Balancing empathic and questioning hermeneutics in therapy: Client expectations and practitioner responses

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City University Declaration

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Section A: Preface

This preface will introduce and summarise the three components of thesis Doctoral Thesis Portfolio. Each of these investigates the importance in therapeutic practice of balancing suspicious and empathic hermeneutics (as defined by Ricoeur, 1970) in responding to client need. Therapists predisposed to a suspicious or questioning perspective tend towards a greater emphasis on their own expertise and training. Those taking a more empathic position emphasise closeness to the client's subjective sense-making and the importance of the intersubjective space. These are believed to be crucial therapist decisions. The studies here aim to throw light on the impact of choices within this dialectic; on their influence on client engagement, the alliance, process and the success of therapy.

In terms of assessing these practitioner choices and behaviours, the studies here are based on a belief there is only one appropriate point of reference – that of the client. Apart from the relatively rare cases where the safety of others needs to take priority, the client's subjective perspective of what is helpful is surely what therapy exists to address. This is a perspective taken in counselling psychology as a discipline. It is based on the humanistic principle that clients and people in general are goal-oriented agents, capable of directing their own lives according to individually held systems of meaning.

In personal terms, my interest in the degree of emphasis given in clinical practice to the client's perspective arises from contact that I had with therapists before I decided to enter the profession. This contact was both direct, in experience as a client, and indirect, through hearing of others' experiences. What I learned left me with a feeling that there may be a disparity between the public idea of how therapy should work (vague though this may sometimes be) and views within the profession. The accuracy of this belief, the way it is experienced by clients and the ways therapists can respond were principal interests underlying the portfolio. These interests guided the choice of a phenomenological approach in the first section of the portfolio, the Doctoral Research Project.

Doctoral Research

The empirical study below is entitled Balancing empathic and questioning hermeneutics in therapy: Client expectations and practitioner responses. It aims to understand instances during therapy which involved clients' expectations. It hopes to shed light on the sense they made of these instances. As such the research focuses on the nature of the expectations clients brought and their feelings and meaning-making associated with these during therapy. Expectations were conceptualised as encompassing what clients want, what they believe will help them and what they think is likely to happen in therapy. It was believed that expectancy is deeply related to client agency. For this reason better understanding of the ways clients experienced their expectations could illuminate how client agency is facilitated or constrained, adding to understanding of a fundamental aspect therapy. Specifically, therapist positions concerning engagement with client expectancy were of interest. These could be seen as hermeneutic stances on a continuum between suspicion and empathy.

The research focuses on relational therapies because it was believed these may allow a broader range of therapist decision making than more structured therapies. Their emphasis on the therapeutic relationship was seen as potentially giving practitioners more choices than therapies where directive approaches and specific techniques are applied. Accordingly the client experience of a corresponding range of therapist hermeneutics could be accessed and the implications for practice examined.

Interpretative Phenomenological Analysis (IPA) was chosen as the research method precisely because it aims to understand the meanings individuals attach to their lived experiences – both through phenomenological analysis and through a more questioning interpretative stance. The former emphasises empathy while the latter is more suspicious, comparing the experiences described with those of other participants, with the understanding of the researcher and with the relevant literature. The choice of research method and questions were also guided by the shortage of literature prioritising the client's perspective in general and the experience of expectancy in particular.

Clinical Study

This study examines ways therapist responses impacted on an individual client's experiences. It recognises that ideas discussed in the research above need to be tested in the "real world" of clinical practice. It aims to investigate the operation of therapist hermeneutics where there are pressures to conform to service contexts governing length of treatment, approach taken, protocols to apply, administrative procedures and more, all of which may constrain therapist choices.

It also seeks to understand the extent to which this dialectic is cross-cutting, applying in any and all therapeutic approaches. Choosing a case study where CBT was used offered a very different context to relational approaches in which to examine the same phenomenon. Therapists' freedom to respond empathically in a service committed to CBT protocols was a specific focus. Would this commitment inevitably necessitate a greater emphasis on knowledge gained outside of the immediate therapeutic experience, i.e., on a hermeneutic of suspicion? If the balance within this dialectic is proposed to be a crucial influence on engagement, alliance and outcome, it would be important to understand how this may be achieved in contrasting therapeutic approaches.

The case chosen added an extra dimension to this study. The client concerned has a scientific background from her training but was highly emotional about her difficulties. As such, her own internal processes paralleled the therapist hermeneutics under investigation. Like her therapist, she had to manage and negotiate between expectations driven by a need for empathy and those requiring a more detached, knowledge-driven stance. The study therefore aimed to examine the interplay of this dialectic between and within client and therapist and its impact across therapy.

The clinical study is titled "Applying cognitive behaviour therapy: A practice-based case study examining flexibility of approach in a given service context". It examines work with one client, over 13 weeks, in an Improving Access to Psychological Therapies (IAPT) service, where use of cognitive behaviour therapy (CBT) protocols is policy. Despite the clear constraints, working in this service allowed a degree of discretion in how the protocols were applied, in personal manner and in the use of

“Third Wave” cognitive behavioural methods. Further complicating the picture, ideas from person-centred thinking (as outlined by Rogers, 1951) are to a degree accepted within CBT too. Beck (1976) said that empathy, rapport and warmth were basic to his model as well as to others. The actual extent to which such traditionally client-centred principles are applied is something of a grey area and discretion is also exercised in this regard.

Paper for Publication

This paper represents the intention to have the findings and ideas from the empirical work more widely considered in the field., in particular the value of re-balanced hermeneutics in therapy If the ideas generated are to influence practice or research, publication is the obvious route. Accordingly, the paper is titled: Balancing empathic and questioning hermeneutics in therapy: Client and practitioner perspectives. Due to the limitations of space in academic journals, it was felt best to focus on specific themes within the overall findings. Participants’ descriptions of the way they experienced their expectations are organised into five themes in the research, and the paper highlighted two of these: Therapist as Leader and Therapist as Facilitator.

The participants’ expectations of therapist lead-taking may in some ways be seen as novel. While they overlap with the well-known notion of directiveness, the descriptions of this expectation also include interventions like opinion-sharing, telling clients the way forward and arbitrating on right and wrong. In contrast, participants’ experiences of expectations relating to therapist facilitation shed light on ways this contrasting approach is appreciated by clients – and also on ways it may was negatively perceived. These themes illustrated the importance of both therapist and client hermeneutics. Links traced between these and engagement, the alliance, therapeutic process and overall outcome in therapy are felt worthy of attention from practitioners and researchers. The findings represent a challenge to certain traditions of thought in the field and one, it is believed here, that offers possibilities for improving the care of clients.

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Section B: Doctoral Research.

Balancing empathic and questioning hermeneutics in therapy: Client expectations and practitioner responses.

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Supervised by Dr Susan Maise Strauss

Abstract

This study aims to understand how clients' expectations of therapy are experienced during the therapeutic process. It aims to explore the kinds of expectations clients bring as well as what happens to these and because of them, but above all the aim is to understand how this feels for clients and what sense they make of it. Much of the existing literature consists of questionnaire-based research, asking clients to choose between quantifiable options identifying types of expectations and how these correlate with types of outcome. However, anecdotal evidence from clinical practice suggests that clients may arrive with a very vague notion, at best, of what they are signing up for. This can mean negligible knowledge of elements central to therapy such as what the process involves, what kind of relationship to expect with the therapist or what will be expected of the client him or herself.

If clients do arrive with a lack of information, together with (sometimes intense) need, it is felt that there is a clear responsibility on the therapist to respond to this. One way therapists can do so is by taking the time to ask about expectations, including those to do with process and relationship as well as goals. They can listen to clients' responses and on that basis, it seems reasonable, they can explain and negotiate a suitable, agreed approach at the beginning of therapy. But how often therapists prioritise such concerns when faced with other priorities (including the need for assessment and formulation, time constraints, earning a living, logistics, contracting and a client's immediate emotional needs) is an important question. It was the belief that client expectations, though crucial, may sometimes be neglected that led to this research.

Importantly, lack of clarity in clients' pre-therapy expectations can be replaced by post-hoc certainty about what they *would* have wanted had they known more. For the current study this raised questions about how best to investigate expectancy. Ask clients before they start and they may say something akin to "I don't know"; ask them afterwards and they may be in a position to draw on retrospective understanding not available to them earlier. Asking beforehand also risks contaminating or influencing the very subject being explored – as well as the therapy itself. For this reason, while it may seem perverse to ask about client expectations

after therapy, hindsight is seen as providing a valuable route to understanding how clients experience their assumptions, predictions, hopes, fears and guesses – their expectations overall.

This is not to argue that expectations are not there before therapy begins. Some may arise during the process but others may be present beforehand. Others still may have been present earlier but only become clear when illuminated by the experience of therapy. This growth in clarity can be central to progress in therapy but can also undermine it and lead to dropout where expectations are not fulfilled. In person-centred terms, expectations can be seen as the first step towards expression of the self-actualising tendency (Rogers, 2004), the most basic starting point of agency. Awareness of expectations can make it possible to work with this force and achieve transformation in therapy. Neglecting expectations can be tantamount to opposing the same drive, thwarting progress and potentially leading to dropout from therapy.

Due to the sometimes elusive and always deeply subjective nature of expectations, clients are asked here to give accounts of their experience in their own words. This means that qualitative methods are seen as appropriate, in particular Interpretative Phenomenological Analysis because this maximises access to the client's subjective sense while balancing this with a capacity to stand back and attempt to bring objectivity to bear as well. Better recognition and understanding of these experiences are likely to help therapists empower their clients and facilitate commitment, engagement, agency and other goals in therapy, as well as improve the overall outcome.

In these ways understanding how clients experience their expectations of therapy during therapy is centrally relevant to counselling psychology and its philosophical bases in phenomenology, humanism and existentialism. In particular it is relevant to the value counselling psychology places on the client's subjective perspective and on the necessity of engaging with this, as well as the core priority it places on understanding and nurturing the therapeutic relationship (Woolfe, 2012).

Introduction

This chapter discusses the concept of client expectations of therapy and considers the literature concerning their importance. It identifies areas where little is known about the subject. It takes a perspective on why these gaps in our understanding can have a direct bearing on crucial aspects of therapy, including outcome, on why they matter to counselling psychology in particular, and how they have helped frame the research questions. Relevance to therapeutic practice and the client's experience and perspective guide the focus taken below.

Defining Expectations

While research indicates that clients' expectations appear to be important and influential in the experience and outcome of therapy, fundamental uncertainties persist concerning their nature, origins and scope. Working definitions abound and expectancy is described, for example, as the client's sense of the likelihood of occurrences during therapy (Watsford, Rickwood, & Vanags, 2013), behaviours thought likely to happen (Arnkoff, Glass, & Shapiro, 2002) and beliefs about what will occur during therapy or about the outcome of therapy (Constantino, Ametrano, & Greenberg, 2012). Expectations have been differentiated from the related and overlapping concept of preference. The latter, according to Swift, Callahan, and Vollmer (2011), concerns what is wanted or thought valuable in therapy and this description is also applicable to what the client hopes for. Unlike preference expectations often, but not necessarily, include a consideration of the likelihood that something envisaged will occur. What is preferred can constitute an expectation, especially where this is unconscious and not explicit in a client's mind. For the current study, expectations are treated as assumptions of likelihood *and* appropriateness concerning therapy, including perceptions of what is realistic and what is desirable.

However, this working definition is not intended to conceal doubts about whether expectations rest on more fundamental, underlying phenomena, nor about exactly what expectations clients bring to therapy. Uncertainty about these issues necessarily means uncertainty about how expectations are experienced during

therapy and about their links to client engagement and the therapeutic alliance. This is because these aspects of therapy must be based in part at least, on the fit or match between expectations and the reality of therapy. Research reviewed below indicating links between engagement, alliance and process on the one hand and outcome on the other, highlights the importance of better understanding these issues. The ultimate motivation for investigating expectancy, therefore, was to gain a deeper understanding of the phenomenon's impact on therapy success.

Dimensions of Client Expectations

A degree of agreement exists about the different components of expectancy. Starting from the idea that complex behaviours are determined by multiple factors and that expectations are just such complicated phenomena, Tinsley, Workman, and Kass (1980) presented a comprehensive assembly of the many dimensions of expectancy likely to be relevant to therapy. Their Expectations About Counseling (EAC) scales (longer and brief forms) have become perhaps the most widely used instruments in the field, though controversy persists concerning the underlying dimensions of expectancy.

Tinsley et al. (1980) identified four factors accounting for 75 per cent of variance: Personal Commitment of the client (including responsibility, motivation and openness to new experiences), Facilitative Conditions created by the therapist (including genuineness, tolerance and concreteness), Counsellor Expertise (including directiveness), and Nurturance (including acceptance and self-disclosure). However, factor analysis by Hatchett and Han (2006) of participants' responses to the 66 items on the EAC brief form identified three underlying factors: Expectations about facilitative conditions (such as counsellor nurturance, genuineness and acceptance), about counsellor expertise (including directiveness) and about the client's involvement (motivation, responsibility and openness).

More recently, however, Anderson, Patterson, McClintock and Song (2013) highlight the degree of uncertainty over the factor structure of expectancy, identifying analyses that find two, three and four factor structures. The applicability of this literature is also limited by the fact that both Tinsley et al. (1980) and Hatchett and

Han (2006) relied on samples who had not had therapy. The same is true of a more recent study (Kakhnovets, 2011). It seems likely that individuals in therapy might base their expectations on greater research, thought and investment (emotional, financial and temporal) than would have characterised these researchers' samples. As such they may measure a different set of expectations to those actually found among therapy clients.

Lack of clarity over factors underlying expectancy may be because expectations are a function of more basic factors determining client attitudes to therapy. Recent studies suggest this may be the case. Kakhnovets (2011) found that expectations had less effect on decisions regarding help-seeking than personality factors, e.g., openness to new experiences. Her treatment of openness as a personality factor is, however, conceptually interesting. If an individual is receptive to novel experiences this implies an assumption that such events may be helpful – i.e., the characteristic could equally be seen as a set of expectations, operating at the same level of the factor structure. More recently Stewart, Steele, and Roberts (2014) found boys had more negative outcome expectations than girls, indicating that genetic elements could underlie certain expectations. Both studies highlight the need to locate expectancy within a network of influences on the client experience of therapy.

The present study, by asking participants who have been through therapy to describe their expectations in their own words, made no assumptions about the nature and hierarchy of the factors involved. As such it was capable of identifying expectations in a way that would shed new light on the subject, moving research on from the inconclusive and longstanding factor analysis literature. Similarly, it allowed participants to give their own understanding of cause and effect relationships involving expectancy. In this way it was hoped this study might tap a new perspective on any hierarchy of priority among these. Finally, by interviewing former therapy clients, it was also able to offer insights into the expectations of actual clients rather than other populations.

Expectations and outcome

In research going back more than half a century, there is a widespread consensus that client expectations concerning therapy outcome have a profound influence on the likely success of therapy, because they may be self-fulfilling with positive outcome expectations making positive outcome more likely. This is applied to pre-therapy expectations but also to new expectations arising during therapy. As long ago as 1961 Frank suggested that creating positive outcome expectations so that clients are no longer demoralised was an essential element of therapeutic growth.

Placebo studies manipulating expectations have also suggested an association with outcome (reviewed concisely by DeFife & Hilsenroth, 2011). The power of expectancy in general is further suggested by research showing, for example, that even the experience of apparently physiological reactions such as the experience of pain are modified by expectancy (as summarised by Seligman, Wuyek,Geers, Hovey & Motley, 2009). If expectancy has such a strong influence in therapy, better understanding of its dimensions and origins is likely to be directly relevant to outcomes and as such an important area for research.

Constantino, Glass, Arnkoff, Ametrano and Smith (2011) conducted an influential meta-analysis of more than 8,000 clients across 46 studies and found a significant association between positive expectations of outcome and therapy success. One study they review is by Borkovec, Newman, Pincus and Lytle (2002). This found that expectations of therapy credibility were a substantial predictor of outcome. Subsequent research has supported this link (e.g., Price & Anderson, 2012 and Patterson, Anderson and Wei, 2014) and expectation disconfirmation has been found to be linked to poorer engagement and to premature termination of therapy (Westra, Aviram, Barnes & Angus, 2010).

While evidence appears to be accumulating, the expectations-outcome literature is limited for a range of methodological and epistemological reasons. Many studies investigate pre-treatment expectancy only. Patterson et al. (2014) and Seligman et al. (2009), cited above, fall into this category (as do many other studies such as Abouguendia, Joyce, Piper & Ogrod, 2004; Delsignore, Carraro, Mathier, Znoj & Schnyder, 2008). This excludes investigation of the possibility that early expectations are modified or replaced and that the active, influential role belongs predominantly to

unmeasured expectations that arise later in the process. There is evidence that this is the case. Dimcovic (2001) found expectations became more positive during therapy and that it was these changed expectations that best predicted therapy outcomes. It is clear that the dynamic nature of expectancy remains under-researched.

Another restriction to what is known lies in the epistemological assumptions made in quantitative research in general. Specifically, the widespread use of questionnaires to measure expectancy paints only a partial picture. Such studies rely on client selection and ratings of researcher-defined expectations. This design may not allow individuals to report accurately, and certainly not in their own terms, what they expect. It may also influence or distort their thinking so that a true picture is obscured.

Further, the literature has focused almost exclusively on correlations between expectations and aspects of therapy (e.g., Patterson et al., 2014; Seligman et al., 2009; Westra et al., 2010). As such, they cannot claim to identify causal relationships involving expectancy. There are also questions about whether existing studies confound expectations with other phenomena. It may be, for example, that the client views on therapy credibility identified by Borkovec (2002) reflect a more rational phenomenon while expectancy includes an affective dimension. Qualitative studies can at least hope to identify one perspective on causation and conceptual boundaries – the client's.

A review of research, in fact, makes clear that the idea that positive expectations have a simple, linear association with positive outcome is simplistic. As well as the methodological, conceptual and epistemological limitations discussed, the literature is characterised by contradictory evidence. Some studies, for example, indicate that pre-therapy expectations are not linked with outcome at all. This may be because they are too vague to have any impact, as argued by Watsford and Rickwood (2014).

There is also research suggesting that positive expectations can actually be unhelpful and that inaccurate expectations can be helpful. In a survey of counselling psychologists' beliefs about their clients, Tinsley, Bowman and Barich (1993) found many counselling psychologists identified "magical thinking" (p. 50) among clients where expectations about counselling were unrealistically high. The therapists

believed such over-optimistic thinking was a barrier to effective therapy. Further complicating the picture, they also believed some unrealistic expectations to be facilitative – especially unrealistically high expectations among clients about the level of responsibility, openness and motivation they would need (possibly because these would tend to increase clients' commitment to the process).

In contrast Dimcovic (2001) found the majority of clients in her sample held moderate or realistic expectations, further complicating any conclusions from existing research. She measured pre-therapy expectancy by questionnaire and repeated this after "the first few sessions" (p. 252). The timing of the second measurement is relevant as the later the measurement the more expectations might be in line with the therapist's and therefore deemed 'realistic'. More importantly, she excluded therapy clients not in sufficiently regular attendance, introducing a bias towards more the collaborative (and thus potentially 'realistic') end of the spectrum. Her sample also all saw the same therapist, meaning the second measurement of expectancy related to that individual's perspective only, further limiting generalisability. Finally, two thirds of her sample had had therapy previously, meaning they were probably better informed than novices and held more moderate expectations as a result. These limitations leave the picture far from clear. The current study aimed to investigate a less restricted sample.

Contradictions in the literature discussed here highlight the need for research on how realistic clients' expectations really are. The studies above also reveal a need to know more about what expectations clients actually bring, and more about how these change. This was exactly the motivation for the current study. In particular it aimed to move beyond the research tradition reviewed above, in which client thinking is accessed through questionnaires forcing participants to choose from researcher-defined options. That methodology may influence and distort participant responses and may exclude expectations that were not predicted. If the evidence to date is accurate, most clients find important expectations are disconfirmed. The potential impact on their therapy makes it all the more important to access unconstrained accounts of the way expectations are experienced.

