, oh well maybe I could do this as a profession, but kind of just like joke to myself. And then..I...realised when I was 15 that that was really what I wanted to do.	159	Sue
I would like to work with students. Personally, I don't think I want to be involved with this, what my brothers got because I don't think I understand it. I get too frustrated with it so I wouldn't want to go near those kinds of things.	438	Zoe	

	<p>I really enjoy systematic work, how we work as a system for my sister, maybe that's why I got so drawn to it, I didn't consciously decide I wanted to do family and systemic work, it just kinda happened.</p>	388	Pam
	<p>It came to my mind how this has impacted on my life, it has impacted to the point of my choice of career. I don't think I ended up in this profession by chance. I'm sure my family background has played a major part in my choice of career. I chose it to understand myself. I think most people in this profession seek to understand themselves and are called wounded healers. I wanted to understand my family dynamics.</p>	307	Lea
	<p>It's strange that it's the work that I feel comfortable doing, maybe that's where the link is. That it's just give me sort of an assurance that I can sit with people like that.</p>	536	Joy
	<p>I wanted to do this course because I think this is probably where my mother does fit it. I'd always be fascinated by how people think and why and I think my mum's depression is possibly what made me think about that. Why does she think in these ways, why does she get so anxious about things, are there different ways of thinking that might be more helpful?</p>	251	Amy
	<p>I think I'm fortunate, now I think I'm fortunate. I used to hate my background, I used to hate to have had that brother, I used to hate to have these sisters, but now I just feel like</p>	1651	Clare

	<p>it really created me as a person. It took me where I am. I wouldn't be in counselling psychology; perhaps I would be so self-consumed and be in fashion, I like fashion. I would most probably be like so shallow and not so deep and not so reflective, or like insightful and understanding.</p>		
<p><b><u>Super-ordinate theme 4:</u></b> <b><u>A space for personal development</u></b></p> <p><b><u>Developing personal insight through a professional role</u></b></p>	<p>I'm not aware of it, but if I put two things together it makes sense, I am probably trying to save him through working with other people who have mental health problems.</p> <p>My counselling role has helped me make sense of things. It's probably had the most, the biggest impact because going to therapy I'm able to sort these issues out on my own, myself.</p> <p>The course has helped me to pay attention to my inner processes, how I interpret things, make sense of things, learning to understand myself in a way that's helped me, finding out more about me and what was too much for me. Knowing who I was gave me inner</p>	<p>191</p> <p>662</p> <p>194</p>	<p>Eve</p> <p>Sue</p> <p>Zoe</p>

	<p>peace and that helps me to work with more patience, tolerance and acceptance.</p> <p>There is an ambivalence there because in a way I can explain but I can't change it. I have an explanation for my mother's behaviour but there is not much I can do so there is a sense of being helpless really. I can only understand but I can't change her, I can't make her seek help.</p> <p>Because of the frankness that this course has given me, I was able to talk to her frankly about some of my shortcomings (pause). She couldn't believe that someone would open up and share their vulnerabilities. That led me to think that she clearly had stuff going on for a long time and had no way to make herself vulnerable, who knows what she was bottling up.</p> <p>I remember when I was a teenager and she was quite sad, I had these kind of fantasies of being able to fix her, that I could help her. It's interesting, I don't have those anymore, and I don't quite know how I managed to move from that to recognising that she can't be fixed. But she can be helped which is different to being fixed. I don't quite know. It might have been when I went away to university and then actually did a doctorate and getting a bit of a distance and a perspective. I can't really remember. I can remember feeling very much like I wanted to fix her and support her and care for her and look after her. And that I don't feel it in the same way now but I don't quite</p>	<p>133</p> <p>300</p> <p>170</p>	<p>Lea</p> <p>Joy</p> <p>Amy</p>
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<u><i>Looking for personal support within a university setting</i></u>	<p>know how I made that move. But it is something that I struggle with and I have moved a lot since I've been on the course I think, the course has helped me to look at what's going on between us more clearly.</p> <p>I mean now, looking at it as a counselling psychologist, I can see how it developed in him</p>	89	Clare
	<p>Thought would look at relatives MH problems on course, surprised we didn't, why they want to become therapists is often related to your family.</p>	712	Eve
	<p>I didn't talk about it because you weren't supposed to, I never asked but it's kind of like unsaid. And I think, I really would have loved to, I would have been absolutely ok to, and it's something that nobody knows on the course but actually I talked about it in my interview, it just happened to come up when I was interviewing for here. It just happened to come up, I wasn't planning to whatsoever. And I still got the place, um, coz I did wonder you know, do they want somebody who's had this or are they gona think, oh god your loony, hmm, but</p>	876	Sue
	<p>The teachers, process groups, they were patient, gave us space to find our own answers</p>	204	Zoe