The importance of expectations

The limitations and contradictions in the research to date comes against a background of near consensus about the importance of expectancy. In a meta-analysis of studies regarding therapists' views on common factors in therapy, Grencavage and Norcross (1990) found the most frequently identified client factor was the presence of "positive expectancies and hope for improvement" (p. 374), named by 26 per cent of authors. The ability of therapists "to cultivate hope and enhance positive expectancies" (p. 374) was named by 20 per cent of authors reviewed as a therapist factor. Not surprisingly some have proposed that client expectations of therapy are among the common factors influencing therapy success, irrespective of treatment modality (e.g., DeFife & Hilsenroth, 2011; Goldfried & Davila, 2005; Lambert, 1992).

So fundamental does the influence of expectations on psychological process and outcome seem to be, that some see them as the common factor at the heart of the therapeutic process itself. Greenberg, Constantino and Bruce (2006) suggest that "the reshaping of patient expectations (or assumptions) appears to be at the foundation of virtually every major model of psychotherapy" (p. 670). They argue that confirmation of expectation is critical saying this is experienced as pleasurable by clients and thus gives positive reinforcement to engagement, which in turn makes a successful outcome more likely. A more general perspective suggested by this review would be to see expectations as a crucial element among many interacting client, therapist, environmental or interpersonal influences from which therapy evolves and develops. The stress on client expectations in central to a line of argument in the literature making the case that progress in therapy is primarily due predominantly to client factors, i.e., that the client self-heals (Bohart, 2006; Tallman & Bohart,1999).

Importantly, the presence of common factors in therapy, still leaves therapists with difficult and important choices to make regarding which specific therapeutic elements are most appropriate for different types of clients. This emphasises the importance of therapist expertise in guiding therapy, in addition to client expectancy. In a refutation of the "Dodo bird verdict" that all psychotherapies produce equivalent outcomes, Norcross (1995) points to many studies supporting "prescriptive matching on various

clinically relevant patient variables" (of the technique or approach chosen, p. 502) including expectations (as well as stage of change, disorder and coping style).

A respect for the client perspective (central to Counselling Psychology, as described e.g., by Cooper, 2009) supports the notion of a link between outcome expectancy and therapy success in that it implies clients are capable of basing their expectations, in part at least, on appropriate thinking and information. McLeod (2012) suggested clients may have a strong sense of what will work for them, based on their life-experiences and this sense may underlie expectations. This perspective highlights the importance of a better understanding of what exactly it is that client expectations express, with agency proposed as one possibility.

The current study aims to throw light on this question. If something as fundamental as client agency is manifested in expectancy, it becomes all the more important to understand how expectations are experienced. For this reason the study was open to any interplay between expectations and alliance formation, process or outcome. As relevance to clinical practice was the main aim of the current study, sensitivity to the client experience of the salience of any expectations over the course of therapy was another interest Such questions are important, going to the heart of the crucial aspects of therapy and seeking to understand the changeable, dynamic nature of expectancy. Confirmed or disconfirmed expectations about roles may be fundamental determinants of client engagement, itself inextricable from client agency.

Expectations and the Therapeutic Alliance.

While research suggests a strong link between outcome expectations and therapy success, the relationship between process expectations (such as assumptions about respective roles and responsibilities) and success is less clear. A review by Arnkoff et al. (2002) recorded 19 studies finding a significant link and 8 with non-significant results. While inconclusive, the research literature is still rich in suggestions regarding the types of links which may exist between therapy and process.

One such link concerns expectations about the division of responsibility for achieving change. Studies suggest that clients may often not be fully aware of their

responsibilities, possibly reflecting lack of confidence in their ability to tackle their problems (Tryon & Winograd, 2011). This accords with work by Bedi, Davis and Arvay (2005) suggesting that clients stress the importance of the therapist role over their own, even when reminded to consider the latter. That could imply that clients need to reconceptualise how therapy works early in their therapy, but little is known about the impact of such challenges to role expectations. Client commitment and dropout are obvious candidates. Nor is it clear how therapists can manage the transitions involved when expectations need to change. It may be that lack of client self-efficacy explains the emphasis on therapist responsibilities, or that clients' hope for the easiest "fix" possible, meaning their expectations focus on the skill of the therapist as the solution to their problems. There is also the possibility that therapists need to reconceptualise as much or more than clients and that the therapist role actually is under-emphasised in the profession. By focusing on the client perspective the current study hoped to help answer such questions.

Delsignore et al. (2008) investigated expectations of responsibility among clients attending group CBT for social anxiety. They found high "internality" of therapy-related locus of control was associated with positive outcome. They also found that higher client expectations of the therapist predicted a greater degree of engagement in therapy, which in turn increased the likelihood of positive outcomes regarding social anxiety and symptoms in general. The study found that low expectations of "powerful others" were especially important after therapy ended, with individuals scoring higher on this factor showing greater continued improvement.

The suggestion that expectations concerning responsibility-taking may be powerful determinants of outcome is important, as engaging with or strengthening these assumptions could offer therapists a route to improving outcomes. Because of this it is worth looking more closely at the methodological difficulties Delsignore et al. (2008) encounter. This also illustrates the type of problems involved in much of the quantitative literature.

Their study was limited to the treatment of social anxiety with CBT and results may not generalise to other disorders. The rationale in CBT, for instance, may more clearly prioritise the learning and application by clients of specific skills than in other approaches. It may therefore require different levels of responsibility-taking.

Individuals who are socially anxious may also be non-representative in that they place less trust in others (including therapists) than those with different problems. Hence the nature of the link between responsibility-taking and outcome may be specific to disorder. Similarly, those attending group therapy may need to take responsibility more than those in individual therapy (as the therapist is less available), so the link to outcome may have been stronger in this sample than in other settings. These limitations are characteristic of the hypothesis-testing literature (reflected in other recent studies, e.g., Price & Anderson, 2012 and Patterson et al., 2014)

Further, the 49-strong sample studied by Delsignore et al. (2008) only saw three therapists. It could be that these practitioners worked in a way where client responsibility taking was more important than for other therapists, clearly limiting the application of the findings. Additionally, “about half” of the sample were on medication and the authors do not mention randomisation by this variable. Clearly the choice of this form of help could reflect a disposition towards external help while the medication may have influenced outcome independently of expectations. The 40 per cent of the sample who continued to see psychiatrists not involved in the study could also have introduced bias.

A final limitation lies in the quantitative methodology. Expectancy regarding responsibility and control was measured by questionnaire rather than in the clients’ own words. This could have influenced their thinking and they answers they gave. It could also have omitted aspects to expectations by responsibility for which no question was included. As discussed, this limitation is built into quantitative investigations of expectancy. The qualitative design of the current study provided an alternative, avoiding this kind of researcher influence.

The work of Delsignore et al. (2008) resonates with the wider literature since Tinsley et al. (1993) suggesting a continuum between unrealistically high client expectations (“magical thinking”) and unrealistically low expectations about their therapists’ abilities. Tinsley et al. suggest this may influence responsibility-taking among clients, in that those with higher expectations of therapists might well take a lower level of responsibility themselves. Further research regarding expectations of responsibility is needed, looking at different presenting problems as well as at the impact and

therapist management of these. It would also be useful to know more about the ways such expectations manifest themselves so they can be recognised as early and accurately as possible.

Suggestions regarding magical thinking and the emphasis on the therapist role build upon earlier work by Rennie (1994). He used grounded theory to interpret interviews with clients and concluded that they “are extremely inclined to be deferential” (p. 436) to their therapists. He found elements of this deference included a sense of indebtedness to therapists, fear of criticising them or threatening their self-esteem and acceptance of their limitations. He suggests that in major part, this attitude derives from the client’s expectation that deference is necessary to maintain the working alliance with their therapist.

Rennie (1994) stresses the cost of this deferential attitude to client commitment and motivation. This emphasis on deference seems understandable if the client, by definition, usually occupies his or her most insecure ground, focusing on personal weaknesses and asking for help. In contrast, it seems likely that clients expect their therapists to be experts, professionals who are in a position to right the client’s own faults. Rennie summarises concisely: “The therapy relationship... is asymmetrical, with most of the power being invested in the therapist.” (p. 432). The way expectations concerning responsibility and this suggested power relationship play out in therapy is a major interest for the current study.

While Rennie (1994) is a major influence on the current study, his findings are based on interviews concerning just one or sometimes two sessions from a course of therapy. As such, the selection of sessions may have introduced bias into the findings. Because the interviews were conducted before the end of therapy, participants may have felt a need to modify their accounts due to a perceived possibility that therapists whom they still depended on would react to what they had said. By asking former clients for a post-hoc overview of therapy, the current design circumvented such difficulties.

Participant deference could also have been heightened in Rennie (1994) because the sample were undergraduates, with courses to pass. Rennie does not state whether or not course credits were at stake. His sample, therefore, was unrepresentative and may have brought specific confounding influences to his

findings. Another limitation was that the therapy period ranged from six weeks to over two years. This could conceal or average-out the effect of time on the degree of deference shown. A final limitation discussed by Rennie himself is that reliance on interviews meant the findings were limited to what participants were conscious of and willing to discuss.

The idea of a power asymmetry has particular importance when its influence on client motivation is considered. There is widespread consensus in the literature that motivation is crucial to outcome (e.g., Frank and Frank, 1991; Rogers, 1951; Ryan, Lynch, Vansteenkiste & Deci; Wampold, 2011). This view holds that the engine and motive force for change may need to come in greater part from the client, the party Rennie (1994) describes as in the weaker position. The implications concerning client agency in relation to power dynamics in therapy are an obvious concern and expectations may be at the interface of these.

A useful conceptualisation is offered by de Shazer, (1985) in solution focused brief therapy. Positive expectation of change during therapy is seen as dependent on client willpower, involving responsibility-taking, complemented by therapist responsibility for “waypower”. In other words the client is responsible for the motivation and impetus, while the therapist steers the process as the expert on how to achieve change. In this way, positive outcome expectations (along the lines of “this is worth working at”) are seen as something that can be deliberately and systematically harnessed though techniques such as the miracle question and questions on coping and exceptions to the problem (as discussed by Reiter, 2010). More research is needed into client expectations about responsibility, looking perhaps more widely than at their effects on outcome alone. For example, if clients believe their therapists are largely responsible for change and then it becomes apparent that the therapist sees things differently, how is this experienced?

Client expectations regarding their own and the therapist’s roles are one element in a wider nexus of expectations about the nature of the therapeutic alliance (as this necessarily includes a level of agreement on their respective contributions). The alliance is generally seen in the profession as centrally important and is given particular priority within Counselling Psychology. It is the focus of a still growing body of research over many years (e.g., Bordin, 1979; Gaston, 1990; Kahn, 1999; Rogers,

1951; Swift et al., 2011). Its importance is indicated by the meta-analysis of research into common factors across diverse approaches by Grencavage and Norcross (1990). They found the therapeutic relationship to be the most frequently identified "consensual commonality" and one regarded as key to the degree of success or failure in therapy. Horvath, Del Re, Flückiger and Symonds (2011) define the distinctive feature of the "modern pantheoretical reconceptualization of the alliance as its emphasis on collaboration and consensus" (p. 26) and this review is concerned with research which focuses on the relationship between this construct and client expectations.

Constantino et al. (2011) suggest one link, that the quality of the alliance is critical in determining whether and how thoroughly expectations are identified and considered in therapy. They argue that only within a suitably collaborative relationship are clients able to state, clarify and prioritise their expectations fully (to themselves and to the therapist). This emphasises the susceptibility of expectations to change, focusing on their dynamic quality. It raises important (and largely unanswered) questions about the way clients will make sense of being able or unable to express their expectations. While the alliance certainly impacts on the weight given to expectations in therapy, the reverse also appears to be true with expectations influencing the nature of the alliance. This bi-directional relationship is suggested by Abouguendia, (2004) who found that clients with more positive outcome expectations later expressed more positive views on their alliance (and the outcome of their therapy).

These studies leave important questions unanswered about process expectations. Clients and therapists appear often to differ in their assumptions regarding the locus of responsibility within the therapeutic dyad. This has a clear potential to weaken or undermine the alliance at the very stage when it needs to be built and later in the process. Better understanding expectations so that a mutually acceptable division of responsibilities can be negotiated seems crucial. However, the nature of expectations regarding responsibility is only understood in broad terms and there is a dearth of research on how clients experience what may be a widespread discrepancy between their expectations and their therapists'. By directly accessing the client perspective, the current study aims to examine this apparent gap in expectations. It offers former clients an opportunity to give an account of their

expectations and subsequent experiences of responsibility-taking. Both of these issues have immediate bearing on collaboration and consensus, on the selection of goals in therapy and on the way of working which evolves. Again, engagement and outcome are ultimately at stake.

Aligning Therapy and Client Expectations

An essential element to collaboration is a sufficient degree of consensus between client and therapist about both goals and processes. Tryon and Winograd (2001) investigated evidence concerning this link in a meta-analysis of 15 studies between 2000 and 2009 and found a substantial relationship (r = .34) between goal consensus and collaboration. Looking at 19 studies of the relationship between outcome and collaboration (also 2000-2009), they found the former to be significantly improved by better collaboration. They define factors comprising client-therapist consensus as including agreement on goals between client and therapist, therapists' explanations of the nature of the therapy and a shared understanding of how the client's problems originated. Expectations appear intrinsic at least to the first of these.

The importance of expectations concerning collaboration is further emphasised by research suggesting that alliance and outcome are improved where therapists work with client preferences including their sense of what is going to prove useful (a recent summary is Swift et al., 2011). Preferences can be defined as elements of therapy which are desired or felt beneficial by clients. Expectations, in contrast, also capture the aspects of therapy they believe they will get. However, the two can frequently coincide – a client may value certain aspects of therapy *and* believe they will get these. Indeed it seems likely this combination is what brings them to therapy. Where clients expect a therapist to match their preferences and this is fulfilled, it may be that motivation and engagement are maintained or enhanced. Where a preference is not met, clients may develop new expectations such as having to "make do" or to accept disappointment.

Significantly for the current study, there is evidence of substantial distance between the views of clients and their therapists on the goals and tasks of therapy. Swift and

Callahan (2009) found convergence (low discrepancies in judgements, beliefs and perspectives) over both tasks and goals only 31 per cent of the time. This could explain evidence that client and therapist ratings of their alliance are only moderately correlated (Tryon, Blackwell & Hammel, 2007). A review by Orlinsky, Grawe and Parks (1994) found that the shortfall may be a reflection of therapist attitudes, identifying consensus as less important to them than to clients. Where collaboration and consensus are found less than expected by clients, the impact of this gap is likely to be important. Little, however, is known of whether and how this is experienced and this was another interest behind the current study.

The importance of the client's assessment of the alliance is suggested by Horvath and Bedi (2002) who found clients' perceptions were more strongly associated with outcome than those of therapists. This finding supports the view of Rennie (1994) that "metacommunication", i.e., explicit discussion of process by client and therapist, is a crucial factor for therapy to succeed. More recently Swift et al. (2011) make the point that despite evidence of the necessity of this kind of collaboration, it is often not available, with public, third sector and private practitioners at times constrained by individual or service-specific inflexibility.

As clients' process expectations are likely to be intrinsic to their perceptions of the alliance, a better understanding of what these are and how they impact on the alliance and on therapy more generally is highly relevant to the conduct of therapy. Giving former clients the opportunity to reveal whether and how their expectations came into play in ways affecting the alliance was a priority in the current study. The possibility raised by Bedi, that clients' views of the way the alliance works are underemphasised by therapists with negative consequences underlines the importance of such research.

There is also recent evidence that therapist flexibility regarding approach – in response to the client experience – may enhance outcome. Owen and Hilsenroth (2014) found flexibility accounted for about 10 per cent of outcome even after controlling for other variables including therapist skill and alliance strength. Their sample of 70 all received psychodynamic therapy and this limits the applicability of their results because variance of approach may be more helpful within certain types of therapy (and for certain types of client). Adherence to model was measured at

three points (3rd, 9th and final sessions) by independent raters. This too limits Owen and Hilsenroth's study, as variation of approach may be highly salient in the first two sessions and this would not have been measured. The flexibility shown by the therapists, who were trainees, may also be unrepresentative of qualified practitioners. Finally, by measuring alliance only at the 9th therapy session a potentially crucial variable was examined at only one point in time, despite the dynamic quality of the relationship.

Despite the difficulties in investigating the match between therapy and individual clients, the evidence to date does serve to highlight the importance of the client perspective. It suggests that therapist responsiveness allows and can govern integration of models and techniques that best suit individual clients and problems. It also indicates that responsiveness can maximise adaptation to changing circumstances in clients' lives (internal as well as external) and that it may be crucial in fostering truly collaborate therapeutic alliances. The current study seeks a better understanding of the impact of therapist flexibility and responsiveness to expectations. By prioritising the participant perspective it aims to broaden insight into alignment between client and therapist perceptions. It asks when flexibility is appropriate, how it is experienced and why it matters. In doing so it recognises the centrality of the alliance. It aims to understand therapist flexibility through a research hermeneutic bringing a different balance to previous studies, one in which the client voice comes through more strongly but is still examined critically.

Therapeutic Approach and Expectancy

It also seems clear that before their first session many clients know little about the therapeutic approach they are going to receive. Seligman et al. (2009) found individuals presenting for cognitive behaviour therapy showed negligible awareness of what to expect. When asked what a therapist does in a typical session, just seven per cent of participants answered in a way that was accurate for the therapy they were to receive and only four per cent held accurate expectancies of the behaviours required from clients. The authors suggest their findings reflect a contemporary representation of psychotherapy in the mass media based on psychodynamic and non-directive approaches. In this respect, they argue, popular culture is out of line

with the recent trend towards cognitive behaviour therapy. More needs to be known about what it is like for clients when their expectations regarding approach are disconfirmed or have to be formed after they begin sessions.

Another important dimension to therapy, likely to be implicated in expectations about therapist approach, is the level of directiveness. In the Solution Focused terms outlined above, directiveness seems an obvious bridge between therapist waypower and client willpower, with the former taking an approach on a continuum between non-directive/facilitative and directive/didactic to help the latter. Since the term "nondirective approach" was introduced by Rogers (2007) the concept has been a focus of attention (e.g., Bohart & Tallman, 1997; Cain, 1989; Kahn, 1999; Lane, Koetting & Bishop, 2002; Levitt, 2005). This review is concerned with the literature focusing on the relationship between the degree of directiveness and client expectations. Non-directiveness is taken to mean an approach where a therapist aims to "avoid introducing content from his or her subjective framework and consistently strive[s] to understand and 'reflect' back to the client the client's subjective framework" (Kahn, 1999, p. 95). Consideration of non-directiveness (and the related psychodynamic concept of neutrality) is particularly relevant to Counselling Psychology, given its commitment to respect subjectivity and phenomenology.

Research does seem to suggest that, where clients' expectations are low, directiveness may be less effective. Constantino, Manber, Ong, Kuo, Huang and Arnow. (2007) found that clients with lower expectations found higher therapist affiliation (overall, this is seen as a less controlling therapist quality) most helpful. More research on this area is needed before it can confidently be applied in practice and the current study hoped to contribute in this direction. This is in part because Constantino et al. (2007) illuminate the affiliation-expectation link only within a very specific sample, among lower expectancy clients, early in group therapy for insomnia.