	<p>and tailor it to our needs, gave a valuing for ourselves which I respected in myself. With the self awareness I was able to draw a line between me and another person, to know what was my stuff and what was someone else's.</p> <p>Now bringing that up is good, but in your first year you're so cautious of being the good therapist, you just want to seem like you know what's going on, in supervision I don't want to talk about it, I don't want her to think I can't cope, I don't want her to think she's incompetent, whereas now, part of being competent is knowing you're struggling.</p> <p>I don't disclose that to too many people, people in my course, nobody knows that actually. People know I took a year off so I am rejoining a new group. So in this new group nobody really knows what is my wound. The other group, some people knew I have some kind of a troubled relationship with my family but they didn't know the details.</p> <p>My undergraduate degree let me know that mental illness wasn't to be feared. Being in this training or in this field has been a huge help more than a hindrance. When I talk to lecturers, it's nice to have been in a field where there's no stigma. You can say, I'm struggling in this lecture because it's bringing up stuff for me and I got a lot of support.</p>	<p>53</p> <p>471</p> <p>440</p>	<p>Pam</p> <p>Lea</p> <p>Joy</p>
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	<p>I wonder how much of it can they really take. How much of that can they really contain? If you really say everything that is there, would they really want you to be on that degree? Would they really think that you're suitable as a psychologist to work? But in fact when you meet a lot of psychologists, coz I've met a few psychologists coz I was looking for a personal therapist, I see a lot of them carrying a lot of the things that they don't really touch upon. Because I think you're supposed to voice only so much and then that's it, you can't go beyond that, you can't be this totally disorganised, traumatic traumatised person, you can have certain trauma and that's it. I mean maybe it's my experience that I think that of myself, I don't know, but sometimes I feel like that exists in the group, exists in the profession, and I guess it exists in the room when we talk about how you have to deal with your own things, you take it to supervision if something comes up about the client, you go and discuss it.</p>	835	Clare
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## Appendix 16: Transcript

P4

1 R: Ok, so, what training are you on right now? How are you  
 2 finding it, do you want to tell me a bit about it?  
 3 P: Ok, I'm on the, I'm on the counselling doctorate  
 4 programme and I'm in my 3<sup>rd</sup> year. Um, and, so yeh, a couple  
 5 months away, hopefully from.  
 6 R: And how are you finding it all? *- Difficult course.*  
 7 P: It's ok, it's really difficult, final year is completely *- Development of course over time.*  
 8 different to first and second year. I don't think there's *- Enormity of course.*  
 9 anything that quite prepares you for it, so it's kinda like you  
 10 can see the end but you can't so, it's really really hard, at the -  
 11 moment it's really hard.  
 12 R: Ok, so obviously my research is about having a close  
 13 family member or friend that does have a mental health  
 14 illness, um, what is your experience around that?  
 15 P: Ok, so, um, my younger sister, my little sister, um, she had *- Sister with an eating disorder.*  
 16 an eating disorder which was, it all came up in my first year *- Significance of social role within family.*  
 17 of training and so, I don't know, I was kinda like heavily *- Importance of time.*  
 18 involved compared to my other siblings. There's four of us *- Heavily involved.*  
 19 and um, I'm the closest, she's like number four I'm like *- Social comparison with siblings.*  
 20 number three, so I'm really close to her out of the four of us.  
 21 R: So she's the youngest.  
 22 P: Yeh she's the youngest, and I'm really close to her so a lot  
 23 fell on me coz I was in training I kinda knew things, my *- Forced responsibility.*  
 24 parents kinda relied upon me to bring things up, or to talk to *- Expectations from therapy role.*  
 25 her, or, I was the one who had to kind of help her emotionally *- Knowing more than family.*  
 26 as well as be the one that was, bridge the gap between my *- Expectations from family.*  
 27 parents and her as well, um, so yeh it was really, I don't *- Having no choice.*  
 28 know, it was horrible to be honest, it was really really *- Supporting sister.*  
 29 horrible coz it's like you go to your placements and you *- Bridging the gap.*  
 30 kinda shut that world off but you can't coz it's always there, *- Horrible experience.*  
 31 and at that time, I don't think I had anyone with eating *- Placement as an escape.*  
 32 disorders or anything like that but it's, but similar things, *- Holding experience.*  
 33 anything could trigger off your own thoughts and you'd be *- Contlescape.*  
 34 like, oh my god I'm thinking about this instead of thinking *- Impact on self.*  
*- Loss of control.*  
*- Loss of sense of self.*  
*- Intruding thoughts.*

- Diverted attention - taking away from client.  
 - Intruding thoughts - uncontrollable. 35  
 - Not wanting to talk about experience - forced. 36  
 - Significance of course year 4/1 - new  
 ↳ 'no one knew me' - isolated.

- Unable to share on Y1 of course.  
 - Felt alone.  
 - Unsupported.

- Time frame; more to deal with in 1st yr of course. Sense of development over the 3 yrs. 46

- Appearance; appearing as can cope 'a good therapist'. Importance of social perception.  
 - Hiding has an E.D.  
 - Hiding being unable to cope.  
 - Expectation from an unknown other. ↳ self?  
 - Sense of personal development/insight from Y1 to Y3 over time. ↳ sense of personal movement for P.  
 - Hidden self.  
 - Worry of others perception of self.  
 - Belief being able to cope shows she is competent.  
 - Personal development over the years! - movement, moving forward.  
 - Personal insight.

- 'she had it' - referring to E.D like it was something contagious.  
 - counter-transference with client.  
 - Uninvited memories.  
 - 'oh my god' - not knowing what to do - shouting out to god for help!  
 - 'supervision' - getting support, sharing.  
 - Honesty. Not hiding.  
 - Ability to talk about own stuff resulted in helping client more.

35 about my client. So things would come up and I would have  
 36 to take it to supervision but I don't really want to talk about  
 37 it, and then, so it was just really really horrible, and no one  
 38 like, it was right at the beginning so no one really knew me  
 39 on the course so I couldn't really be like oh my god, like how  
 40 I would now, I would be completely, if I was now I could  
 41 talk to people, but then you don't know anyone, you're still  
 42 starting off. Um, so I don't know if I had anyone in that  
 43 sense...I don't know.  
 44 R: And you said in supervision, you didn't really want to talk  
 45 about it, what was your experience about it then?  
 46 P: Yeh, because I think I was still um, in first year so you've  
 47 got all of that, now bringing that up is good, I'm  
 48 understanding my personal life, but in your first year you're  
 49 so cautious of being the good therapist, or you know, you  
 50 don't wana bring up your stuff, you just want to seem like  
 51 you know what's going on, you've got this expectation, you  
 52 don't quite understand it as much as I would now, or the  
 53 insight I have to it now. But then in supervision, I don't want  
 54 to talk about, I don't want her to think that I can't cope, I  
 55 don't want her to think, oh my god she's so incompetent, you  
 56 know, coz in your first year you're so worried about it,  
 57 whereas now, I'd be like, that's part of being competent,  
 58 knowing that you have troubles or you're struggling or  
 59 whatever.  
 60 R: So, now being in your third year, how do you feel talking  
 61 to your supervisor about that?  
 62 P: I would feel a lot, I had recently a client that had  
 63 something like that come up, like she had it, I was like oh my  
 64 god this brought back so many memories, and so I took it to  
 65 supervision and I was able to say exactly everything that  
 66 happened, like with my family, but it helped me to give  
 67 another level of insight to my client work, and I felt really  
 68 comfortable, so it was a completely different experience to

- Sister eclipses client.  
 - Personal in therapy session.  
 - Being ethical.  
 - Sharing personal.  
 - Time frame of course.  
 - Sense of isolation.  
 - Not sharing.  
 - Isolated.  
 - Unsupported.  
 - Time frame of course.  
 - Development on course.  
 - Understanding personal on course.  
 - Expectations of self.  
 - Importance of social perception.  
 - Hidden self.  
 - Understanding/insight over time.  
 - Importance of social perception.  
 - Hidden self.  
 - Problems mean incompetency.  
 - Personal development over time.  
 - MI as something contagious  
 - Insight into counter-transference.  
 - Intruding memories.  
 - Sharing personal.  
 - Personal impact on client.

Personal development from Yr1 to Yr3 of course movement. ↳ insight into personal journey.

69 how it would have been in my first year, or how it was in my first year.

- Personal development over time. - Insight into personal journey.

71 R: Ok. Talking about the course, obviously you're on your third year now, and you have developed, you have learnt a lot academically, how do you feel the course may have impacted your relationship between you and your sister? Or how your sister impacted the relationship between you and the course.