A non-directive relationship may be experienced negatively more widely. This is the argument made by Kahn (1999), who write that some may experience it as "frustrating, constraining, counterproductive, annoying, and possibly indicative of passivity, lack of involvement, caring or willingness to help" (p. 91). If this is true, it

seems likely that clients' expectations influence the way directiveness is experienced in therapy. Client characteristics too may influence such experiences and this is suggested by research. A meta-analysis looking at the relationship between directiveness and client resistance indicated that more resistant clients benefit more from non-directive therapy (Beutler, Harwood, Michelson, Song & Holman, 2011). The client experience of directiveness is under-researched especially when it comes to client description of this crucial dimension.

Responding to such concerns, some have investigated the effectiveness of manipulating or changing client expectations before therapy e.g., Demyan & Anderson (2012) and Ahmed and Westra (2009). Findings regarding the effectiveness of such interventions are contradictory. Taking a counselling psychology perspective, the current study is less interested in preparing clients to fit in with existing models or templates of therapy and more concerned with how therapy might be shaped in response to client factors, particularly expectations.

It is hoped clients' descriptions of their experiences will prove useful by informing therapist responses to expectations, such as reviewing and managing these more or less flexibly. Participant accounts could also help explain and address the discrepancy between client and therapist alliance ratings and what the literature suggests are their differing respective views on the importance of consensus in therapy. Any new light on areas like these could, facilitated by the idiographic methodology taken here, could help practitioners achieve better alliances and guide their decisions concerning approach, techniques and disagreements in therapy.

Ruptures in Therapy

Disagreements in particular seem likely to arise out of discrepancies between client expectations and the way therapy turns out. Attention to these events provides a sharply focused lens highlighting which expectations matter most to clients, how and why they matter. The content of disagreements and the way they affect process are important issues in light of their influence on the alliance and therefore on outcome. For these reasons the literature on ruptures in therapy is part of the relevant context for the current study.

The definition of rupture preferred here is from Safran, Muran and Eubanks-Carter (2011) and covers a continuum from a sudden failure in collaboration to relatively small strains that client or therapist may only sense vaguely. It seems reasonable to suppose that ruptures will lead to a lowering of outcome expectations and possibly of the quality of the alliance or motivation. Research suggests this is the case. A study by Westra, Constantino and Aviram (2011) found that outcome expectations fell after ruptures. They also reported that this effect was far greater among clients who started out more sceptical about their therapy, i.e., among clients with lower expectations.

Client reactions to rupture appear to vary in part according to the level of therapist directiveness and other relationship factors. This link was the focus of research by Ahmed et al. (cited in Constantino et al. 2012) which found clients' positive expectations proved more resilient where therapists were perceived as more autonomy-granting and less controlling. Other factors positively associated with resilience were therapist affirmation and understanding. An investigation by Constantino et al. (2007) of how confrontations are experienced suggests a similar link to an autonomy-granting approach when perceived confrontation arises. In a study of clients attending group CBT for insomnia, they found that where a therapist is perceived as confronting critically, clients were less satisfied with therapy and this was especially true of clients who brought higher outcome expectations to therapy. It was hoped the current study would throw new light on links of this kind between expectancy and client perceptions of process.

Research on the link between expectations and the alliance imply that, by monitoring expectations, therapists can pick up on the effects of ruptures they have missed, or not attended to (Westra et al., 2011). They point out that the evidence suggests reduced expectancy can be a marker of rupture. The implications of this area of research are that by monitoring expectations, through informal checks or using a validated questionnaire, therapists can address and repair ruptures that might otherwise derail therapy. Westra et al. (2011) describe specific techniques, based largely on metacommunication, that can be used to rebuild the alliance post-rupture, implying improved outcome expectations as well as better outcome. Without a focus on expectations such opportunities might be lost. The research also indicates that

expectations mediate the effects of ruptures and ruptures can impact on expectations.

The current study was in part motivated by an interest in whether clients believe the two phenomena, ruptures and expectancy, relate and if so in what way. Do expectations, for example, determine whether ruptures are interpreted in terms of weaknesses in therapist competence, poor therapist commitment, a need for client self-examination and/or shortfalls in the therapy rationale? Strong nurturance expectations, for example, might mean ruptures involve disappointment at the nature of the alliance while those expecting directiveness may be less disappointed. More also needs to be know about whether the response to an expectation-disconfirming rupture includes defiance, demotivation, new hope, encouragement, anger, hurt, disappointment or something else – and in what circumstances? The current study, it was hoped, would be capable of getting closer to answering questions such as these by remaining as receptive as possible to the experiences of former clients. In this way it aimed to create space for them to express ideas on subtle or complex issues like these. New information of this kind, it was believed, could help therapists in identifying, negotiating and managing expectations to achieve stronger engagement and alliance and thus better outcomes.

The Contribution of Qualitative Research

What is clear from this review so far is that the overwhelming majority of research has measured client expectations using questionnaires, just before therapy begins. Frequently research design means clients must choose from researcher suggestions about their perspective. This means that, as Constantino et al. (2011) put it, "although the clinical importance of patient outcome and treatment expectations has been documented, we have a paltry understanding of factors that develop and maintain such beliefs" (p. 189). Qualitative methodologies are providing an important complementary source of evidence helping understand stability and change in expectancy and how this is experienced by clients.

Qualitative research can also help address the shortfall in studies from the client's perspective, accessing their subjective experiences of expectations in their own

terms. Rennie (1994) traces this lack of interest in clients' accounts to the historic dominance of behaviourism, positivism and psychoanalysis, which, he feels have all "contributed to the field's misgivings about the value of verbal reports of conscious experience" (p. 427). The need for phenomenological research methods follows from this. While a qualitative approach based on client accounts and treating expectancy as a dynamic phenomenon is taken in this study, the role and continuing potential of quantitative or mixed methodologies is also clear. The remainder of this review looks at qualitative research complementing the questionnaire-based work discussed and at the attempts to apply research on expectations to clinical practice.

Watsford et al. (2013) used interviews with clients to identify pre-therapy expectations among 12 to 24 year olds. Their main finding was that the majority of their sample was unsure and ill-informed about what to expect (building on Seligman et al., 2009). They also found this to include clients who *had* had therapy before. They identified wide discrepancies in expectations about the processes that would be involved, with some assuming these would consist of advice from their therapist, others that they would be given coping strategies and others that therapy would involve just talking. Most participants in this study expected therapists to be directive and to set the agenda for each session. Another useful theme to emerge was a lack of certainty regarding the duration of therapy, with answers ranging from one session to over a year and more than half of participants having no idea what to expect. The primary conclusion of Watsford et al. is that the pervasive uncertainty about what to expect among their sample is likely to be anxiety-provoking and that mental health services can respond to this by providing clear information.

Qualitative research of this kind provides rich and relevant data, though it involves greater subjectivity in interpretation, and potentially raises questions concerning the reliability and validity of client accounts. More clarity over the type of therapy the participants interviewed by Watsford et al. (2013) actually received would mean the accuracy of their expectations could also be assessed. Their findings do seem to be important and helpful and further research is required to establish how much they generalise to adult populations and what the impact is on clients during therapy. The impact of inaccurate expectancy identified by Seligman et al., (2009) was disappointment in the helpfulness of the therapy, lasting throughout that therapy. However, as they state, the duration of this therapy was just three sessions, so

further research on the possibility that such effects are short-lived is also needed. The vagueness of expectations found by Watsford et al. chimes with other research by Kamin and Caughlan (cited by Constantino et al., 2011), finding that 75 per cent of patients in a war veterans clinic had no clarity concerning what type of therapy to expect.

Another study using client interviews, by Westra et al. (2010), focused on confirmation and disconfirmation of expectations and how this was interpreted by good-outcome clients as compared with poor-outcome clients. They found that clients who regarded their therapy as more successful frequently reported the disconfirmation of negative expectations (such as concern therapy would be over-directed by the psychologist) and were pleasantly surprised by positive outcomes. They conclude that more research on the influence of expectancy disconfirmation in particular would be valuable, supporting this recommendation with reference to expectancy violations theory suggesting that disconfirmations are more arousing and distracting than confirmations and can be particularly impactful for this reason.

Westra et al. (2010) are clear on the limitations to their study, stressing that they looked only at a client sample presenting with Generalised Anxiety Disorder, i.e. at participants likely to have a bias towards negative expectations. Further, their sample all received the same therapeutic approach, CBT, and the authors say that clients' negative expectations were mainly concerned with the way that approach worked. It also seems plausible that many expectations will be experienced as partially accurate or inaccurate and fall outside these authors' frame of reference which is focused on confirmation and disconfirmation. The study raises questions about how expectations are identified and then modified, affirmed or denied – and how clients experience these developments. There is also an interesting contrast between these authors' findings and those of Marcus, Westra, Angus and Kertes (2011) on the issue of the affective reaction when expectations are disconfirmed. Marcus et al. found some evidence that disconfirmation of positive expectations (through their replacement with more highly valued new expectations), left participants happier with and more committed to the therapy.

Research on clients' reactions to the match between their expectations and the way therapy actually turns out is still in its infancy. On the basis of existing studies, such

reactions and the ways therapists attempt to manage are potentially decisive in terms of the usefulness of therapy. By using qualitative methods, the current study examines clients' subjective experiences in a way that takes account of stability and change in expectancy. It asks the impact of the lack of information clients seem to have about what to expect and whether or how expectations develop subsequently. Finally, by remaining open to discovery rather than being concerned to test hypotheses, it aims to remain open to new ideas, over and above specific questions identified here.

Expectations, Contracting and Collaboration

With so many unknowns about how clients experience their expectations, practitioners have no choice but to operate on the basis of various informed assumptions of their own, probably based on their therapeutic approach as well as experience and research. Possibly the clearest way they attempt to do this is through contracting. Sills (2006) argues that although some see contracting as sterile, the therapist has no choice but to contract even if this is implicit and changeable through renegotiation during therapy. She suggests that contracting for therapeutic goals and tasks is integral to achieving collaboration and argues that "if therapists believe that their job is to assist in the empowerment of their clients, it is essential to invite them [clients] to be active in designing the counselling relationship" (p. 5). The idea that expectancy is a manifestation of client agency meant the role and nature of empowerment were central questions in the current study. Stated differently, the ways the power balance in the therapeutic dyad may facilitate or thwart expectancy and therefore agency was a key concern. Equally, information on how expectancy change during therapy interacts with agency was sought.

Sills (2006) defines three types of contract, each tied to client expectation. The administrative contract ensures both parties feel that practical arrangements like duration, frequency and payment meet their expectations of fairness and function adequately. She argues that payment implies an expectation of equality in the exchange of the therapist's skill for the client's money, reflecting an expectation that the therapy will be worth the money. The professional contract concerns agreement on the tasks and goals of the therapy. Finally the psychological contract involves

(often unspoken) client expectations based on their therapeutic needs and manifested in the transference. Sills gives the example a client who felt abandoned as a child and expects not to be heard by the therapist who, as a result, adopts a withholding stance. The counter-transference can be complicit, e.g., if the therapist responds with boredom. Such reactions can be understood from different theoretical perspectives and can be addressed, but they reflect the kind of contracting that can take place based on unconscious expectations.

Tryon and Winograd (2011) offer recommendations for fostering collaboration by incorporating the need to consider client expectations. Therapists should not start work, they advise, until they and the client agree on treatment goals and approach, they should only rarely "push their own agenda" and they should modify their "treatment methods and relational stance, if ethically and clinically appropriate, in response to patient feedback" (p. 164). While these recommendations seem sound, expectations regarding treatment goals and approach may or may not be known or made clear by clients. Agreement on goals may be an ongoing and even contradictory process, with the clients deciding that areas they initially expected to be priorities were, in fact, less important than emerging but unexpected goals. Implicit in all these authors' recommendations is the necessity for a level of therapist awareness of expectations.

Clients may also to some extent want and need therapists to "push their own agenda", at least at first, because they arrive in a state of turmoil, having exhausted any agenda of their own and feel unable to make decisions about either goals or process. Cooper and McLeod (2007) suggest that it may only be once the therapist has demonstrated a certain level of trustworthiness (expected or not) that a client becomes confident enough to engage sufficiently in a collaborative exploration of goals. The same could be suggested about expectations of expertise, empathy, acceptance, and more. This does not contradict the recommendations from Tryon and Winograd (2011), but the moment-by-moment experience of therapy, including that of expectations, inevitably means the application of such recommendations will seldom be straightforward.

Use of contracting to address expectancy is also dependent on the theoretical approach of the therapist. For instance, in CBT explicit agreement on goals,

treatment rationale, roles and relationship is inherent in collaborative empiricism (Beck, 1976). Person-centred approaches to contracting vary widely. Worral (2006) argues that many clients' problems originate in "contractual living" (p. 52) and that even the subtlest reproduction of this in therapy would be wrong. This can even mean "a contract in the person-centred approach places demands on the counsellor and not on the client" (p. 53), with those demands being based on the core conditions outlined by Rogers (1951). In contrast, Mearns and Thorne (1988) stress that client and person-centred counsellor both need an understanding of the commitment they are about to make, though they only specify the duration of therapy and the terms of payment. In psychodynamic therapy, clients may be told they should say anything that comes into their minds and duration needs to be contracted for in short term dynamic therapy, but the overriding emphasis given to "frame" is the degree to which unconscious communication is represented in its breaches (Jacobs, 2006).

All this is deeply relevant to working responsively with client expectations in practice. Where therapists decide to resist either contracting or less formal negotiation over their treatment approach, it is crucial to understand the way clients make sense of this. The role of expectations at these times is likely to vital. Not getting what is expected may, for example, be deeply surprising or unsettling for clients, with damaging consequences. Equally more detailed and specific contracting could leave clients feeling the process is imposed and unresponsive. Understanding clients' perspectives on contracting as a way of establishing and negotiating expectations may help avoid such problems. It may guide practitioners' decisions about the scope and nature of contracting. While expectations need to be addressed in contracting, contracting may also constrain or help express expectations – not just initially, but throughout therapy.

The current study asks how much contracting is needed, i.e., where the balance lies between the need to know what one is signing up for and the need to feel therapy is flexible and responsive to the individual and the moment. Does, for example, the appropriate balance between expectations of flexibility and of therapist expertise vary according to events during therapy? The nature and dynamic aspect of expectations is included in such a focus. By allowing former clients to describe how their expectations came into play, specifically and in overview, the current design

was capable of helping answer these questions in ways directly relevant to understanding therapy process and outcome.

Overview and Research Questions

In summary, more research is needed on many aspects of client expectations. In particular, there is scant qualitative research capturing the client's perspective on what appears to be a deeply influential and important part of therapy. Little is known about how and when expectations exert their influence, about how long they act for and how they are maintained or can themselves be changed. Little is understood about the impact of confirmation as opposed to disconfirmation of expectations or whether this varies according to the type of expectation.

It seems expectancy may be a basic factor across all aspects of therapy. The literature indicates a central involvement in therapeutic process but questions concerning which particular aspects of process are more or less susceptible to expectations and which expectations are susceptible to those processes, remain unanswered. Research suggests the client experience of directiveness, therapeutic approach more generally, contracting, engagement and the alliance are all closely bound up with expectancy. It is important to gain more understanding of the ways expectancy relates to these phenomena and the ways this relationship evolves. Crucially there is also a dearth of research on such client experiences, let alone research giving them the freedom to discuss this in their own terms.

Processes like alliance, contracting and negotiation are portrayed in the theoretical and research literature both as intrinsic to outcome and strongly linked to expectancy. However the nature of the links between such complex, interrelated influences has proved hard to pin down. Should, for example, contracting focus on expectations regarding administrative matters or do clients feel the rationale or approach is more salient? It also seems crucial to understand how directive, honest, accepting or nurturing therapist contributions are expected to be – and what happens if these expectations are or are not confirmed. Underlying all these questions is the issue of the balance between questioning and empathic hermeneutics for both client and therapist.

The counselling psychology perspective, emphasising intersubjectivity and empathy, was believed here to provide a route toward greater understanding of client expectancy. By focusing on what clients found significant (in their own terms) it was hoped to redress a predominance of questioning hermeneutics in the extant research. By taking a post-therapy overview it was also intended that the dynamic, changeable quality of expectancy could be captured. The design also maximised the opportunity for former therapy clients to express their own take, in their own words, on issues like the hierarchy of priority involved in expectancy, without relying on researcher-defined questionnaire options. It left space for them to identify other factors interacting with their expectations, be these socioeconomic, environmental, clinical, therapist factors or something not considered here. It hoped to elicit participants' sense of which expectations were important to the overall success of their therapy, and how. Overall, an openness to discovery was prioritised in the current study so that while the specific gaps in knowledge discussed above were of interest, it hoped to contribute new ideas to the literature.

Methodology

This chapter details the way in which the research was carried out. It begins by looking at questions about what can be known and takes a position on these. It links assumptions made about the nature of reality to the choice of research method. The procedures used in data collection and analysis are described. Ethical issues relevant to the study are discussed. The chapter concludes by considering the researcher's influence in the study along with questions of validity and research quality.

Epistemology and philosophical assumptions

This section discusses the assumptions made in this study about what research can hope to illuminate, that is to say what can be claimed to be true in the first place, before any attempt is made to add to existing knowledge. This is because any investigation has as its starting point assumptions about the nature of reality, i.e., an ontological viewpoint. Having made the ontology explicit, the way in which such truth can be examined, the epistemology of the research, will be considered. The relevance of the research question to counselling psychology has been touched upon, but a more detailed discussion of this also follows below. The section ends with an outline of the procedure followed.

The dominant philosophy of science in psychology (at least until relatively recent times), has been positivism. Based in realism, it views the universe as composed of objects and structures that have cause and effect relationships to eachother. This reality is seen as existing irrespective of any individual observer's subjective viewpoint or interpretation (Willig, 2008). Positivism holds that science can examine, understand and predict that reality through empiricism, the scientific method based on observation through the senses (Ponterotto, 2005).

In the last century, Western science was overwhelmingly positivist in nature, possibly because of the tangible benefits derived from this position in fields like medicine and engineering. Psychology was no exception and positivism provided its prevailing

paradigm, behaviourism. While the current study adopts a different standpoint (discussed below), the importance of advances made by behaviourists is not denied, but is incorporated within a broader conception of psychological reality, one that values psychology as a human science rather than wholly as a natural science.

More recent developments in psychology have been marked by a growth in the use of research paradigms deriving from a relativist ontology. Relativism holds that reality is created individually, socially or culturally and that there is no “correct” version of truth but instead many subjectively held versions (Willig, 2008), a view opposing the realist basis for positivism. In its radical form it sees reality as independent of objective structures. Each individual is seen as constructing reality for themselves on the basis of their particular perceptions, shaped to a greater or lesser degree by cultural, linguistic, religious, historical and social influences. As reality is viewed as a subjective phenomenon, relativism can claim to be more fitting than other ontologies for the study of human psychology and experience, because these too are (at least in part) subjective. Influenced by this tradition, Woolfe (2012) sees “subjectivisim” above all as the philosophical cornerstone of the discipline of counselling psychology. The current study sits within that discipline, but is not purely subjectivist in outlook.

The philosophical standpoint taken here is one of critical realism, accepting elements of realist philosophy, but qualifying this with more relativist notions (concisely described by Ponterotto, 2005).It is believed here that individual construction and subjectivism are essential elements to understanding human experience. The way reality is perceived, by researchers and by those being studied, inevitably involves interpretative, hermeneutic processes (discussed below). However, it is also argued that this subjective interpretation takes place within an objective world which exists independent of any observer perspective. The existence of objective facts, including psychological facts, is believed to mean there is common ground, shared reality, between the interpreted, perceived worlds of different individuals. This is especially, but not only, true within any given social group, culture or subculture, at a given time.

The very possibility of a therapeutic relationship and progress within this seems to suggest fundamental commonalities between individuals. That relationship is one of a variety of ways human beings can cooperate and communicate and this capacity is

felt to reflect the existence of shared phenomena of experience. For example, human reactions to attachment and loss include generalised elements, implying that some of the same truths are universally shared. Psychological reality is felt to reflect external, objective reality because it has come into existence in response to such facts. It is seen as adaptive, albeit imperfectly.

Typically (though not necessarily), quantitative methods and experimentation are associated with realist-positivist research as it attempts to identify, explain and predict objective facts. Qualitative methods reflect an intention to describe and explain subjective meanings and the number of studies using these methods has increased in psychological research in recent years. Interestingly, Ponterotto (2005) reports that less than 0.5% of searches of the PsychINFO database in the 1990s yielded hits for any of the terms qualitative research, grounded theory, discourse analysis, phenomenological psychology, or empirical phenomenology.

Behind the shift towards qualitative research, and shared in the current study, is a desire for discovery rather than confirmation, for close contact with clients (facilitating the inclusion of their perspective and input) and a recognition of the need for more accessible research to enhance the profession's credibility with clinicians and the general public as well as researchers (Rennie 2002). This outlook is in line with the core principles of counselling psychology, that is, with the recognition of the priority of individuals' perspectives, a position cogently outlined in James (2013). Quantitative methodology, it is argued, can risk:

> Inappropriately fixing meanings where these are variable and renegotiable in relation to their context of use, the neglect of the uniqueness and particularlity of human experience...[and] overwriting of internally structured subjectives by externally imposed "objective" systems of meaning. (Henwood & Pidgeon, 1992, p. 99)

The conception of counselling psychology here stresses the commitment within psychological research to science as well as the distinctive commitment to the importance of the subjective, as outlined by Woolfe (2012). He discusses this distinction and the model of the scientist-practitioner as a way of bridging the divide.

Woolf points out that in reality scientists and practitioners often hold different aims and values, especially with regard to what constitutes “evidence”. Here it is argued that the quantitative, natural scientific approach to research can be incorporated and valued at the same time as recognising the importance of participant, researcher and practitioner subjectivity (and the methodological value of self knowledge this implies, as discussed by Lane and Corrie, 2006). Put another way, there is a level at which research aiming to be objective and value free contributes to understanding – and a level where focusing on the subjective creation of meaning is also vital.

This view is felt to locate the current research firmly within counselling psychology’s distinctively broad epistemological range, accepting and prioritising diversity of approach in understanding human beings. Such pluralism, in clinical practice as well as in research, means methods can be chosen which best fit the task at hand, the individual concerned or the question being asked (McAteer, 2010). While subjectivism may be at the core of this study, a commitment to science is retained in as far as systematic, rigorous and replicable methods are the goal and are felt to bring research as close as humanly possible to objective, perspective-free reality. Such subjectivism, it is argued, requires reflexivity (described, for example, by Schon, 1995), an attitude encompassing rational thought and meta-cognitive awareness combined with careful attention to internal states and sensations. The specific methodological implications are discussed separately, below.

Rationale for choosing Interpretative Phenomenological Analysis

Consistent with the ontology outlined, and because the aim here is to understand individual experiences of expectations in therapy at a descriptive and heuristic level, Interpretative Phenomenological Analysis (IPA) was felt to be the most suitable research methodology. It is committed to rigour and replicability while emphasising the roles both of interpretation and subjective construction (Smith, Flowers & Larkin 2009). In other words, it is adopted because of its ability to balance the hermeneutics of suspicion and of empathy (as described by Willig, 2013). That balance is felt to be an appropriate fit to the critical realist basis of this research. Empathy is necessary to understand the subjective view of another and suspicion is required to attempt relate this to that which aims to be objective.

IPA is phenomenological in that it is concerned with how humans make sense of or feel about phenomena, with how, for example, they experience their expectations of therapy when these are tested against processes or events during therapy. That type of experience is seen here less as a pure phenomenon, what Husserl would have called the “thing itself” or “eidos”, and more as something “worldly” or relational – experience as understood by Heidegger (the philosophical precursors of IPA are outlined in Smith, et al., 2009). Husserl was closer to the realist end of the continuum, arguing it is possible to transcend the cultural, linguistic and interpretative. Heidegger’s hermeneutic phenomenological perspective, shared here, moves closer to the constructivist, emphasising the creative, interpretative nature of experience. It is the latter which IPA is designed examine.

While IPA is seen as the most appropriate way to get close to participants’ experiences, it was also chosen because it recognises and accommodates the inevitable role of the researcher’s interpretations of participants’ accounts. In so doing it places what Smith and Osborn (2008) refer to as a double hermeneutic at its centre; the two levels of interpretation being that of the researcher and participant (though if the participant’s interpretation of the researcher’s questions is included it might be accurate to talk of a three stage hermeneutic). In this study, it was felt that close analysis of participants’ words, contrasts and similarities between different participants’ accounts and comparison with existing literature on client expectations and the researcher’s perspective would provide a fuller understanding than research restricted to description.

In this regard Husserl’s notion of “bracketing” off the researcher’s own ideas and preconceptions, of taking a “phenomenological attitude”, is significant (Eatough & Smith, 2008). Interpretative phenomenology holds that the researcher’s ideas are the only starting point available from which to understand and engage with a participant’s account. Though bracketing is attempted when examining what participants say, self-awareness and reflexivity are seen as necessary to balance this with the inevitable influence of the preconceptions and perspectives of the researcher. Repeated re-reading of the account (or “re-listening”), with attention to both the biases and the understanding enabled by the researcher’s preconceptions, is seen as the best way to get close the phenomena of the participant experience. This process where the researcher gains knowledge from an awareness of and a

detachment from their own perspective is likened to counter-transference in Willig (2008).

IPA takes an idiographic rather than a nomothetic approach to research, meaning it is concerned with depth of understanding regarding particular participants and particular circumstances, rather than seeking to generalise its findings across populations. Typical sample sizes and selection methods do not allow this. However, IPA does not reject comparison and in looking for themes where related meanings are found across participants' accounts it can take cautious steps towards theoretical generalisation, considering the transferability of ideas. If or when research studies accumulate, this can change (Smith et al., 2009), but within a study like this it is conceptual applicability only that is sought beyond the individual. The participants in this study are seen as likely to share certain cultural norms, experiences and evolutionary dispositions, most obviously distress and some level of expectation that this can be reduced. As such it seems reasonable to look for ways expectancies are experienced which apply across this small sample and to discuss whether these may be more general in the wider population of therapy clients.

The combination between this sharply idiographic focus and an ability to question the participant's perspective was felt to be a unique appeal of IPA. The methodology has the ability to understand individuals' subjective perspectives empathically, while balancing this with a questioning hermeneutic based on researcher reflexivity, the extant literature and comparisons between participants. The triangulation between these contrasting interpretative perspectives was felt to offer an opportunity for improved understanding of clients' experiences of therapy in general and of the involvement of client expectations in this experience in particular.

The hermeneutic dialectics in IPA were also felt to parallel a similar dialectical tension operating in psychotherapy, between expectations prioritising empathy or suspicion. Both therapists and clients, it is argued, have to achieve a balance between closeness and distance, empathy and suspicion. The way this difference is reconciled in the interest of recovery can be seen as a basic dimension of difference between theoretical approaches. Classical psychoanalytic approaches, for example, are characterised by a suspicious hermeneutic rooted in the dynamic model, while person-centred therapy prioritises empathic understanding through the Rogerian

core conditions. Because the research methodology was based on a dialectic that also characterises the therapeutic process, the fit was felt to offer a powerful route to understanding.

Despite this, qualitative methodologies other than IPA were also considered. Grounded Theory (Charmaz, 2003) offered a similar capacity for close textual analysis while aiming to bracket preconceptions (at least initially) and seek themes of meaning within the data. However, in contrast to IPA, the generation of explanatory theory is its clear goal (Ponterotto, 2005). This was felt to be overambitious for the current research, in part because the significance, range and complexity to expectations of therapy and the way these are experienced. The prediction was made that theoretical saturation (described, e.g,, by Willig, 2008) one of Grounded Theory's key aims, would not be possible with so complex a subject and one informed by a literature arguably still in its infancy.

With only very limited research to date using clients' own accounts of their expectations of therapy, it was felt that advances towards answering the research questions would be valuable even if they fell short of providing an explanatory model. As such a model was not the goal, Grounded Theory was not considered appropriate. Further, procedures central to Grounded Theory such as theoretical sampling and constant comparison (where each data collection episode is influenced by the preceding one) were seen as meaning this approach was less idiographic than IPA. IPA, for example, can be adapted for use in a single case study, unlike Grounded Theory. IPA aims to come to each participant account as open as possible to new discovery, while Grounded Theory seeks to move towards model-building. It is argued that openness to the data is necessarily traded off against the latter. The greater idiographic attention to the detailed individual life-world offered by IPA was felt to be better suited to the priority given in the current study to the client perspective.

Approaches focusing on language and discourse were also considered. Such approaches emphasis the construction of meaning within the process of social discourse (Holt, 2011) and the 'action orientation' of communication, its underlying motivations. One branch, discursive psychology, focuses on interpersonal communication and immediate context in the construction of meaning through

choices of interpretative repertoire and discursive strategy. Foucauldian discourse analysis gives a central role to the 'subject position', i.e., the consequence of the chosen discourse for individual subjectivity and identity (Willig, 2008). As such it offers a route to understanding individuals' ways of being and of seeing.

A focus on discourse offers a distinctive lens through which to understand accounts of client expectations in therapy. However, the social constructionist beliefs underlying discourse analyses, seeing reality itself (or realities) as actually constructed through social discourse (Frost, 2011), were too distant from the researcher's ontological beliefs. The position taken in this study was that the participant accounts, to a degree, described experiences of a stable reality independent of the accounts themselves. A focus on the means of communication rather than on experience itself was another reason to reject discursive approaches in favour of IPA. In hermeneutic terms discursive approaches were seen as weighted towards the suspicious end of the continuum, while the more even balance between empathy and suspicion in IPA was felt to offer a broader view of the research questions.

Despite this, discursive approaches are felt to highlight certain limitations of IPA. IPA does rely on the ability of language to give a true representation of experience (Willig, 2008), and this ability is not total or perfect. Neither participants' descriptions of how they experience phenomena, nor researchers' ability to convey meaning in questions and to understand participants' responses, are unmitigated by socially constructed meanings. These limits to IPA are, however, not seen as meaning that one cannot to a large extent understand others' experiences. The differences between IPA and discursive approaches can be seen as a question of extent and Eatough and Smith (2008) describe IPA as "located at the light end of the social constructionist continuum" with both emphasising the hermeneutic dimension to subjective reality.

While the current research is based on critical realism, this is not seen as incompatible with recognising that at a certain level individuals do construct their reality. Aspects of how a person sees the world may be unique to that person, while other aspects are shared and objective. Frost (2011) defines critical realism as seeing the world as composed of "fixed entities to which the actor brings their unique

perspective" – a bridging ontology with room for both realist and constructivist elements. In overview, then, it is felt there is very real truth to be found by applying IPA to client expectations of therapy, notwithstanding a certain distance between what is said, what is understood and actual individual experiences.

Two further criticisms of IPA will be discussed briefly. Firstly, IPA has been criticised for following Heidegger more closely than Husserl in focusing on the heuristics of experience, on the role of interpretation, rather than "eidos", the pure, pre-cognitive, essence of experience (described by Willig, 2008, as "non-propositional" perception). Here, the argument of Smith et al. (2009) is preferred, that experience is probably inseparable from interpretation and sense-making and that without preconceptions phenomena could not be interpreted at all.

Secondly, it has been argued that by focusing on experience, IPA does not speak to the facts on which experiences are based and neglects explanation (see e.g. Larkin, Watts & Clifton, 2006). The contention of Smith et al. (2009), that IPA mobilises both the hermeneutics of suspicion and of empathy (described by Willig, 2013), is felt to be relevant here. The closest description is seen as made possible empathically while the clearest explanation requires an additional level of suspicion. The balance of these two is seen as one of the most attractive features of IPA.

Research procedure

This section describes the procedures and criteria used to recruit participants, the nature of the sample and the conduct of data gathering. It outlines the sequence of technical steps involved in the data analysis process while the abstract conceptual process of analysis is described in the section headed Extraction of Themes in the Results and Analysis chapter. Implications of the sampling procedure for the validity of the study and potential biases are discussed in the section headed Limitations in the closing four pages of the study.

Pilot studies.

Two pilot studies were carried out primarily in order to test the interview schedule and trial the manner of semi-structured interviewing appropriate for an IPA study. The participants were a student and a family contact in full time employment. The first had finished dynamically-informed integrative therapy two weeks earlier and the second had integrative counselling three months prior to interview. After interview they were asked for their views on the questions and the process. Neither pilot was included in the study. This was because it was clear that changes were needed. It was clear that the interviews required very little structuring, but that at times more formality was appropriate. A lesson learned was the degree to which, after agreeing to participate, interviewees still had limits on how much they were willing to disclose about the content of their therapy. It became apparent that the ways in which expectations were relevant could, with tact and care, be discussed without involving very explicit accounts of therapy content and that it was helpful to begin with a tentative and indirect style so participants would not feel pressured to disclose.

It also emerged that a former therapy client could give a richly detailed account of experiences from as long as three months previously. This insight needed to be balanced with consideration of how much her account might have been different after a shorter gap, how much she "filled in" or relied on memories of re-telling as opposed to the experience itself and whether her perspective had altered since the experience. As a result it was decided that the earlier decision that interviews must take place within two weeks of therapy ending would be relaxed to four weeks.

Participants.

Recruitment.

As the goal of this study was a better understanding of a particular aspect of the therapy client's experience, most clients were seen as able to contribute and the balance to be struck was between homogeneity of sample (as recommended by Smith et al., 2009) to allow greater focus; and a degree of variation between participants to accommodate a contrasting range of perspectives that could

illuminate the subject. For these reasons purposive rather than representative sampling was used.

Inclusion criteria.

Adults (over 18) of either gender and any sexual orientation or ethnic background with experience of any duration of therapy were included. It was felt that homogeneity would be served through these broad recruitment criteria because the aim was to investigate all types of expectations (or lack of expectations) that are brought to therapy. In this way links between expectancy and the experience of therapy could be examined. It was felt that the research questions were so fundamental they would be widespread among the help-seeking population and would be reflected among this relatively broad sample base.

It was decided only to include participants who had recently completed their therapy, primarily for ethical reasons. Interviewing during therapy was seen as carrying the potential to interfere with the process and especially with the therapeutic relationship. Although expectations of therapy were likely to be at their most "live" during the early sessions, it was felt that waiting until therapy was complete was not only more ethical but would mean participants could look back at the entire course of their therapy in overview.

One important limit to this breadth of recruitment related to the nature of the therapeutic approach used by practitioners. This aspect of therapy was thought likely to be influential in how expectations were experienced. For example, an expectation of goal-oriented directiveness could be experienced differently in cognitive behavioural therapy and in person-centred therapy. It was believed that the mode of therapy was likely to be a major influence on the findings so in the interest of homogeneity and making sure a consistent phenomenon was being examined across participants, the decision was made to focus on more relational therapeutic approaches. It was also predicted that there would be sufficient contrast within such a sample to allow comparison and consideration of divergence and similarities among participants. This was also because a qualitative study of the expectations of clients of cognitive behaviour therapy had already been conducted (discussed in the

literature review above). Lastly, it was thought that relational therapies were likely to show more variance in the way expectancy was managed than more protocol driven or directive therapies, also creating sufficient opportunities for comparisons within the sample.

As such therapists using transference and countertransference, being guided by and/or sharing their emotions, giving primacy to the Rogerian core conditions or relying on the relationship as a central instrument of therapy were included. In practice this meant participants were recruited via person-centred, psychodynamic and integrative, pluralist or eclectic therapists.

As rich data is necessary for an IPA study (as outlined by Smith et al., 2009), participants fluent enough in English and psychologically minded enough to discuss their experiences in detail were sought. For this reason those with problems thought unlikely to affect their ability to communicate in the desired way were recruited (in the event this meant anxiety and depression were the disorders clearly represented in the study). Due to the resources available all recruitment took place from within a ten mile radius of the researcher's home in north London or from those visiting City University London where flyers were displayed (see recruitment procedure below). An appeal to therapists and therapy services to refer clients meant that some filtering of potential participants was in the hands of this providers even though they were asked to put anyone willing to participate in touch.

Exclusion criteria.

Those with current psychosis or who were in-patients were excluded for ethical reasons as well as due to potential difficulty in communicating effectively. Because of the requirement for the therapy to be of the more open or relational modalities, former clients of cognitive behaviour therapy and other directive therapies were also excluded. Individuals working as therapists were also excluded because their experience as a client was seen as likely to have been influenced by their work.

Participants who had enrolled in therapy because they were students of psychology were treated differently to professional therapists in that a limit of two was adopted on such students rather than a blanket exclusion. In the event just one psychology

student was recruited and that participant began her studies after she started therapy. It was reasoned that students' experiences would be overwhelmingly personal, despite the academic or professional reasons they went into therapy and thus would be appropriate to the study. The influence of studying therapy, it was felt, would not be as pervasive as for working practitioners. Their likely ability to articulate their experiences giving rich data was also a reason for their inclusion. However, as students were likely to be better informed than most about therapy and might be overrepresented in the recruitment, it was felt necessary to restrict their number so that a breadth of client type was included.

Recruitment procedure.

Private practices offering therapy were found using internet searches through BACP and BPS websites within a 10 mile radius of the researcher's home in north London. Information on these websites was used to establish whether the therapists offered predominantly relational approaches. Contact was made with these therapists by telephone, willingness to support the study was established and therapeutic approach confirmed. Some therapists felt it would be unethical to refer clients. Reasons they gave included confidentiality and the sensitivity of issues the research might raise. Those willing to support the study only did so once a verbal explanation of the purpose behind it was given. This emphasised the need to understand the client perspective better, to understand the role of expectations and to investigate how therapists can respond to these in the client's interest.

Many of therapists asked for reassurance that they, as well as their clients, would not be identified in the study, and this was given. A maximum of two clients from any one therapist was accepted, to maintain a level of variability (though all but two participants came from different therapists). Many of the therapists who supported the study asked that they be informed of the outcome of the study and were offered (and accepted) a summary of the findings after completion.

University counselling services were also approached by e-mail (shown in Appendix B). The aim of the study and procedure were explained and it was requested that therapists pass a recruitment flyer (shown in Appendix C) to clients who were due to

complete therapy. Flyers were also displayed on notice boards at City University London. As explained in Smith and Osborn (2008), with in-depth interviewing richness of data is prioritised and traded off against any attempt to randomise recruitment and seek a representative sample in IPA. Accordingly, a total of eight participants were sought. Five participants were recruited through therapists, two via notice boards and one through word-of-mouth.

Where a prospective participant replied to the flyer, they were e-mailed an information sheet (shown in Appendix D) enabling them to make an informed decision about taking part and ensuring they were told of their rights as outlined in the British Psychological Society Code of Human Research Ethics (BPS, 2009). Where they were willing to proceed (which was in all instances) a telephone call was arranged in which their ability to articulate their experiences was assessed by asking them what it was that made them interested in taking part in the study.

The telephone call was also used to explain that audio-recording would take place, to assess whether they had the necessary emotional stability for interview and to answer any initial questions. If the individual appeared appropriate a suitable time and location for interview were arranged. As recruitment proved very slow, the flyer was amended to include a financial incentive of £25 (second version of flyer shown in Appendix E) and this flyer sent to all therapists who agreed to pass it on.

The sample.

In all eight participants were interviewed. A further four got in touch but did not follow up, for unknown reasons and three offered to participate but were not included because they were in therapy at the time. Participants ranged in age fairly evenly from 20 to 61 and their educational level similarly from GCSE to postgraduate. Six participants had lived in England since birth and two were from other countries. The type of therapy they received was often unclear to them and to the researcher, but one appeared to have had psychodynamic therapy and four to have seen therapists significantly influenced by person-centred thinking. It was not possible to ascribe a modality to the remaining three, beyond the fact that it was not directive.