- 'weird' 'hard' wanting to be ss therapist. ↳ applying therapy techniques.

76 P: Yeh, I don't know it's hard, it's really weird because you're like, I'm like her sister but I also want to be her therapist, and so when I talk to her, I start doing CBT and I'm like, no I'm her sister, so it's really hard to be like what

- 'hard' 'weird' sister v.s therapy role.

- battling with self to stay in the sister role. - struggling with identity at home. ↳ figuring out what position to take in a new situation.

79 position am I taking up, I don't know, who am I to her, who am I trying to be. And I felt like oh, I should be the therapist because that's who I am, that's what I'm doing, so I should

- Struggling with identity.

- Questioning own identity. Old identity doesn't fit anymore, figuring out new one.

81 be the one who's like no come on think about this and do like crisis plans around helping her, and when things got really

- Self-expectations. - Taking on therapy role.

- Expectations from self to be ss therapist - to help sister. (20) - combination of two positions recognising herself in relation to sister.

83 serious and we went to see her GP and saw the doctors and stuff, um, my parents were kind of, not push me, but their

- Parents expecting from P-relying on her. - 'push me' - forced requests from parents. - complying with parents expectation.

85 expectations of me, they would kind of push me to ask questions, like, coz they were like oh I would know, and so it was really really hard, yeh, so that was really really difficult.

- Expectations from parents.

- Forced to help.

- 'hard' 'difficult'. - repetition of word 'really' indicating how heavy it was.

87 R: Ok, um, yeh so you said that your parents had a view of you or an expectation of you, so what was your experience around that?

- Difficulty of therapy role.

- 'split' - separated, not whole ↳ split person, split feelings.

93 P: I felt pressured, I felt like split, like a split person, like I'm the sister, I'm her sister but I'm also expected from my parents and from everyone else to be the one who

- 'Split person'.

- Sister v.s therapy role.

- 'pressured' - heavy. - Identifying with sister role, others see therapy role - different perception to others. - expectations from others to take therapy role with sister.

94 understands psychologically what's going on for her, to ask the right questions to the doctor, what therapeutic support is she going to get, what groups is she going to attend, what's

- 'Pressured'.

- Expectations from parents.

- 'ask the right questions' - responsibility to get the right help.

96 her like, you know we met the dietician and they were like oh as her oh what kind of foods will help lift her mood. How am I supposed to know, you know.

- Knowledge as beyond self.

- Recognising the knowledge is beyond her - knowledge should belong to her parents? P seeing herself as like sister - not meant to know what to do.

101 R: Hmm

- Not knowing.

- both sides of the split  
 - 'couldn't hold both' - too heavy/big  
 - to be sister & therapist.  
 - 'horrible!  
 - Questioning how she could be  
 - sister & therapist having to choose one?  
 - wanting to be the sister, having to be the  
 - therapist  
 - Recognising the knowledge to  
 - understand J is beyond her.  
 - 'fuck' - angry emotion.  
 - Not knowing how to help but  
 - expected to.  
 - 'had to' - forced, expected.  
 - 'no I get it' - hiding true feelings  
 - to meet other's expectations.  
 - Not wanting to be the therapist.  
 - (ins) - suppressing own emotions.  
 - wanting to show true emotions.  
 - Questioning sister's behaviour.  
 - ↳ being in the sister role.  
 - wanting to forget - coping, avoidance.  
 - Not wanting to repress true feelings  
 - ↳ repressed anger.  
 - 'your' - speaking as if talking to Snow  
 - Very real to P, very much still raw  
 - to her  
 - Overwhelmed with therapist vs  
 - sister battle, finding identity.  
 - Feeling separated from family.  
 - Unable to share emotions  
 - Family responded like family but  
 - she couldn't - was supposed to  
 - understand - combine understanding  
 - with rationality.  
 - Expectations from sister to  
 - understand her.  
 - Top role was heavy to wear -  
 - burden - others' expectations.  
 - 'holding so much' - heavy.  
 - hidden self, loss of identity.  
 - 'covered up' - hidden self.  
 - 'optta' - putting expectations  
 - on self.  
 - 'holds her' - heavy language used.  
 - Tiring to hold something  
 - continuously.  
 - Top role covered sister role.  
 - Expectations because of top role.  
 - 'unfair!' - disregard from others for P's  
 - own needs.  
 - 'act' - being someone else. Hidden  
 - self.  
 - not knowing how to help sister -  
 - hidden feelings.  
 - No choice, forced.  
 - Loss of control.  
 - Family responsibility.