The relatively articulate nature of the sample may have reflected a prevalence of certain types of expectations among participants. Those with verbal fluency and ability may be used to expressing themselves in a way that enables them to attain what they expect more often than others. This may be linked to a sense of their own rights or entitlements.

The participants were six women and two men and two out of the eight had been through therapy more than once. The duration of the therapy six of them had just completed was less than three months, with the remaining two spending more than two years in therapy. Only one participant may have ended prematurely. Participant characteristics were ascertained through a brief questionnaire shown at Appendix A.

The problems they went to therapy with were difficult to establish with certainty but three described symptoms consistent with depression and five with anxiety. Co-morbidity was not apparent, but may well have been missed if it was present. Only two of the participants gave accounts suggesting they suffered from severe mental health problems. The remaining six described more moderate symptoms. Their experience of therapy outcome ranged from extreme satisfaction to extreme dissatisfaction. Two felt their therapy had been so positive they described it as transformative, three others were pleased with the outcome if less unambiguously so, one was clearly ambivalent about outcome and two were strongly dissatisfied and disappointed with their experiences. This ratio is similar to that for therapy clients in the population as a whole (see e.g., Lambert, 2013).

Three participants responded to the version of the flyer that did not offer a fee for participation, two declined to take the £25 and three were given the fee. The role of payment and other potential motivations for participation and the ways the nature of this sample may have impacted on the results of the research are discussed in the section on limitations in the final four pages of this study.

Interview schedule, procedure and transcription.

Interviews were held at public libraries convenient for the participant or at City University London. The interviews took place between July 1st 2013 and Feb 13th, 2014. Once researcher and participant were seated it was explained that there was

some paperwork to ensure the research was properly conducted. Participants were asked whether they had read or would now read the information sheet and this was handed to them. They were also asked to sign an informed consent to participate, including agreement to audio recording (Appendix F). They were also asked to fill out the participant characteristics questionnaire.

Participants were reminded there would be time for questions after the interview, but were encouraged to ask any questions that they wanted answered before the interview. All but one of the participants were happy to proceed without questions. The exception asked for confirmation that their former therapist would not be identified in the study. Participants were also reminded that they were free to take a break or terminate the interview at any stage if this was what they wanted (none did so). Finally, before beginning the interview, participants were reminded that it was what they felt was important about their expectations of therapy that was being sought. They were asked to feel free to say what was on their mind even if there were not sure it was of interest. Throughout the interview process counselling psychology skills were used with the aim of containing participant discomfort or distress, being sensitive to the effects of questions in this regard and to express empathy and acceptance.

Once the interview was over, participants were reminded that any questions or comments they had would be welcome. Some of them had questions about the next stages of the research and some of those who had been dissatisfied with their therapy asked for an opinion on their therapist. Regarding the last point, they were advised that their feelings were important and were seen as such within the profession but also were told that there were many contrasting yet respected and professional approaches to therapy. They were offered signposting to regulatory bodies if they desired. None wanted this information. Participants were asked how they had found the interview process and whether they had felt any of it to be distressing or difficult. None raised any concerns and several said they had found it interesting. They were also informed of their right to withdraw from the study and to get in touch if they had any questions at a later date. They were given names of organisations offering therapy and advice as part of the debrief process, in case the interview had raised difficult issues for them (the debrief sheet, including list of therapy organisations, is shown in Appendix G).

A semi-structured interview format was chosen as this seemed the most likely way to cover areas of interest but at the same time to remain open to new ideas and able to follow these up. This was in accordance with the view of Smith et al. (2009) that the format is appropriate for IPA. The interview schedule itself (shown in Appendix H) was designed with the intention of giving participants freedom to prioritise information as they felt appropriate within the framework of the research question. As such it started with general questions about the nature of their expectations. These gave scope for participants to talk freely and for more than half of them it meant most of the subsequent questions were covered during development of the first answers. A rough list of questions was drafted before reading the literature on client expectations and these were modified after discussion with peers, supervisor, piloting and reading existing research.

While interviewing, the goal was to maintain an accepting and respectful demeanour, showing empathy and understanding to encourage the interviewee to speak freely and honestly. Though this reflects Rogers' (2004) core conditions, a level of directiveness was also necessary and the need to balance receptiveness with judgements about relevance was a focus during interviews. Occasional notes were taken during the interviews to record points to follow up or threads in danger of being lost, but these were kept to a minimum to maintain a conversational feel to facilitate the interviewee's account.

Where a participant's response showed they did not understand the question, prompts were used to clarify. Follow-ups were also used to funnel answers towards areas of interest in a graded process, as discussed by Smith and Osborn (2008). Funnelling aimed to reveal the researcher's specific interests by degree as necessary. This sequence allowed participants to say what they felt was important before issues of prior interest to the researcher were introduced. It was found that such supplementary questioning elicited responses of at least as much clarity and conviction as the more general questions. The final question asked the participants whether there was anything they would like to add that had not been addressed in the interview.

After each interview notes were taken in the reflective diary about how the encounter felt to the researcher, including impressions of the participant. As recommended by

Smith et al. (2009), transcription of the interview recordings included non-verbal communication as well as all the words spoken, including mistakes, verbal “ticks” and repetitions. Recordings were listened to in full before transcription to try to get an accurate sense of the meanings in the accounts, unmediated by the need to get through transcription of all the words spoken. All information that could lead to identification of the participant or his or her therapist was removed during transcription. Transcription was done by the researcher in person as it was thought the time spent doing this could help achieve a close engagement with participants’ accounts.

Analytic procedure.

In the interests of transparency the process used in analysing interview data is outlined below. This began, inevitably, during the interviews themselves, with impressions being formed of the major components of individual participant narratives.

Each recording was listened to without any note-taking after the interview and a further sense of participant experiences was formed. The next stage, transcription, involved a much slower review of accounts, but one that was broken up by the task of writing. It felt impossible to do this without stopping frequently to review and think about sections of interest or uncertainty. At all these stages the urge to note overarching themes was resisted in an attempt to suspend judgement and remain as close as possible to the data, despite certain ideas forming about potential themes.

The transcripts were then read through once more and listened to once more without taking any notes. The next step involved recording descriptive, linguistic and interpretative notes in the transcriptions. These were added as they suggested themselves during repeated re-reading, rather than in any specific order. The transition to establishing themes was started by noting emerging themes on the other side of the transcript page. An excerpt from a transcription after the addition of notes and emergent themes is given at Appendix I. This process was repeated for each participant transcript.

Once emerging themes were noted for a participant, these were collated in a separate document where they were consolidated within higher level themes (example given in Appendix J). A further document was then created and these higher level themes for all participants were transferred to this so they could be reviewed together. Relationships between these higher level themes were traced in this document and those which subsumed the majority of others and related most directly to the research question were used as the superordinate themes. The final table showing all superordinate and subordinate themes is shown in Appendix K. The notation used is the analysis is summarised for clarity in Appendix L.

Ethical considerations

Ethical approval was obtained from the City University London Ethics Committee (Ethics Release form is at Appendix M) and the study was conducted in accordance with the British Psychological Society's Code of Human Research Ethics (2009).

All participants were given an informed consent form. In this, as well as during telephone contact, they were advised of the possibility that the research and especially the interview could raise difficult or painful issues for them. They were told that they had the right to take breaks at interview or to withdraw from the study completely at any stage before, during or for two weeks after the interview. They were also advised that information which could identify them would be removed from transcriptions, that full transcriptions would only be seen by the researcher and that anonymised excerpts only would appear in the finalised study. For this reason details that might identify participants or therapists were removed or altered in the study (with care not to affect the analysis).

Any study asking clients of therapy to talk about their therapy inevitably touches on sensitive matters. However, these measures to anonymise data were felt sufficient to minimise any risk to the privacy of participants. The importance of research which aims to understand clients' experiences was felt to justify the discomfort participants may have felt in talking about their therapy. Nonetheless minimising this was a

priority and regular checks were made to see whether they were distressed at the subject matter or in any other way because of the process.

Participants were also advised that recordings would only be accessed by the researcher, that excerpts from transcripts would appear in the final thesis, that examiners could request copies of these materials and that data would be stored on a password protected computer or in a locked cabinet. They were advised that the study would be published in the university library and that recordings, personal information and transcriptions would be destroyed five years after the date of publication.

Care of participants was a priority during interviews and recruitment. The research was conducted with empathy and acceptance and it was clear in the flyer and phone call that they were dealing with a researcher as opposed to a therapist. They were however all given a full debrief with the opportunity to ask questions or raise issues. During the conduct of the interview care was taken to have regard for the participant's emotional state so that this could be prioritised over the interview if necessary.

Reflexivity

Having discussed the ways the researcher can be a "co-author" of a participant's experience, it is appropriate to include a first person reflexive account of how I saw my own preconceptions, interests and context and how these might influence the research. These factors and reflections on my assumptions concerning what can be known given the nature of reality are considered. They have been summarised as personal and epistemological reflexivity respectively (Willig, 2008). Further reflexive discussion is included when it appeared relevant within the analysis of participant accounts and within the discussion chapter, where a contrasting perspective, one of hindsight, is taken.

Validity in qualitative research has been seen as limited by the impact on both data and its interpretation of subjective researcher factors, especially preconceptions (Langdridge, 2007). This line of thinking questions the very possibility of "bracketing". Authors like Willig, (2008) however, have suggest that a researcher's individual

perspective can be useful in illuminating the experiences of others in a way analogous to the therapist's use of countertransference in therapy. Without a perspective, it can be argued, nothing can be seen at all. Reflexivity, then, means awareness of one's own influence as researcher. It means that attempts to bracket preconceptions are worthwhile, even while they are imperfect. This is because even imperfect bracketing can maximise validity by helping to reduce the bias a researcher's own positioning might otherwise create.

In considering my own preconceptions my aim is to own my perspective as fully and explicitly as possible in the interest of research quality and credibility (as discussed by Elliott, Fischer & Rennie, 1999). To start with, the origin of my interest in client expectations is relevant. The focus grew out of my concern with the sense of urgency I had noticed in clients in my own practice, especially anxious clients in early sessions. I was aware of my concerns, driven by service context, such as carrying out a thorough assessment, formulating and prioritising and estimating what was achievable within a limited timescale. I was also aware of a pressure to stick to protocols so that I would be seen as a "good", competent therapist by colleagues. However, I often felt a gap between these considerations and the urgency of clients' distress. It seemed clear these clients wanted and expected therapy to make a very immediate impact and this sat awkwardly with the administrative and assessment protocols of the service.

In thinking about this I was bound to consider clients' expectations of their therapy. What had they expected? How had they felt if they expected immediate relief and did not get this? Did symptoms like discomfort and anxiety mean attention to distant causes was felt to be inappropriate, disproportionate or uncaring? What kind of process and relationship had they expected in therapy? How did they make sense of what actually happened and how important was this in their therapy?

Considering such questions I came to feel that expectations represent something precious and worthy of close attention. As explained, a client's expectations struck me as perhaps the first expression of his or her actualising tendency (Rogers, 1961). My attachment to this concept means I have given great weight not only to what a client wants to achieve, but to how they wish to go about doing this. I felt what happened to a client's expectations was inextricably linked with the client's agency.

My assumption was that client agency is the fundamental engine of change (as argued by authors like Bohart and Tallman, 1999; Rennie, 2002; and Bohart, 2006). I wondered how well clinical practice in general takes account of and engages with such concerns and I felt there was a risk that asking clients for their goals might sometimes be the beginning and end of any discussion related to expectations.

So a sense that there might be a gap between what clients wanted and what therapists offered was one idea I held before the research even began. I was interested in how such a gap might be experienced by clients. I also had a sense, derived from personal experience and anecdotal evidence, that therapy almost by definition involves a power differential between therapists and clients. I felt that in some ways the latter will be occupying and disclosing from the ground they find most difficult, while the former looks on from a safe distance. I wondered if there is a discrepancy between what the two parties envisage concerning things like responsibilities, the relationship and process and how this affects the client's experience of the therapy.

Given the weight of such assumptions I was aware of the challenge involved in bracketing during research and remaining open to the possibility that my participants might see things differently. They might, for example, feel their here-and-now experiences completely overrode any "baggage" of expectations. I was to find that I often recognised the significance of parts of the participant accounts only on repeated reading and I realised I must have been less receptive to some ideas than to others. It seemed clear that the influence of my preconceptions could obscure important data that I was less attuned to. To avoid "contaminating" clients' actual experiences (Finlay, 2003), I needed to be reflexive and work to bracket strongly held views.

I attempted to do this throughout the research process by repeatedly checking my motivation and my reactions to the data. Especially useful was repeatedly asking myself whether what I was hearing from participants left me feeling uneasy or dissatisfied in any way. This feeling signposted divergences from my own expectations. Where I recognised surprise or unease in myself I took time to focus closely on the source of this tension and on what the participant meant. I frequently

revisited these sections of the transcripts and recordings in order to slow down and examine my own thoughts and feelings (as well as those of the participants).

Another device which helped me bracket my preconceptions was keeping a reflexive diary about how I had felt and what I had thought during the interviews and the analysis (extract shown in Appendix N). In this way I was able to be more aware of my own reactions and feelings so I could stand back from these and consider which parts of the accounts I should look at again. I also tried to maximise consultations with my research supervisor and peers to become less wedded to my own perspective. Within the analysis searches for negative cases and exceptions and re-examination of interpretations in light of these was employed. During interviews I tried to minimise my input and retain a listening and accepting stance.

I was also aware of an epistemological tension within myself as I undertook the research. As a critical realist I believe in an objective reality that includes a degree of universality within the psychological realm (discussed above). I qualify this realism with recognition of the impossibility of perfectly apprehending others' experiences and the existence of linguistic constraints in creating and expressing meanings and in interpreting others' meanings. I accept that there will be elements of my own meanings and constructions as well as those of participants that are idiosyncratic and make it difficult or impossible to fully understand eachother. However, despite this stated epistemology I am aware of strongly positivist family, cultural and educational influences in my life. I hold assumptions at some level that contradict my more intellectual recognition of the limits to realism. The result is a tendency to want to generalise and to claim certainty at odds with my epistemology.

The solution I attempted to this internal tension was regular, systematic checking of my thoughts, supported by input from peers and my supervisor and with the use of the reflexive diary throughout the research process. The more firmly I found myself drawing conclusions and the more quickly and easily I arrived at these, the more I tried to check for realist naivety. I found it helpful too to remind myself that recognising uncertainties about the importance of client expectations was at least as valid and potentially useful as arriving at more definite conclusions.

Finally, I needed to consider the impact on the participants of the context and setting of the research and of my own appearance and manner. These factors were present

in my written style, on the telephone, in emails and in person at interview. At all these stages I could have conveyed my views and values without intending to. I probably appeared a psychotherapy “insider” - the research documentation referred to City University London, most of the interviews took place there, I was described as a psychology student and when I communicated with participants I may have fitted stereotypes associated with this role in many ways. This could have led participants to try to match my outlook by showing understanding or approval of the profession or agreeing with me. I tried to minimise this through a relatively informal and conversational style, by not expressing any views and by emphasising several times that it was their views that mattered to me. Interviews were mostly much less than “semi”-structured and I tried to maintain an accepting and interested manner throughout. Finally, I reviewed my questioning in the transcripts and audio recordings for times I may have shown my own views and considered how these may have influenced participants and biased my interpretations. Where these biases appeared possible I revisited relevant sections of the accounts and reconsidered interpretations.

Validity and research quality

The status and the amount of qualitative research in psychology has lagged behind that of quantitative methods, though that gap has been closing in recent years (Ponterotto, 2005). The discrepancy is in part explainable by ontological differences among researchers but also by political and financial considerations for holders of healthcare commissioning budgets. Qualitative researchers do not control these factors but can attempt to maximise the credibility and validity of their own studies. This section describes efforts made here in that respect. Chwalisz, Shah and Hand (2007) summarise the steps qualitative researchers need to take as making a careful choice of methods and then giving a clear rationale for each methodological decision. In an analysis of research within rehabilitative psychology, however, these authors found an adequate level of such specification in just 105 out of 173 studies. While the current study includes details about its methodological rationale, this is seen as just one element in claiming credibility. More broadly, certain criteria traditionally seen as determining the standard of quantitative research also apply to

qualitative research. These are summarised in “publishablity” guidelines by Elliott et al. (1999) as including relevance to existing research, clarity of research question, informed consent and ethical research conduct, specification of methods, appropriately tentative discussion of implications, clarity of writing and contribution to knowledge (relevance). Each of these was a specific concern here (respectively addressed in the literature review, introduction, procedure/ethics, methodology, analysis/discussion and throughout).

Qualitative research, however, requires additional elements of rigour, due to its distinct ontological bases, and there is a degree of consensus about what this consists of (see e.g., Elliott et al., 1999; Henwood & Pidgeon, 1999; Morrow, 2005). Reflexivity is one priority (discussed above), referring to the need for researchers to own explicitly their ontological position, values and opinions and to consider how these have impacted on their research. Remaining closely grounded in the data is another. This means, for example, citing examples from participant accounts which show how interpretations and conclusions were reached. It also means taking the time to listen and read repeatedly and reconsider these accounts. Remaining grounded in the data was also felt to apply to the conduct of the interviews in as far as attempts were made during interviewing to check understanding with participants as a way of increasing validity. During the analysis a deliberate effort was made to look for “negative cases” that did not fit with emerging interpretations, so that interpretations could be modified or elaborated in the light of all the accounts.

Another important way of increasing validity and thus credibility is to involve others in reviewing a study’s design and the researcher’s interpretations. Fellow doctoral students helped in this respect throughout the course of this study and discussions with the research supervisor included close attention to validity. A further source of “peer review” was discussion of the conduct of the research and of interpretation of data with members of the London Regional IPA Group. The coordinators of this group as well as peer researchers (using IPA in academic study or within their employment) discussed excerpts from studies in progress. Independent scrutiny was also facilitated by maintaining a “paper-trail” making it possible to trace all significant elements of the analysis back to the participant accounts, as recommended by Lincoln and Guba (1985).

It is worth stating that while attempts were made to bracket and minimise the researcher's influence on the process were made, these are recognised to be fallible. As argued by Yardley (2008) the distinctive value of qualitative research would be hard to retain if eliminating researcher influence was the overriding priority. Suspicious interpretation in particular seems to require researchers to use their subjective perspective. Instead of trying to deny this possibility through rigid standardisation and control of the process, qualitative researchers prefer "maximise the benefits of engaging actively" (Yardley, 2008, p. 237). For these reasons bracketing was regarded as appropriate while attempting to engage empathically with the data, but not during other elements of interpretation.

The applicability of research is a fundamental aspect of its quality. That is to say methodological considerations alone do not ensure relevance. In qualitative research involving as it does small sample sizes, claims of generalisability are often highly tenuous and the notion of "transferability" is preferred. For Elliott et al. (1999) situating the sample by describing its parameters is the appropriate response, giving a basis for determining an appropriate range of transferability. Smith and Osborn (2008) come to this problem from a different angle, defining qualitative research's goal (initially, at least) as one of theoretical rather than empirical generalisation. This is understood here to mean that understandings derived from one small research sample may transfer to the conception or design of other studies and to discussion within the literature. Any claims of generalisability across populations need to rely on further research.

In a response to Elliott et al. (1999), and equally applicable to Smith and Osborn (2007), Reicher (2000) argues such claims of transferability apply only to certain qualitative ontologies. He points out that constructionist researchers such as discourse analysts do not believe even one participant's discourse and meaning-making is necessarily stable across different contexts. If transferability does not exist within individuals, he argues, it cannot be claimed to exist between them. The current study accepts that people change and that individual constructions of reality are not always consensual and include idiosyncratic elements. The position taken

here though, is that people own and share a stable sense of reality to a far greater extent than is assumed by more relativist ontologies (discussed above).

Relevance also refers to the significance and importance of a study. One way to maximise this was to aim for a rigorous approach in the execution and scope of this research. Another was that by prioritising the perspective of therapy clients, the study collected data from those the process is intended to help. A further way of maximising relevance was by bringing reflexivity and care to the choice and framing of the research question. This requirement was addressed through examination of initial assumptions about the relevance of the question in discussions with peer researchers and the research supervisor. Time and space for reflection were also created by maintaining the reflexive diary.

Results and Analysis

This section is intended to summarise and interpret the participant accounts, while presenting sufficient data to explain interpretations as transparently as possible. Literature relating to issues that arose and implications of these is presented separately in the discussion chapter which follows. It was felt this would help in remaining as close as possible to what the participants said. By limiting the focus to the data, the influence of existing theory and literature on the sense made of participant sense-making (i.e., on the double hermeneutic central to IPA) was minimised. It is hoped that this separation gives the reader the best opportunity to ground his or her own interpretations in the data too.

Exemplar of data analysis

The following example shows how themes concerning the experience of expectancy were extracted from a section of one participant's account. This abstract and conceptual element of the analysis is differentiated from the relatively mechanical steps involved, described in the section headed Analytic procedure (page 58). The column headed "spoken account" in the excerpt shows the words Dirk used. As the initial line and a half refer to a preceding unit of meaning, these have been left out. The right hand column in the extract shows descriptive, conceptual and linguistic notes prompted by the account through close attention to the words and forms of expression chosen.

This example is used to highlight how a dialectical hermeneutic operated in the analysis of data. Certain elements of what is said are taken at face value, relying on empathic interpretation aimed at getting as close as possible to the text. Others are understood through a questioning or "suspicious" hermeneutic that involves a distanced perspective. The same passages sometimes engage both forms of interpretation. The example also shows how, once extracted, elements of meaning from Dirk's interview are summarised within emergent themes (shown in the left hand column of the example). The way these emergent themes contributed to subordinate and then superordinate themes is exemplified below.

Transcribed excerpt from Dirk's interview (page 13)

Emergent themes		Spoken account	Descriptive, conceptual and linguistic notes
	1		
	2	And you	Willing to defer. Importance of understanding.
Inexperience	3	know maybe it's something I	Implies therapist has been through it? Contrasts therapist's experience
of therapy	4	don't understand, because I've	to his lack.
	5	never been through it and so	Inexperience would explain why process not clear so feels has to wait.
	6	once I've been through it, I'll	Felt this was the (only?) way forward.
	7	understand it and I could say	So many times – feeling that the amount of talk seemed excessive?
Flexibility as	8	okay, I understand why I came in	"just" spoke – speaking in itself feels like only a small thing?
no other	9	so many times and just spoke.	Kept on going like soldiering on. But what options? Doubt in process
option	10	Um. And so, so i kept on going,	seems to have weighed heavy.
Lack of	11	because I was hoping to get the end	Hoping to get end result: Process required trust from him. Meant doing
options	12	result.	something that didn't make sense, staying with it, giving it a chance.

On an empathic analysis, the opening phrase, "And you know maybe it's something I don't understand, because I've never been through it" (lines 2-5) refer to Dirk's sense of his own lack of understanding of his therapist's process. The salience for him of a need to understand is emphasised in the descriptive note "importance of understanding". The idea is highlighted not just because of the meaning of the words he uses, but also because this sense is repeated in the phrase "once I've been through it, I'll understand it" (lines 6-7) and again in "I could say okay, I understand" (lines 7-8).

Having highlighted the importance of understanding, a more interpretative point is also noted – a willingness to defer, implied by carrying on with a therapy that was near incomprehensible at this stage. The notion of deference does not rely directly on the text, but on its context, that of a client persevering despite seeing little basis to the therapeutic process. This more questioning or suspicious hermeneutic adds the value of a distanced perspective to understandings gained empathically from remaining close to the text.

The comment in the notes here, "Contrasts therapist's experience to his lack" also brings the more suspicious hermeneutic into play. It speculates that implicit and unspoken meanings underlie the participant's phrase "because I've never been through it" (lines 4-5). These are expectations that his therapist would have the experience necessary to guide the process in a way that would be helpful and the

expectation that deference to his therapist would therefore be repaid. The speculation involved is reflected in the question mark after the note “implies therapist *has* been through it?”. The same implicit meaning is highlighted in the notes by the phrases “process required trust from him” and “staying with it, giving it a chance”. These notes interpret the text to mean Dirk expected that trust would be repaid.

This section of the interview was felt to express significant and substantial aspects to Dirk’s experience that should be reflected in the themes extracted. This sense was derived from the way he repeatedly refers to the need to understand. A more suspicious hermeneutic is applied to the phrase “so, so I kept on going” at lines 10-11. The linguistic meaning, it was felt, was just part of a larger sense of an experience of difficulty involved in keeping on going. This was suggested by the repeated “so, so”. The halting moment of speech is speculated to reveal his doubts about the process, (as noted) and the sense of a burden being carried (noted as ”seems to weigh heavy”).

Another focus in this section of the account was the phrase “why I came in so many times and just spoke” (lines 8-9). The word “just” is interpreted empathically as reflecting a sense that the talk involved was often of little consequence. The description of going in to therapy and “just” talking “so many times” was felt to express the view that the quantity of talk was sometimes excessive.

One interpretation prompted by a suspicious hermeneutic was considered and rejected. This was the idea that understanding was not important to Dirk in the way he describes and that unhappiness about his therapy arose for other reasons. The questioning of his account in this way was informed by other sections of his interview in which he explained that his therapy had lasted between two and three years but that he never came to understand the process involved. The issue of why he would have stayed in therapy where an expectation so important was denied for so long made an empathic interpretation harder to sustain. However, other less suspicious explanations felt more credible. For example, while an understanding of the process may have been very important to Dirk, even a slight feeling of being heard or accepted could explain why one deeply unsatisfactory aspect of therapy was tolerated for value gained elsewhere, even modest value.

The note “felt this was the (only?) way forward” summarises what Dirk explains about carrying on without the understanding he wanted. Different hermeneutics competed at this point in the analysis. The participant’s explanation makes empathic sense (he saw no alternative). However, the unspoken option of discussing process with his therapist prompted a questioning and suspicious interpretation. Again, other sections of the transcript informed the decision to lean towards empathy. While keeping on going was clearly not the only option, the meaning carried was thought most likely to be that it was the only option that felt appropriate in the circumstances.

Cumulatively the meanings in this section were felt to reveal two “emergent” themes, constructs that were more abstract and analytical than those discussed in the notes. These were: “Inexperience of therapy” and “Flexibility as no other option”. The former reflects empathic interpretation as the point is made explicitly. The latter is more suspicious in that Dirk does not actually say “I had no other option”, but this is surmised from the speculation that he “kept going” despite the burden of incomprehension.

In order to manage the huge amount of meaning in Dirk’s account, these emergent themes were compiled together in list form with all the emergent themes from the entire interview. To try to convert this into conceptually manageable data, they were then clustered together into higher level themes. “Inexperience of therapy” was felt to be captured within a larger, higher order cluster of themes described as “Therapist is responsible”. Examples of other emergent themes included in this cluster were “Put myself in their hands/trust”, “Deference”, “Therapist points out the road”. The emergent theme “Inexperience of therapy”, was felt to form part of the larger expectation that the therapist had to take responsibility because she, in contrast, had the necessary experience to do so.

“Flexibility as no other option” was clustered with emergent themes from other parts of the interview including “Frustration at process”, Doubt re value” and “I didn’t know what she wanted”. This higher order cluster was described as “Process was disempowering”. The emergent theme “Flexibility as no other option” was felt to form part of a wider sense of disempowerment as it implies a lack of choice. In all, the emerging themes from Dirk’s account were felt to fall into nine clusters of higher-order meanings (shown at Appendix J). Because the other seven participants

averaged a similar number of clusters, these in turn were clustered on the basis of meaning to arrive at a conceptually manageable number of “subordinate” themes. “Therapist as responsible” was understood as constituting one aspect of the subordinate theme “Therapist as instructor and guide” (subordinate theme 1:2) and was also felt to reflect a subordinate theme that was simply described as “Inexperience of therapy” (subordinate theme 5:1). “Flexibility as no other option” was seen as a part of the theme “Lack of options” (subordinate theme 5:3).

The final distillation of meanings took the form of superordinate themes under which the subordinate themes were organised. “Therapist as instructor and guide” was seen as a component of Superordinate Theme 1: “Therapist as Leader”. It was seen as one aspect of therapist lead-taking of the kind expected by participants (along with, for example, “Therapist as arbiter of reason/objectivity”). This theme captures meaning from the participant’s explanation “so I kept going, because I was hoping to get the end result” (lines 10-12) in that the underlying point was that the therapist would lead him to an end result. Thus Superordinate Theme 1 can be traced back to specific words used by the participant.

Similarly, the subordinate themes “Inexperience of therapy” and “Lack of options” were felt to be aspects of Superordinate Theme 5: “Agency and Constraint” in that they illustrated ways disempowerment was experienced. This superordinate theme can be traced back to the specific words “why I came in so many times and just spoke” at lines 8-9.

Overview of theme structure

Participants’ experiences of their expectations during therapy were felt to divide most usefully into five overarching themes and 14 subthemes (these are shown with illustrative quotes at Appendix K). In summary these themes are expectations concerning therapist lead-taking, therapist facilitation, contracting, agency and constraint and attempts to change the therapy. It is worth noting that separation into themes was felt to add clarity despite disrupting the integrity of participant narratives. To preserve anonymity, details have been omitted or changed where they may identify participants or their therapists.

While analysing the accounts it was clear that the data could have been organised in differing ways. However, the intention was that the themes used should be convincingly grounded in the participant accounts. While other researchers would have found valid alternatives, it was felt that important aspects of the accounts were stated by participants with considerable clarity. The inevitable influence of personal values and preconceptions involved in qualitative research still allows for rigour and the priority given to this aim is discussed in the reflexivity and validity sections. Relevance to clinical practice has been a major consideration throughout. Overall, the structure used was intended to help organise interpretations meaningfully and accessibly to that end. An overview of the organisation of data into themes is as follows:

Summary of themes

Superordinate themes	**Subordinate themes**
1. Therapist as leader	1:1 therapist as arbiter of reason/objectivity
	1:2 Therapist as instructor and guide
	1:3 Therapist will fix the problem
	1:4 Therapist will provide tools
2. Therapist as facilitator	2:1 Appreciation of space/being heard
	2:2 Expected more intervention
3. Contracting	3:1 Formal contracting
	3:2 Informal contracting
4. Attempting to change therapy	4:1 Negotiation of tasks and goals
	4:2 Negotiation of process
5. Agency and constraint	5:1 Inexperience of therapy
	5:2 Frame
	5:3 Lack of options
	5:4 Deference

Superordinate Theme 1. Therapist as Leader

This theme concerned feelings and thoughts about the perceived degree of leadership shown by therapists. The word leader was used to include attributes of directiveness, such as guidance, instruction in technique and process, and psychoeducation, but to take things further by including expectations of stronger interventions such as “fixing” clients, judging them and expressing opinions unambiguously. Participants were not asked about leadership or any of these aspects of leadership, but it was felt the experiences they described were often connected by expectations of this type. Four dimensions emerged within this broad theme: Therapist as arbiter of reason/objectivity, therapist as instructor and guide, therapist will fix the problem and therapist will provide tools.

Subtheme 1:1 Therapist as arbiter of reason/objectivity.

Several participants appeared to hold assumptions that their therapist would provide the objectivity they struggled to find on their own. They used words like facts, perspective, objectivity and reason to describe what they were looking for.

Dirk explains his expectation of this kind of therapist:

> My role would be to explain a situation, a dilemma, a feeling, and for her to say well this is how you can put it in perspective or this is how you should have felt or you know, something like that. Or these are the range of things and here is your range, it’s not too bad. 18/1-4

The implication is that his therapist should provide meaningful responses to any of a range of issues he might bring. Her position or perspective would be one of clarity or expertise and she should express this by judging issues and telling him what he “should” have felt. A more suspicious hermeneutic suggests a note of reassurance-seeking may be present too in the example he gives where he would be told “things” or his feelings were “not too bad”.

Richard describes a similar expectation that his therapist would enjoy 20:20 vision. He highlights her access to “facts” but also looks to her for arbitration or judgement:

> I wanted someone I didn't know who had no idea about me or my history or my situation or anything, to judge it on the facts. 1/11-13

Distance is underlined as the attribute enabling this firm grasp of "facts". His therapist's lack of knowledge about "anything" to do with him would perhaps allow her the certainty he himself lacked. Therapist judgement is explicitly expected.

Lack of certainty seems to underlie Serena's expectation that distance and objectivity must characterise her therapy. She says she started therapy "really, really messed up" (1/15):

> "I needed help, because I couldn't really kind of, I mean I wasn't eating, I couldn't sleep, I was really, really stressed" (1/17-20).

Physiological failure and the repetition of "I" (six times here) might suggest her very identity was in question. Urgency and helplessness are suggested strongly and seem central to her expectations. She goes on, for example, to say: "I had this urgency to understand *now*, what is happening *now*" (31/4-5) where the repeated emphasis on "now" stresses immediacy. This would help to explain her expectation of very firm judgement from her therapist:

> Maybe I expected the fact that she was this professional, she was actually objective enough to actually tell me when I was talking rubbish or doing or thinking something wrong. 28/1-8

Later she adds:

> I thought, you know, she is not a friend. She is exactly, you know, a professional who has to be objective and distant and tell me how things are. 55/14-56/2

A hard-edged, rigorous judgement, without concession to warmth was expected. The repetition of "actually" suggests that sugaring the pill, a softer approach, was seen as possible. However, professionalism and "distance" rather than warmth or closeness are seen as more helpful and this is strongly felt; the therapist "has to be" this way. This is made necessary because Serena has no doubt that she is not thinking straight – she should be told not "if" but "when" she is "talking rubbish".

Jacqueline also expected her therapist to provide objectivity by expressing plain, explicit judgements. She seems to have seen this as the defining characteristic of any therapy that would be useful to her, again because of a sense of extremity, of being “in freefall” (2/9). She says she wanted:

> Somebody who I could talk over the problem with who could say, oh, either that was rational or irrational. 1/5-2/2

Her therapist should not only see whether she was being rational, but should say so. Judging from her account this expectation remains stable throughout her therapy. The outcome, she believes, was that she learned to be rational and that her expectation was fulfilled:

> It was towards the last two sessions I think, so probably the last month or so, that I began to think more rationally about the situation. 9/5-8

Sinead is not entirely clear whether she expected a therapist who would be robust in sharing opinions, but it makes sense to her when this is what she gets:

> That was really helpful that I had someone who was not afraid to be like well I think you can approach this better or something like that, so I was like really grateful for that because I think if I was left to my own devices I think I would have made a huge mess out of the whole thing. 9/9-16

Gratitude for someone “not afraid” suggests she felt some therapists lack the courage to share their views. This echoes a possible implication of Serena’s phrase “actually tell me”. Again, someone who saw herself as unable to cope and suggests an potentially extreme situation (“I would have made a huge mess”) believes it follows that they should be told how to manage. The expectation that a therapist bring objectivity may not be difficult for practitioners to share, but the view of these participants, that objective positions should be explicitly shared, is more challenging.

Subtheme 1:2 Therapist as instructor and guide.

Another variety of therapist leadership to emerge from the narratives concerned process. Participants expected their therapists to share expertise by guiding them firmly. This meant plain-speaking, explicit instruction rather than subtler enabling or creating space in which clients could find their own way.

This did not necessarily mean the therapist's guidance would be seen as beyond challenge. Sinead, for example, expected to be led and told what to do, but:

> Like I wouldn't be like wow, just because she said this, I wouldn't like just because she said this I really need to do it, but I would always like, well, she is trained to deal with these kinds of things so that means that her opinion should have some weight. 26/12-18

Therapist expertise is emphasised and the implication is that this should be shared. Expertise is seen as giving "weight", something with impact and substance. The repeated "just because" may hold denial, may suggest she actually gives her therapists even more weight than she says. Sinead seemed to be thinking this through as she spoke and to have carried this expectation unconsciously or implicitly only.

Anna too makes it clear she wanted her therapist to lead her and to tell her what to "aim for", though in her case this would be combined with a more facilitative approach:

> I wanted there to be enough kind of talking and compassion around the human condition rather than, not, you know, plus ok, well then this is what you should aim for. 5/2-6

While her overall account emphasises "talking", here Anna may be expressing an expectation that there is a sequence, that talk would "then" lead to being told the way forward. The movement from "rather than" to "plus" (instruction on what to "aim for") may indicate a weighing up of priorities for the first time, again suggesting an expectation that was not conscious previously.

However, Anna is enthusiastic about occasions when her therapist apparently took the reins. About one instance she says:

> She immediately seized on this information and tried to unpick it a bit. And basically she mapped it back that all of the things that traumatized me the most about [identifying detail removed]. 12/23-29

Then:

> And it was like a light bulb literally. When she just joined those two things up. I kind of went, it made perfect sense why my unconscious had just struggled so much. 13/4-9

The picture painted is of an illuminating or even dazzling ("light bulb") experience, of not just being shown what to aim for but why. Her therapist was dynamic and decisive – she "seized" on crucial information. Anna appears deeply impressed at the level of skill being shown. The completeness of the experience "joined" things, integrated elements of the problem, thus adding up to "perfect sense". The expectation of being shown or told what to aim for was exceeded with causes and connections supplied too. Indeed, Anna goes on to talk (below) about the benefits of "giving up responsibility" (27/19), taking the notion of being led further still.

Maia, speaks in more moderate terms of an expectation that "therapists would give you some pointers on where to go or how to deal with things" (1/5-6). However a clear priority attached to therapist guidance is conveyed:

> I wanted to talk to someone neutral who could give me some spin or some positive way of getting out of what I was, what rut I was in. 2/7-11

By highlighting neutrality Maia recalls Serena's description of someone "distant" and Richard's of someone who had "no idea about me". Maia's problems appeared chronic when she began therapy. The "rut" she was in was a dark place and her repetition of the word "some" conveys how badly she needed almost any way of changing things. She had struggled on her own for years and she needed someone else to "give" her a way of out, possibly in contrast with "finding" a way.

One other factor involved in Maia's expectation of "pointers" was her concern with pace. Like Serena, though it seems for financial and temperamental reasons more than due to a sense of urgency, she was clear that she needed results fast:

> I don't like to meander so I guess, you know, and I kind of had it in my head that I wanted a few sessions, as that was only so much as I could afford. 31/10-32/2

The fact she could only afford short term therapy, in her mind, seems to have necessitated direct, plain-speaking communication. The alternative would amount to "meandering", finding value or being content in the journey itself, rather than in reaching the goal. Wandering without clear direction or progress is not compatible with the brief therapy she envisioned.

Dirk (during his therapy or and the research interview) held an expectation of instruction from his therapist – despite their disagreement about how therapy would work. He explains:

> I thought how long are we going to take for this person who probably may never reach the conclusion that we want them to reach, without telling them: This is what you should be thinking about, this is the route. It's clear to anybody. It may even be clear to you but you want knowledge, that kind of thing. And so that was in my opinion the way to deal with these kinds of things. And that contrasted strongly with the counsellor's approach and my counsellor's approach in situation I guess which was more similar to the let's let it roll, hopefully this person will come to the right conclusion just by talking about it. I find that very difficult to comprehend. 14/2-22

His use of the pronoun "we" comes from his memory of advising people himself which he had described before this excerpt. It may also avoid explicit reference to his own need, perhaps out of pride though this is speculative. His question "how long" and his tone in general reflect apparent frustration and even incredulity at any approach without "telling them". Consistent with this he describes the alternative he was faced with as "let it roll", a phrase implying passivity or even complacency.