103 P: I couldn't do both, I couldn't hold both, and I felt, it was  
 104 so horrible, coz how can I be both, how can I be, and I  
 105 wanted to be the sister, I don't know, I don't know what the  
 106 fuck is going on with you, you know.  
 107 R: Yeh  
 108 P: I don't know how to make you eat, you know, but yet I  
 109 had to be, no I get it, and I don't want to be that, I don't want  
 110 to be the rational one.  
 111 R: What did you want to be?  
 112 P: Just the sister who is pissed off with her. Like how can you  
 113 do that, you know you kinda wana forget she's  
 114 psychologically unwell, but I just wanted to be the one who  
 115 was like I'm pissed off what are you doing, just put food in  
 116 your mouth.  
 117 R: Yeh  
 118 P: You know like completely be the sister, like how my  
 119 parents were reacting and my other sisters, yet I had to be the  
 120 one who was like no you should understand, and she would  
 121 say that to me, you should understand, you should understand  
 122 what I'm going through.  
 123 R: What was stopping you from saying that to her and  
 124 shouting at her and saying just eat?  
 125 P: Because, I was so kind of, I don't know, burdened with  
 126 that, expectations of, I was holding so much of that that I  
 127 couldn't allow myself just to be, I was so covered up with ok  
 128 I've gotta be the one who holds her, contains her, you know,  
 129 does understand her, gets why she goes through this coz I've  
 130 learnt about it through uni or I've learnt about it through  
 131 whatever  
 132 R: Yeh  
 133 P: that's, it was really unfair coz it's like no but I don't, I  
 134 don't know, but yet I had to act like I did or I had to just deal  
 135 with it. I had to help my parents find a therapist, I don't want  
 136 to help you find, I don't wana do that

- Split roles.  
 - Heaviness of two roles.  
 - 'Horrible'  
 - Questioning others' expectations of self.  
 - Sister vs therapy role.  
 - Not knowing.  
 - Expectations from others.  
 - Forced.  
 - Hidden self.  
 - Limitations of therapy role.  
 - Hidden self.  
 - Suppressed emotions.  
 - Sister vs therapy role.  
 - Intense emotions.  
 - Active emotions.  
 - Loss of control.  
 - Separate from family.  
 - Suppressed emotions.  
 - Expectations from family.  
 - Expectations from sister.  
 - 'Burdened'.  
 - Expectations from family.  
 - Hidden self.  
 - Loss of self.  
 - Self expectations.  
 - Therapy role as heavy.  
 - Unfairly treated.  
 - Not seen.  
 - Hidden self.  
 - Not knowing how to help.  
 - Loss of control.  
 - Expected responsibility.

- Expectations from parents & sister.  
 - cultural differences by bridging the gap between parents' culture & culture of M.I.  
 - Parents not understanding M.I.

- Parents not understanding E.D. - not equipped to help daughter.

- Parents black & white thinking.  
 'theres that' - what? P didn't elaborate, may reflect the kippur but unspoken culture at home.  
 - bridging this gap - keeping the family connected, given a huge responsibility, helping family understand.  
 - Educating parents about M.I.

- E.D. is not real to parents; the impossible topic of making parents understand something that is not real.  
 - 'I don't know anyone' - parents haven't seen it before.  
 - cultural expectations!

- Empathising with family - family not empathising with her.

- Responsibility put on self to talk about what family couldn't talk about. - 'had to' - gave self go choice.

silence - bridging the silence.  
 - 'weird' - alien situation.  
 - sisters able to just be sister.

- Taking on responsibility to be sisters therapist.  
 ↳ self-expectations.

137 R: Hmm. And you said the expectation, you used that word,  
 138 where is that coming from you or is it coming from your  
 139 parents, or is it both, where did that expectation come from?

140 P: I think from parents, I think from her as well, my parents  
 141 and her, um....because a lot of it is like, a lot of the stuff is  
 142 like culture, in the sense that my parents don't really  
 143 understand

Expectations from family.

- Not understanding of a cultural difference.

144 R: Ok

145 P: They don't really understand eating disorders, they don't  
 146 get it. In the sense that they're like, what you just eat.

- Parents not understanding E.D.

147 R: Yeh

148 P: What can be wrong with you that you don't eat? You  
 149 know, there's that, so I was the one who was bridging this  
 150 gap between my sister trying to explain what's going on, and  
 151 them like, I don't get it, I've never heard of this before what  
 152 the hell is this

- Culture as a presence

- Bridging the gap.  
 - Huge responsibility.