A striking aspect of Dirk's therapy was many months of stalemate, with his expectation of instruction poles apart from his therapist's approach. A suspicious hermeneutic based on this context to the words he chooses, raises the question of why he would have continued for so long with a therapy he says did not match his

expectations. It may be that he found value in the process that outweighed his frustration at the perceived “let it roll” attitude. This is discussed further as part of the theme, Attempting to change therapy (Superordinate theme 4).

The excerpt reflects no apparent distance between Dirk’s view of the “conclusion that we want them to reach” and the right conclusion for the individual concerned – “it’s clear to anybody” he says. His realism appears total and he seems to feel his therapist had access to facts which she should have stated explicitly.

Richard’s expectation was also for explicit instruction and a didactic process: “My expectation was to be, ah, you know, taught how to handle things” (22/6-8), he says. Possibly explaining the hesitation, he also refers to competing expectations:

> I needed to have some form of, um, discussion really and getting things off my chest in a way that would let the therapist know when, what, tell me why and how to, how to deal with it really. 1/20-2/4

“Discussion” and the phrase “getting things off my chest” suggest an expectation that he would contribute and play a role in addition to simply being told. A sequence may (as with Anna) be implied in the sense that once he has been taught or told what to do, he is the one who will “deal with it”. Unlike Dirk, he additionally expects to identify his problem himself, to “let the therapist know when, what”, so that she can tell him what to do. He also believes his therapist will “tell me why” to follow her instructions, rather than just instructing.

Subtheme 1:3 Therapist will fix the problem.

Most participants said that they expected to be fixed by their therapist. This is compatible with the first two themes (above), emphasising the therapist’s responsibility as in the medical model. Being fixed could take place by means of guidance, teaching, giving instructions, or through some other process and participants did not necessarily feel they needed to know what this would be. Whatever the means, they emphasised the therapist’s role rather than their own.

Natasha focuses on the notion of awareness in her account of this expectation. She says:

> I think on a conscious level it was someone else would fix where there were problems in my life. 4/10-14

This alludes to the existence of another "level" of expectancy, but does not elaborate. She found this "conscious" expectation was not met:

> I would struggle, I would struggle with, we're back at square one, like I feel like I have been here for a while and how is this progressing? 8/12-16

She seems to be describing an illusion of progress, crumbling continuously under her feet. It may be that the expectation of being fixed explains this, that her point of reference when it came to "progressing" was itself illusory. The implication appears to be that for actual improvement, she felt she had to drop the idea of being fixed:

> Now having gone through it, it was much more about going deeper and just kind of stripping back the layers and, yeah and doing that myself. 4/16-20

It is not clear what the "layers" were. They may refer to finding her own agency beneath the distractions and diversions that comprised her problem (though this is speculative). Natasha's overall narrative is that the expectation of being fixed was replaced by a new expectation, that if she took responsibility she would progress, so the layers may consist of avoidance. Responsibility, ("doing that myself") she seems to feel, would achieve more fundamental, "deeper", change. In particular she felt this meant learning to work relationally, being "open and honest about what was going on in the room". 6/20-7/1). Again, taking responsibility, honestly facing issues, may be crucial for her.

In contrast, Anna's expectation of being fixed was not obviously clear at the start of her therapy, but grew as the process progressed and took an unexpected form. She explains this as follows:

> Anna: I think she was very, very good at what she did. So, and that also was one of the, actually one of the pleasant surprises and now I'm just getting

> back to your other question that I couldn't think of, was giving away responsibility actually.
>
> Researcher: Giving away?
>
> Anna: Giving away. So coming into that room, into her room, when she steered that hour was a really, like really lovely (laughs). 27/14-24

The pleasure and surprise she felt at being able to concede responsibility, willingly, is still strong enough to make her laugh aloud. "Actually" seems to address a perceived improbability that this would be something helpful. However, her expectation of being fixed was subsumed within the larger, unexpected experience of "giving away responsibility". In modifying "that" room into "her" room, Anna stresses the therapist's ownership – not just of the physical space, but the therapeutic too.

For Dirk, the idea that he would be fixed is analogous to what he would expect from a dentist:

> I don't expect him to say tell me what's wrong or where is the pain coming from, can you feel it and discuss the pain in immense detail and then eventually for *me* to say oh, look I've got decay on my tooth. I was there for *her* to look at my tooth and say there's decay there, let's fix it. 19/21-28

Dirk's emphases, that identifying the problem is "*her*" responsibility and it is not "for *me* to say", are heartfelt. He contrasts this expectation with what he seems to portray as an almost absurd alternative, the he should identify and fix his own problem. This expectation is expressed consistently through his interview. He explains that after diagnosis his therapist's next responsibility is to fix things. There is some ambiguity in the pronouns he chooses, "you" need to drill it out and "let's" fix it, but the dominant sense is clear.

Attribution to his therapist of ability to fix or repair him was also a feature of Richard's expectations. This strengthened through the course of therapy. He started out emphasising instruction, being "taught" how to deal with things but looking back he credits his therapist with more mysterious, powerful skills:

> The way she did it, it was, it wasn't possible for me, maybe because of the way I was being led, whatever, I wasn't consciously thinking about well that's a breakthrough or that's something I want to get out. It was just a kind of, this is going to sound a little bit twee, but it was kind of like magic. 22/18-23

The excerpt suggests Richard felt his expectation was confirmed. His therapist took responsibility and perhaps for him to do this was not even an option, it "wasn't possible". "Being led" meant an almost passive progress, without knowing or understanding ("consciously thinking about") where he is heading. His almost incidental reference to "being led" (worthy of just a subordinate clause) shows how much he regarded this as a given, how fundamental it was to his expectations.

His delivery of the words "like magic" is sincere and passionate and seems to sum up his view of his experience.

Serena's feeling that because she was "messed up" her therapist should be "objective and distant and tell me how things are" (56/1-2) has been described. This, she seems to say, is how she will be fixed:

> She really said to me I'm not here to judge to you, so you have to, you know, you have to come to a conclusion yourself. And I just didn't, I didn't, because otherwise I would have done it before, because I talked to a lot of people. 59/4-8

Serena explicitly excludes the possibility of fixing herself, of reaching conclusions. Like Dirk she suggests incredulity at this notion and has to emphasise that her therapist "really" (truly) did not intend to judge her or offer conclusions. She sees herself as perhaps willing but practically unable to fix herself and feels she has proven this repeatedly in previous attempts to talk to people.

Subtheme 1:4 Therapist will provide tools.

Six of the eight participants named an expectation that they would be given specific methods to help them overcome their problems themselves. They referred to "tools", "coping mechanisms", "techniques" or "practical ideas". There was little in the way of

elaboration and the extracts below are brief, but participants described this expectation without prompting beyond the general question “What were your expectations of what would happen in therapy?”.

Richard named a range of expectations about how therapy would work (being taught, getting things off his chest, someone to judge it on the facts), but he singles out:

> “Probably coping mechanisms was the most important to be able to, erm, cos I tried, I mean I tried lots of things coming into this” (1/15-17).

His focus in on the future and coping mechanisms are the priority because they will equip him to take responsibility *after* therapy in a way he was not able to before.

Jacqueline also expected therapy to be multifaceted but to include tools:

> I suppose being helpful and constructive and you know giving me maybe some coping mechanisms, that kind of thing. 4/5-7

Coping mechanisms are not raised far above the other aspects of therapy and uncertainty is clear, but the expectation was fulfilled:

> She did give me those things, when required, not every week but you know there were certain things that she suggested I do in certain situations. 5/1-4

Again, it is managing alone in “situations” outside therapy that appears to underlie her expectation.

Maia too says she expected “practical ideas and what I should be doing” (23/1). At the very least this refers to applicable advice, though it seems to mean techniques or tools as well (it seems) as being told what she should do.

Some sense of why tools are valued comes from Sinead. She says she expected being given “techniques I could do, instead of just like telling her how I am feeling” (35/8-10). The word “just” illuminates her attitude to the apparent alternative, more exploratory methods. She seems close to implying that the alternative to practical suggestions about action, what she “should be doing”, would be a limited or empty affair. Tools, it appears, are valued because they are “practical”, they are, again, clearly applicable outside therapy.

Serena too offers some elaboration. She wanted “some techniques, some methods, not to do the same mistakes again” (14/2-4). She saw patterns in her behaviour which she wanted to change or eliminate and again the direct link with behaviour is emphasised.

Finally, Anna, the participant who was to speak most passionately about being given the space to explore for herself (see below), still expected to get tools as part of the mix.

> I also knew from my friend who had recommended her that there would be some kind of tangible, practical sort of tools given to me through that process as well, which is why I was keen on, I didn’t just want to talk. 3/14-19

Tools are contrasted with “just” talk in a similar way to Sinead’s reference to “just telling her how I feel”. They are “tangible” in that they can be grasped, taken away and used. The reason why this expectation was so widely raised by participants seems to lie in exactly this appeal.

Superordinate Theme 2: Therapist as Facilitator

This theme is concerned with participants’ experiences when they felt therapy focused on their own ability to solve their problems and their therapist’s role was to facilitate this. This included how they found it when they were given space to talk and explore. The theme is not conceptualised as opposite to theme 1 (Therapist as leader). Facilitation can be a form of guidance and many participants held multiple, contradictory expectations simultaneously concerning the nature of guidance. Two subthemes emerged: Appreciation of space/being heard and expecting more intervention.

Subtheme 2:1 Appreciation of space/being heard.

Facilitation in therapy can be manifested as a form of guidance, focus or exploration – without the overt opinion sharing by therapists described above. One way this can

be experienced is as space created when a therapist eschews “interventions”. This subtheme looks at how participants made sense of this type of therapy.

Maia describes an initial anxious expectation that the success of her therapy would depend upon her ability to discuss her thoughts and problems. She feared she would find this difficult and this would undermine her therapy. In her third session there is a major turnaround as her expectation is shown to be misplaced.

> That was a surprise. Especially to, a, more or less a stranger, to, to speak so much about things. I was really worried that I wouldn’t have enough to say as well, so (laughs). 24/3-6

Her laughter is eloquent about the surprise this ability to “speak so much about things” represented for her and how good it felt. For the interviewer it elicited a strong sense of shared pleasure and warmth. (Moments like this indicated the ability of qualitative research to capture significance and nuance, matching counselling psychology’s focus on subjective sense-making.) Maia’s halting speech in this excerpt seems to reflect her sense of being reserved and her laughter seems to include surprise at the radical reappraisal of self she experienced.

She expands:

> I didn’t hold much hope in talking can help. I know there’s people who have said it does, but I didn’t think it would maybe work for me. So then I realised it does and I can now see in just some small part why people like therapy (laughs). 21/17-22/4

Reflexively, this was a particularly moving part of the interview, with Maia’s explanation that she “didn’t think it would work maybe for me” being the most poignant. The research hermeneutics applied here are powerfully empathic. Wrapped up in her surprise, it seems, was a major moment of normalisation. The surprise itself seemed threefold. Firstly she had not expected to be able to talk and disclose as fluently as she did. Secondly she was surprised at how easy she found this and thirdly that it felt so good.

In part at least, Maia attributes the ease she felt to her therapist and “the way she was asking the questions and that kind of thing” (21/9-10). She feels there was more to it than questioning alone when she adds “and that kind of thing”, hinting at the unexpected reach of a facilitative approach.

An important aspect of her narrative was that initially her therapist said little. After Maia fed back on how this felt the therapist changed her style and spoke more. The contrasting impacts of silence and reciprocity seem crucial for her:

> Maia: I must say the first couple of sessions she didn’t really do much guidance so, and that was a bit of a surprise cos I thought there would be a bit more, but (pause).
>
> Researcher: So what did she do instead of guide?
>
> Maia: She just listened (laughs). 12/6-10

Then later:

> I felt I wasn’t getting value I suppose, you know. I felt I could just be talking to the wall or something. I would have preferred a bit more. 13/26-14/1

Some facilitation, some help talking, was needed. The laugh after “she just listened” nervously recollects her discomfort and appeared to invite the researcher to laugh at the very idea of a therapist who “just listened”. Maia implies that this was without “value” and pointless and as such unexpected. She underscores the difference between facilitative space and just listening. For her to keep talking with so little reciprocation was as useful to her as talking to a wall and she seems to choose that metaphor to imply a structure designed to keep people out. This kind of space meant “just feeling uncomfortable really. Wasting my time, wasting her time” (24/15-17).

When she felt her therapist became more responsive, “it gave more clarification about what I was feeling and why, and you know that did help me” (17/13-14). Maia seemed to want an exploratory dimension to her therapy in addition to being led, to “pointers” on how to deal with things.

Responsiveness had another crucial effect for her:

> It felt that she was listening more I suppose and then, sort of, “right but what did you feel when this happened?”, sort of more like questions given to me about how I felt and what I was doing so that felt good just responding back to those questions. 35/14-20

Maia ’s language in referring to questions being “given” to her powerfully indicates how she experienced such therapist contributions as helpful and possibly as generous, showing engagement. Overall she did not expect such effective facilitation. She adds:

> At the beginning it was very neutral and then it got more collaborative I would say towards the end. A bit more sort of intermeshed. 20/2-4

Silence, or ”just listening”, seems to have been experienced as an absence of alliance and collaboration, questioning and responsiveness enabled a sense of bonding, becoming “intermeshed”.

Anna’s account of the way facilitative therapy helped her is also heartfelt. From the start of her interview she seems keen to share her passion about the space she found:

> It’s, yeah, just a reflective approach that I can immediately appreciate how healthy that is, but because of the speed at my usual life I don’t get that space really, to do that. 11/7-12

A little later she expands on this:

> Anna: I loved it. (Laughs)
> Researcher: Yeah. Well. What did you love about it, what was
> Anna: Just that you know that, that, um, uninterrupted space to really explore deeply to look, find patterns, to connect things up to the past and make sense

> of things. It just, I found it thrilling at times, you know like really a couple of real epiphanies an exercise so pleasing for me (laughs). 11/19-30

The words “thrilling” and “epiphanies” show the power of a “reflective” or exploratory approach for her. She seems to mean that sustained, uninterrupted focus required time and space to think and feel. Space allowed her to find understanding but “epiphanies” also motivate, possibly removing confusion or inspiring.

Unlike the participants who wanted to hear their therapists arbitrate on logic or facts, Anna believes the space she enjoyed depended on a non-judgemental relationship:

> At the beginning I was quite tempted because that’s in my nature to say, “do you think that was wrong the way I [identifying detail removed]?”. And then I realized that wasn’t part of the narrative, that wasn’t part of the dialogue. 18/23 - 19/1

She suggests here that another unexpected aspect of facilitative therapy was liberation from approval-seeking. Anna experienced the space she found as both an absence of judgement and an absence of pace. In contrast to Serena, slowness was something she could “immediately appreciate” (11/8). She credits her therapist with creating this “conducive space” (23/13).

In as far as his expectations were conscious, Richard appeared to anticipate a combination of facilitation with the instructional approach he describes above. He expects therapy will help in part through “getting things off my chest” (2/3-4). He says:

> She guided me so well it was, it was, it was you know I was almost, I found myself talking about things that I had been much more guarded about 21/9-11

The benefits of this guidance seem to have been more surprising than those of the didactic aspects of his therapy (e.g., being given tools). In fact the way he re-starts this sentence several times seems to indicate that he had barely thought about it before the research the interview. Later he address facilitation from a different angle:

> There was a kind of optimism coming from her that I would bounce off on. It did feel like team-work 31/12-14

"Teamwork" suggests that there was impetus and responsibility-taking from both himself and his therapist, However, there is also a strong emphasis on sensing a generalised, non-explicit approach, the "kind of optimism".

Even Serena, a participant whose account is almost devoid of any positive experience of her therapy, acknowledges some (heavily qualified and possibly grudging) benefit in simple acceptance:

> Even though she didn't give me much input you know, it's still, the little bit that she gave, even if most of it was actually just acceptance and everything and I wasn't particularly pleased with that, but, er, it was still good. 50/13-18

While on balance Serena was dissatisfied and wanted a more judgemental therapist, this raises the idea that a facilitative approach involving more "input" may have been experienced much more positively. This excerpt hints that facilitative talk without tangible intervention was "still good", despite clearly being unexpected.

Subtheme 2:2 Expected more intervention.

Several participants felt a facilitative approach lacked value and felt their therapists had an inexplicable faith in letting them talk. They doubted or dismissed the potential of space, silence or exploration. Therapists who attempted this form of facilitation were experienced as withholding or lacking in honesty in ways that seemed to undermine the therapy.

Sinead's expectation that her therapist would state opinions was matched by an explicit rejection of anyone who would not do this:

> I expected her to be, I don't know what the word I am looking for, but not, really wishy-washy, like "you might want to do this or you might", like I expected her to be like "this is my opinion on what you should do but by no means do you have to". 27/5-11

A therapist who did not take positions and make these clear would be a “wishy-washy” therapist. The term seems visual, implying something blurred and unclear, washed-out. The individual it describes may fail to offer options due to insufficient strength or competence. This would be consistent with Sinead’s description above of being “grateful” for someone who was “not afraid” (9/10). She saw this in terms of her therapist being brave enough to be honest and she saw a risk of getting a wishy-washy therapist.

Serena also wanted to hear her therapist’s opinions and for her the barrier was an excess of acceptance:

> She wouldn’t want to give me any opinion and she wanted just to be totally understanding and accepting over anything. 12/3-6

Saying her therapist “wouldn’t” express opinions implies a refusal in the face of a reasonable expectation. “Totally” and “anything” add to the sense that the alternative, “understanding and accepting” was indiscriminate and unhelpful. She adds:

> I wasn’t particularly happy, for me it was too soft in terms of non-judgement and stuff. 60/9-10

Softness seems to have meant a blurring or vagueness at a time when she wanted clarity. She parodies acceptance in explaining further:

> Let’s be honest, you know, this person doesn’t know me. She is really like, she is a professional and so I don’t want someone to pretend that, you know, they are patting, like this [demonstrates being patted on the head] “oh, poor thing”, you know, I didn’t want that, so I wanted someone who would remind me every time that they are a doctor they are kind of like helping me to fix a problem. 17/7-15

The notion of pretence and honesty is contrasted with task-focused straightforwardness. It may be that Serena felt this was withholding to the point of dishonesty in a way reminiscent of Sinead’s view that bravery was needed for her

therapist to express opinions. The feeling that lack of honesty was accompanied by condescention is also clear in the gesture she makes. The approach is also seen as logically flawed:

> She was constantly telling me that I have the right to feel how I feel and for every horrid thing I said, yes, this person had been naughty to me and that person has been horrible, yes, you have the right to feel how you feel and blah, blah, blah. As I said, I'm not saying I liked her anyway, as I like, I just think that, that kind of therapy is not strong enough for me. I really think I need something more convincing. 12/6-13

Acceptance is boring or senseless, her therapist may as well say "blah, blah, blah". Serena does not believe it because it is illogical to validate bad behaviour or naughtiness. She does not make a distinction between validating bad behaviour and validating her feelings at the time. What would be convincing is being repeatedly reminded "they are a doctor". Clinical detachment is expected and disappointment and frustration at the perceived weakness of her therapy are clear in her parodies.

Maia too senses concealment and lack of honesty when her therapist's position is not shared openly:

> I would have preferred some kind of comment even if it is you know, slightly, um, negative towards me I don't mind. But I don't know, I just wanted someone being a bit more honest. Like "this is how I see things about your life, about what's going through, what's going on in your mind". 42/10-43/1

She would rather difficult truths than consideration of her feelings. Her therapist's judgements, "what's going on in your mind" are wanted. For one thing, she could only afford a small number sessions and does not have time for a gentler approach. "But", she emphasises, the apparently central point was concern to have "someone more honest". Silence meant "just feeling uncomfortable really (laughs). Wasting my time, wasting her time" (24/15-17). Evasion and pointlessness, Maia seems to say, were hard to sit with.