- Parents not understanding E.D.

153 R: Hmm

154 P: you know this doesn't exist, I don't know anyone, trying  
 155 to make them understand, this is what people go through, this  
 156 happens, and this is why, and this is what we should do.

- Parents not seeing M.I.

157 R: yeh

158 P: That, the expectations came from all of that, like the  
 159 cultural, the family stuff. And it's all a bit, I don't know  
 160 maybe they found it really hard as well, my sister found it

- Cultural expectations.  
 - Family expectations.

161 really hard to talk about it, my parents found it really hard to  
 162 talk about it so I had to talk about it, and my other two sisters,  
 163 I don't know..it was really weird, it's really weird because

- Unspoken.  
 - Avoidance as a coping mechanism.  
 - Putting responsibility on self.

164 my oldest, the oldest one, she's a doctor, but she, she kind of  
 165 like stayed out but she was able to just be the sister, she  
 166 didn't ever bring in her work, like oh let me help you, you

- Bridging the silence.  
 - Conflict in siblings role.  
 - Forced therapy role.

167 know medically, but yet I'd put it on myself to do the  
 168 counselling

- Taking responsibility.  
 - Therapy role at home.

169 R: Here you're saying you'd put it on yourself whereas  
 170 before you said your parents put it on you.

**Appendix 17: Chronological order of themes; Participant four**

Line Number	Theme
1	
2	
3	
4	
5	
6	Difficult course
7	Development of course over time
8	Enormity of course
9	
10	
11	
12	
13	
14	
15	Sister with an eating disorder
16	Significant of social role within family
17	Importance of time
18	‘Heavily involved’
19	Social comparison with siblings
20	
21	
22	
23	Forced responsibility
24	Expectations from therapy role
25	Knowing more than family
26	Expectations from family
27	Having no choice
28	Supporting sister

29	'Bridging the gap'
30	'Horrible experience'
31	Placement as an escape
32	Holding experience
33	Can't escape
34	Impact on self
35	Loss of control
36	Loss of sense of self
37	Intruding thoughts
38	Sister eclipses client
39	Personal in therapy session
40	Being ethical
41	Sharing personal
42	Time frame of course
43	Sense of isolation
44	Not sharing
45	Isolated
46	Unsupported
47	Time frame of course
48	Development on course
49	Understanding personal on course
50	Expectations of self
51	Importance of social perception
52	Hidden self
53	Understanding/insight over time
54	Importance of social perception
55	Hidden self
56	Problems mean incompetency
57	Personal development over time
58	
59	
60	
61	

62	MI as something contagious
63	
64	Insight into counter-transference
65	Intruding memories
66	Sharing personal
67	Personal impact on client
68	
69	Personal development over time
70	Insight into personal journey
71	
72	
73	
74	
75	
76	‘Hard’
77	‘Weird’
78	Sister vs. therapy role
79	
80	Struggling with identity
81	
82	
83	Self-expectations
84	Taking on therapy role
85	
86	
87	Expectations from parents
89	Forced to help
90	Difficulty of therapy role
91	
92	
93	‘Split person’
94	Sisters vs. therapy role
95	‘Pressured’

96	
97	Expectations from parents
98	
99	
100	Knowledge as beyond self
101	Not knowing
102	
103	Split roles
104	Heaviness of two roles
105	'Horrible'
106	Questioning others expectations of self
107	Sisters vs. therapy role
108	Not knowing
109	Expectations from others
110	Forced
111	Hidden self
112	Limitations of therapy role
113	Hidden self
114	Suppressed emotions
115	Sisters vs. therapy role
116	Intense emotions
117	Loss of control
118	Separate from family
119	Suppressed emotions
120	Expectations from family
121	Expectations from sister
122	
123	
124	
125	'Burdened'
126	Expectations from family
127	Hidden self
128	Loss of self

129	Self-expectations
130	Therapy role as heavy
131	
132	
133	Unfairly treated
134	Not seen
135	Hidden self
136	Not knowing how to help
137	Loss of control
138	Expected responsibility
139	
140	Expectations from family
141	
142	Not understanding as a cultural difference
143	
144	
145	Parents not understanding E.D
146	
147	
148	Culture as a presence
149	
150	'Bridging the gap'
151	Huge responsibility
152	Parents not understanding E.D
153	
154	Parents not seeing
155	
156	
157	
158	Cultural expectations
159	Family expectations
160	Unspoken
161	Avoidance as a coping mechanism

162	Putting responsibility on self
163	'Bridging' the silence
164	Conflict in siblings role
165	Forced therapy role
166	
167	
168	Taking responsibility
169	Therapy role at home
170	
171	Accepting others expectations of self
172	
173	Accepted therapy role at home
174	Forced therapy role
175	Hidden self
176	
177	
178	
179	Suppressed feelings
180	Sister vs. therapy role
181	Loss of control
182	Sense of separation from family
183	
184	
185	Not wanting the responsibility
186	Hidden self
187	
188	
189	
190	Negative impact of therapy role on relationship
191	
192	Separate from family
193	Therapy role as exposing
194	

195	
196	Therapy role as unprotecting
197	
198	Despising therapy role
199	Understanding through course
200	
201	
202	Therapy role as 'exposing'
203	
204	Separate from family
205	Negative impact of therapy role on relationship
206	
207	Loss of sister role
208	Misuse of therapy skills
209	
210	
211	Seeking understanding
212	
213	
214	Negative impact of therapy role on relationship
215	Separated from family
216	
217	
218	
219	Negative impact of therapy role on relationship
220	
221	
222	
223	
224	Analysing sisters behaviours
225	Natural therapist
226	
227	Negative impact of therapy role on relationship

228	
229	
230	Sister vs. therapy role
231	Forced therapy role
232	Blurred roles
233	Wanting to be the sister
234	
235	
236	
237	
238	Negative impact of therapy role on relationship
239	
240	Changed relationship
241	Hidden MI
242	Shut out
243	Conflicting views between roles
244	Hidden MI
245	Separate from family
246	
247	Rejected therapy role
248	
249	Expectations of self
250	
251	
252	
253	
254	
255	
256	
257	
258	Countertransference
259	Silenced by family
260	Increased empathy

261	Impact of experience in client session
262	
263	Increased insight in client session
264	Countertransference
265	
266	Hidden feelings in client session
267	
268	
269	Countertransference
270	Resonating with client
271	
272	
273	Stationary amongst thoughts
274	Development of self awareness
275	
276	
277	
278	
279	
280	Countertransference
281	
282	Misunderstood
283	Using supervision
284	
285	Countertransference
286	
287	
288	Personal impact on client
289	
290	Recognising professional limitations
291	Personal spill-over at work
292	
293	Actively improving self

294	
295	Actively improving self
296	Seeing an end to MI
297	Split self
298	Sisters vs. therapy role
299	Recognising professional limitations
300	Questioning own identity
301	Separated from sister
302	
303	Being sisters therapist
304	Sister vs. therapy role
305	
306	
307	Recognising professional limitations
308	
309	
310	Improving personal through therapy
311	
312	Resistance in talking
313	
314	Recognising professional limitations
315	Being ethically safe
316	
317	
318	
319	
320	E.D as professionally manageable
321	
322	
323	
324	
325	
326	

327	
328	Countertransference
329	Being ethically safe
330	Supervision for support
331	Personal therapy for support
332	Personal development over time
333	
334	Boundaries
335	Affirming therapy role
336	Separating parts of self
337	Wounded healer
338	Expectations of self
339	Therapy as ‘serving’ role
340	
341	
342	Benefiting from supervision and personal therapy
343	
344	Recognising professional limitations
345	
346	
347	
348	
349	
350	
351	Impact of personal on professional
352	
353	
354	
355	Personal experience as a moving process
356	
357	Impact of personal on professional
358	
359	

360	
361	Increased insight with client
362	
363	
364	
365	A different perspective
366	Personal and professional development
367	Using personal in client session
368	Wounded healer
369	
370	
371	
372	No control over situation
373	Self in a caring role
374	Making sense of self
375	Impact of experience on self
376	Different to others
377	
378	
379	
380	
381	Deeper insight from personal
382	Different to others
383	The self as a resource
384	'So close' to MI
385	No control over situation
386	
387	
388	Wounded healer
389	Rewarding
390	No control over situation
391	Shared responsibility
392	Conflicting thoughts

393	Unconscious process
394	
395	
396	Wounded healer
397	Unconscious process
398	
399	Self-reflection
400	Personal growth
401	
402	
403	Interest in others experience
404	
405	'Weird'
406	Interview as space for personal
407	
408	Interview giving a different space
409	
410	
411	Supervision serves client
412	
413	
414	
415	
416	Personal therapy serving self
417	Interview giving complete space
418	
419	
420	
421	
422	
423	Triggered emotional
424	
425	

426	Intense emotions
427	Carrying the anger
428	Burden
429	Repressed anger
430	Making sense of self
431	
432	Expectations to care
433	
434	Expectations of therapy role
435	
436	Repressed self
437	Repressed anger
438	Hidden self
439	Separate from family
440	Sister vs. therapy role
441	Therapy role expectations
442	Forced self
443	Suppressed emotions
444	Expectations from family
445	Therapy role as 'automatic'
446	
447	Accepting therapy role
448	
449	
450	Experience embedded in time
451	MI as always there
452	Ignoring self
453	Development of MI over time
454	Relapse anxiety
455	
456	Ignoring self
457	
458	

459	Hidden emotions
460	
461	Sharing emotions
462	Seen as separate from family
463	Experience embedded in time
464	Alone with experience
465	Burden
466	Hidden emotions
467	
468	A sense of not moving forward
469	Realisation in interview
470	Intense emotions
471	'Pushing away' as a coping mechanism
472	Emotional triggers
473	Impact of experience on personal
474	Questioning identity
475	Unconscious revelation
476	
477	
478	Feeling trapped
479	Loss of control
480	Wanting to be different
481	Impact of experience on family
482	'Living in' MI experience
483	Losing self
484	Loss of own life
485	
486	Blocking as a coping mechanism
487	
488	
489	
490	
491	Fear of own MI developing

492	Self-care
493	Placement as an escape
494	Blocking self out
495	
496	Separating parts of self
497	
498	
499	
500	Personal growth over time
501	Analysing self
502	
503	
504	
505	
506	Split self as a coping mechanism
507	Hidden self
508	Split self
509	Silence
510	Pretending as a coping mechanism
511	
512	
513	
514	Whole self as more manageable
515	Understanding self better
516	
517	Placement and course as growth promoting
518	
519	
520	Being the sister
521	Being own therapist
522	Using personal experience positively
523	
524	Personal development over time

525	'Different' self
526	
527	Child vs. adult
528	Self-awareness
529	Personal change
530	MH experience as an active process
531	Personal change from experience
532	Professional change from experience
533	'Different' self
534	
535	
536	
537	Wanting to know others experience
538	
539	
540	Sharing with others
541	
542	
543	
544	
545	
546	
547	
548	
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550	
551	
552	
553	
554	
555	
556	Separating self through language used
557	Unspoken

558	
559	Unsupported at university
560	Benefits of a wounded healer
561	
562	Not seen
563	
564	
565	
566	
567	Wounded healer
568	
569	Impact of experience on self
570	Found personal identity
571	Found professional identity
572	Loss of control through course
573	Course encouraging split self
574	Personal therapy encouraging a split self
575	Unspoken
576	
577	
578	
579	
580	
581	
582	
583	
584	Unspoken personal on course
585	
586	
587	Worry of social perception
588	
589	MI 'experience happened to me'
590	No control

591	
592	Worry of others perception
593	Hidden MI
594	Hidden self
595	
596	
597	
598	
599	
600	Anger
601	Rejected therapy role
602	Impact of therapy role on relationship
603	Lost hope
604	Permanent changes
605	Wishful thinking
606	Expectations from others
607	Not knowing
608	Sister vs. therapy role
609	Suppressed self
610	Not coping well
611	Therapy role as part of identity
612	Forced expectations
613	Huge responsibility
614	Burden
615	Heavy
616	Tiring
617	Therapy vs. sister role
618	Therapist spill over
619	Self-care
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623	Self-care

624	Intruding home life
625	Constant worry
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628	Burnout
629	Forced expectations
630	Suppressed self
631	A sense of difficult journeys
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633	Personal development through course
634	Self-care
635	Progression of a better self
636	Personal development over time
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639	Changing through course
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642	Developing sense of self on course
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644	Personal growth
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647	Personal development over time
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649	Not hidden
650	Changing perception
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656	Career interests

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659	Expecting the unexpected
660	Worry
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662	Learning from experience
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664	E.D as permanent
665	E.D as continuous battle
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667	Permanent caring role
668	Expectation of self
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670	Sister vs. therapy role
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672	Being the sister
673	Using laughter to deflect difficult emotions
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675	Caring as 'hard'
676	Therapy role as part of identity
677	Therapy role with friends
678	Therapy role as automatic
679	Therapy role part of identity
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682	Self-expectations
683	Therapy role as out of her control
684	Therapy role as a sense of duty
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688	Speaking about the 'whole' not parts
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690	Hidden
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699	Reflecting through interview