Jacqueline also expected and wanted to hear her therapist's opinions. She based this partly on a previous therapy where she felt space and listening were overemphasised:

> I had had this bad experience of this woman [identifying detail removed] before who never uttered a word during the entire session and I found that impossible. (18/3-6).

She expected to hear another's judgement, somebody who would say "either that was rational or irrational" (1/15-2/2) and without this therapy was "impossible". Exploratory work and space are not mentioned anywhere in her interview, instead it was help in thinking rationally that she appeared to value.

Dirk, who had been expecting to be fixed by his therapist and used the analogy of a patient going to a dentist, is amazed when her realises how little his therapist intends to say. His surprise and incomprehension are encapsulated in his tone, rising in pitch when he explains: "It was almost it was almost completely one sided!" (6/11-12). He remembers:

> I used to wrack my brains before I was going there, going like, "What the fuck am I going to talk about", you know, "What am I going to say to her today". And you know and I would talk and then there would be long silences and I talk some more and then she would say, "Okay, time's up, thank you" and I'd leave and go like, "What was the value of that?" 7/29-8/5

Like others he sees little value in silence. When his therapist says "time's up" he seems to feel she is yet to contribute. Overall, facilitation makes no sense to Dirk:

> I wanted progress, because I'm that kind of person who likes to see progress. I'm not somebody who wanders around in some nebulous kind of maze of things and I very clearly want to have a direction and progress. I want to see progress. 29/29-30/1

His description of an exploratory approach is scathing and like Serena he parodies it to express his view that it is incomprehensible. His expectation was for evident, tangible "progress" (the word is repeated four times) and he seemed to feel this required explicit direction from his therapist. In contrast, exploration is without

substance, “some nebulous kind of maze” (something cloudy and wishy-washy, perhaps). Mazes themselves are full of wrong directions and dead ends, the last place for someone who wants progress. He says:

> That mindset of not telling people what to do, but letting them reach their own conclusion. So, I don’t know, is it some form of psychology out there? One of the brands of Freud, Jung, who knows. 21/18-24

Dirk is aware of different therapeutic modalities, but almost indifferent. “Some” kind of psychology suggests something irrelevant to him and “who knows” has the ring of ‘who cares’. Without “telling people what to do”, the whole thing seems in danger of pointlessness to him.

Superordinate theme 3: Contracting.

The themes above deal with how certain important expectations were experienced when the reality of therapy was encountered. Closely tied to such experiences – by both omission and inclusion – was a process of contracting. Through contracting, expectations could be addressed and the “rules of engagement” negotiated and agreed. For some, contracting took place at the outset of therapy and for others it was an evolving and more implicit process. Participants were not asked about contracting but some raised it themselves and others described experiences that seemed to reflect a sense of an absence of agreement on how to work. Two subthemes emerged in the narratives and focused on formal and informal contracting respectively.

Sub-theme 3:1 Formal contracting.

Half the participants describe going through a process of formal contracting at the start of their therapy. Discussions they relate covered payment, notice periods, absences, therapy duration and goals. All those who raised this process felt dissatisfied with the way it went.

Natasha is the most explicit:

> I would have liked to know more about ok, how does, how does therapy wind, what about the end, how do you know when it's the end? Or maybe, maybe it would have been nice to get a handout which would literally have been about boundaries, timings, expecta-, *something* that just, you know, makes it feel like the service that it is. 30/8-22

She limits comment on her feelings to "would have liked to know more" and "would have been nice", but her tone, and especially her emphasis on the word "something" strongly indicate that this mattered deeply to her and that the uncertainty she carried was a burden. She also wants to stress that therapy is a "service", suggesting perhaps that in exchange for payment she expected her right to be informed to be given more priority. Interestingly, she does not mention negotiation as a part of contracting. Later she returns to the issue of termination:

> When I did finally say to her listen I think I'm done here kind of thing, how, what is the process of it ending? It was only then she sort of said "I usually give it four weeks to wrap up". 33/1-8

The implied criticism ("it was only then") is clear. More effective contracting, addressing her rights as well as obligations, could have avoided such surprises, she suggests. She gives no indication that she had the option of altering about the "wrap up" period and her descriptions may indicate a lack of empowerment. In fact, she seemed to feel certain "rules" were decided by her therapist alone and gives an example concerning the therapist's routine:

> Those rules were kind of determined really by the therapist. I mean maybe if I had seen someone before her I might be going I really don't want to sit here while you [identifying detail removed] and you know cos I've got fifty minutes and I am paying you. 26/2-12

Other passages of Natasha's account prompt a suspicious interpretation here. Her belief that her therapy worked through learning to become honest about what was going on "in the room" sits uncomfortably with rules determined by the therapist and ideas about what she "might" have said. "I've got fifty minutes" suggests acute

awareness of the time lost as she waited. In an affecting comment about this situation, she adds:

> I didn't mind it but I thought I am not sure if she was like that with everyone or, you know, was, she was kind of (pause). 27/3-7

The idea that she might have been singled out for this particular 'rule' is clear. The fact that the sentence goes unfinished gives an impression of still unresolved doubt and struggle to understand exactly what she had the right to expect and, based on that, how she should have felt. Formal contracting may have taken place, but along with subsequent informal contracting through practice or custom it seems to have left Natasha struggling with ambiguity or confusion about the way her therapy worked.

Serena found at least one aspect of formal contracting unwelcome:

> I must confess that I was really stressed also, because she made me sign, which was quite unusual, she made me sign a contract that said I had to go every week, otherwise I would pay anyway (laughs). So I found that quite stressful. 23/3-7

Her laughter seems to indicate just how unreasonable she felt the condition to be (even if it is not as unusual as she thought). Serena felt this contract was not a negotiation at all. "Made me sign" (twice) reflects a sense of being forced, probably against her will, and again the participant does not feel sufficiently empowered to decline and makes no mention of even discussing this. The stress she refers to (also twice) recalls her earlier description of being in a desperate emotional state where she seemed unlikely to have felt able to negotiate on equal terms. All this is not to say her therapist did anything unusual in attempting to set our terms and conditions and it is based on an entirely one-sided account, but it underlines the perceived power imbalance involved. The experience seems to have contributed to Serena's anxiety and to the frustration she felt at her therapy.

She also feels contracting excluded matters she needed clarified. She attempted, she says, to reach an understanding about the duration of her therapy:

> At the beginning there was a strange situation, because yes, she said she wouldn't make any plans about the duration and I personally, well partly for

> financial reasons, but also for time, finding one evening a week, I really wanted a short therapy. 19/5-10

She expands on her dissatisfaction and on what she means by “strange”:

> Serena: She said it takes as long, it takes as long as it takes and we cannot do that.
>
> Researcher: How did that feel for you, when she said that?
>
> Serena: I wasn’t particularly happy with that, and that probably, that already triggered something, that may be kind of a psychoanalysis thing, like you go on forever and talking and talking and talking. 20/3-11

This unhappiness seems based on an expectation that clarifying duration is a standard at the beginning. At the same time it created or strengthened more generalised negative expectations concerning modality. She seems already to have felt there was a risk that she would get a “psychoanalysis thing” involving endless talk – “talking” is repeated three times exemplifying the perceived redundancy involved. This expectation was to harden as her therapy progressed and contribute to her terminating (discussed below). When her attempt to map out a timeline failed, she simply makes her own decision: “I thought I’ll give it a couple of months and see” (19/18-19).

Serena also wanted to clarify her therapist’s approach, but says:

> She didn’t know about the therapy, how it would work, she didn’t have a fixed plan. It depends, you know, how things go and how the person manages, which again, didn’t really make me happy as an answer. (Laughs) 37/18-23

The laugh seems to be at the understatement of her description of her reaction. Her therapist may have wanted to emphasise that flexibility was key but Serena understands something closer to “she didn’t know...how it would work”. With the luxuries of hindsight, time and distance, a fuller discussion of this issue may have prevented the stress and growth of negative expectations she experienced.

A similar frustration comes through in Sinead’s account. In her case this is focused on being unable to clarify and agree goals:

> It was a little frustrating because I think like I think she was trying to deal with, like I said, more issues that were springing up at particular times, and not the whole anxiety thing. 12/1-5

On the same issue she says:

> As far as like anxiety and any other issues that might pop up like, are more deep seated and like affect me a *lot* more, it wasn't so much helpful on that. 11/18-22

In the circumstances "a little frustrating" seems restrained. Sinead expresses emotion perhaps more than at any other time on the words "a *lot* more" and seems to have expected her therapy to focus on anxiety, the fundamental, ("deep seated") goal. She refers to being given:

> A checklist of things like that I wanted to talk about or that I could write in, but I don't think I ever discussed a like specific end goal it was kind of like I would come in every time and it would be like how are you feeling and we would just kind of take it from what had happened since the last time I saw her. 13/5-13

It is not clear whether the checklist was all or just part of the formal contracting Sinead had. She seems to be saying that agreement of a more "specific" goal could, probably should, have taken place and this seems to have been expected, albeit not consciously or explicitly. She implies an ad hoc approach ("just kind of take it from what happened") was taken instead.

Sinead was also left feeling she did not understand certain basic parameters of her therapy and that her therapist was unaware of this:

> I think she assumed that I knew that it was only a certain amount of time. I didn't really understand why it had to be every two weeks either. 38/11-14

Her reaction when she realises this is "just annoyed" (38/23), but her anger, though very relevant to the process, is not expressed. Sinead seems to have understood all this as follows:

> I kind of thought it would be more in depth but as I was going I realised it was not quite such a personal thing because I didn't hire her personally. She is just like a service arranged by [identifying detail removed]. 1/8-11

She says impersonal therapy was a surprise ("I thought it would be more in depth"), linked with disappointment, and this does not appear to have been discussed. Instead, once aware of this, Sinead explains it to herself in terms of the context of the "service" (discussed further in Theme 5:2, Frame). An unfortunate effect of all this for Sinead was self-blame:

> I was just like a little bit disappointed in myself because if I am going to reach out to someone I should tell them what's going on. 15/3-6

A sense of failure at even asking for help must have been dispiriting and could explain why she did not "reach out" more effectively by raising these issues.

Jacqueline's experience represents something of a divergence from the other participants. She considered herself forewarned about the possibility of a non-responsive therapist and felt strongly enough about this to check specifically:

> I wanted to go to somebody who I felt was giving something back, so that's something that I discussed with [therapist]. 3/16-4/2

She seemed to have had a strong sense of what she would accept and her therapist was willing to agree to this clearly stated expectation.

Despite this effective and collaborative contracting, Jacqueline did have some doubts over other aspects of contracting. She says her therapist "came across as quite firm" (25/6) and that the contract said "if you are ill and you miss a session you still have to pay and all of these, you know, big things" (25/9-11). Doubt over whether this was appropriate are suggested and Jacqueline needs reassurance from others:

> I had to sign the contract. I thought oh this is all, um, serious stuff. I remember thinking that 'cos I remember bringing the contract home and discussing it with people and then I felt perhaps more reassured. 26/1-6

Even after being advised by others to sign the contract she feels only "perhaps" more reassured. While appearing to find the "big things" in the contract a little

disconcerting, Jacqueline moves on from the subject fairly swiftly in her interview and seems to have done the same in her therapy. She was able to get agreement on the issue she expected to be important and was able to accept aspects she had not expected.

Jacqueline may have declined to sign the contract when it was first shown to her and her checks with others suggest a degree of agency at the start – one that seemed to influence her therapy later (discussed below). After this, she appeared very satisfied with her therapist and makes no mention of any difficulties concerning rules or approach.

Subtheme 3:2 Informal contracting.

This theme focuses on participants for whom formal contracting either did not take place or was not felt relevant enough to mention at interview. It looks at ways that an understanding or way of working evolved during the therapy instead. This sometimes meant contracting was an implicit, informal understanding. This was experienced in varying ways.

Dirk and his therapist's way of working seemed to be a matter of ongoing mutual pressure and disagreement. His expectation was that he would be in expert hands and that the expert should ensure the therapy works:

> I don't like, I don't like fiddling around with people's processes and she had a particular process. I was going to go through the process. Presumably she was old enough, she's been through this long enough and done enough, so she could advise me rather than other way round. 9/2-10

He seems either to have expected his therapist to explain her process, or to feel this would not be necessary because on the basis of her experience "she could advise me" (as a dentist would). He was confident she would take care of the process effectively. When he is disappointed in this expectation (21/32) his response seems includes what seems like substantial disengagement:

> I was really just going through the process rather than been involved it, just to see where it went. 28/28-32.

Simple curiosity may have been part of Dirk's motivation to continue, but he stayed with his therapist for some time and it seems vanishingly unlikely curiosity alone would have kept him there. A fuller explanation may be that at times he did attempt to move the process closer to one he expected (discussed in Theme 5:2, Negotiation of process), with some success.

However, he comes to feel that he should have raised the issue of process directly:

> I actually should have discussed it with her I guess and asked her why we couldn't, why we couldn't have a different process. 8/27-31

Self-blame, I "should have", results, though apparently mildly and possibly only in retrospect during the research interview ("*actually* I should have"). Dirk's incomprehension of any alternative to the leading style he expected may have made this conversation difficult to frame. Deference about "fiddling around with people's processes" (9/2) might also explain why he did not air this issue directly. Clear contracting is not mentioned by him and if it was absent this may represent a lost opportunity for more constructive engagement.

In contrast, Maia seems to have benefitted from successful informal contracting. When the content of one session became painful, she felt able to say "I don't really want to go any deeper than this" (10/10-11). She explains that this was because boundaries had been discussed:

> You know, if there was anything that I don't want to talk about that would be fine. You maybe go back into it in another session but whatever I want to do. 11/7-9

This clarity, even though Maia does not mention a formal contract to sign, seems to have helped enable her to find her voice despite her doubts she would be able to do so. Without it she may not have drawn a line in the way she did and alternatives like evasion or denial may have followed instead.

Anna and Richard offer negative cases in the sense that contracting (formal or informal) did not appear to be a substantial issue for them. Anna recalls:

> I was recommended this particular therapist [identifying detail removed], so. And I was told in a lot of detail about the processes. 2/1-6

She was confident in her expectations about the nature of the process and these assumptions were later confirmed, which explains why contracting would be less of a priority.

Richard diverged from the other participants in that he was happy to proceed without knowing or establishing what the process would be. His expectation had been to be told "why and how to, how to deal with it really" (2/3-4). The fact that this expectation (like Anna's) was fulfilled meant contracting was less important for him too.

Superordinate theme 4: Attempting to Change Therapy

This theme deals with participants' experiences when they expressed dissatisfaction with or suggested changes to the nature of their therapy. These instances appear to be strongly linked to empowerment or disempowerment. They also seem linked to a special type of client disclosure giving valuable access not just to the way they experience their therapy but to their internal models and processes. As such client attempts to change therapy are felt to be full of therapeutic potential. Two subthemes emerged: Negotiation of tasks and goals and Negotiation of process.

Subtheme 4:1 Negotiation of tasks and goals.

Attempts to discuss and agree the aims of therapy and the methods used are the focus here. Participants were roughly split down the middle when it came to the success or failure of these negotiations.

Overall, Jacqueline seemed to feel her therapy was successful and brought her more peace: "It was my suggestion that we stop, I just felt more aware that I had accepted the situation that I was in" (9/8-11). However she did not feel happy with all her therapist's ideas, and did not expect to:

> I thought she is bound to ask me about [identifying detail removed] and I knew that it would crop up and also that it wasn't related with the problem that I was going to her about. 13/15-13/19

When the expectation was confirmed, she stuck to her intention:

> I said to her I don't really want to talk about, that's why I don't want to talk about [identifying detail removed] because I am not here for [identifying detail removed]. And she was perfectly okay with that. 23/4-9

Jacqueline's therapist valued family work, but the fact that in this context her client did not was good enough for her. This flexibility meant Jacqueline felt free to focus on what she saw as her priorities. This may have avoided potential loss of engagement and strengthened the alliance.

Jacqueline felt a consistent ability to say "no" and the therapeutic value of the openness involved was perhaps clearest when she decided against her therapist's suggestion of a particular task:

> I did think about that task in the weeks and I thought no I can't do that. And I did go back and I said I think that would, if I did that task I think that would make me even more angry. 16/9-14

Jacqueline appears to have believed anger was unhelpful for her, signposting the importance she attached to controlling her emotions and anticipating what she herself only later came to see as the best outcome possible – being more accepting (the role of negative emotion in therapy is considered in the following chapter).

She feels free to make decisions like this, saying it is "not like a teacher pupil relationship, you know, I didn't think I was going to get told off (laughs)" (18/3-18/7). In laughing at the idea of a reprimand she shows her sustained expectation that this was *her* therapy and that she was empowered to share in decisions about what it would involve. This appeared to co-exist with expectations that she would be led implying she would retain independence or agency despite this.

Sinead felt that the goals of her therapy needed to be changed to focus on issues like anxiety that "affect me a *lot* more" (11/21-22):

> I think the second session I came back I did, like I didn't go into super detail, but I was like I feel like I maybe wasn't honest about at least this one thing and we talked about it a little more but I didn't just go into detail about like everything 16/16-17/4.

The strength of her attempt to redirect her therapy is not clear, but the self-blame is (as discussed). She seems to have felt guilt and regret at the fact that her goals were never clarified. "When I first came home I was like, oh I messed up" (16/7-8), she says. She reached a less self-critical understanding only later, feeling the opportunity for the therapy she wanted was never really there. Referring to the issues that affect her "a lot" she says:

> I just feel like they would have come up if I had felt closer to her or had seen her more but I wasn't just going to pull up all this really dramatic stuff like in the first twenty minutes of meeting someone. 15/16-22

Had her attempt to raise these feelings been more successful it seems likely she could have been spared the self-blame and found her therapy far more relevant and valuable. Again, the opportunity for therapeutic benefit from her attempt to redirect her therapy was there (though she did not "go into super detail" and it is not clear whether the signs were possible to read).

Serena wanted to start with "emotional management" but felt her therapist preferred an alternative:

> I was very disappointed because I knew that was the right thing to do. From the beginning she wanted to like, "Oh! Lets discuss, you know, your family". 4/13-16

The parody in her "Oh!" stresses her feeling that her therapist was not doing "the right thing" and possibly hints at some resentment. The disappointment is apparent. Serena moved on to a second expectation; that she would get help with thinking patterns:

> I'm pretty sure there are patterns of thought, for example, or behaviour. Wrong basically. That was the main thing that, in the end it was frustrating

about not getting that and not getting any way of learning how to recognise them and kind of correct them somehow. 62/9-14

She seems to say it was this mismatch with expectations that was the "main" frustration. This may have been because she felt it dealt with the future, being equipped to deal with the rest of her life (one of her stated goals), or because of the cumulative weight of disappointments. Either way, she did not feel able to agree tasks or goals and appears to have decided she had to impose her agenda without agreement:

I said no, now I'm going to talk about [identifying detail removed]. She didn't say a word and I felt like, oh! I wasted a session because of you. So she didn't really want that. 31/11-15

Serena seems to have been interpreted the lack of reply she describes as something approaching a punishment. Her "oh!" sounds almost like an exclamation at physical pain and clearly includes surprise and shock. She expected more of a response than she felt she got. A sense of therapist refusal seems clear as does a sense of blame ("because of you") for an absence of value ("waste").

Anna expected that her therapy would include a focus on her relationship with her spouse, but accepted her therapist's guidance towards a different goal:

Anna: I was expecting like a kind of relationship counselling kind of thing and she very quickly realised that it was (pause), I needed the space to really understand my-*self* much more.

Researcher: I see.

Anna: And I agreed with her through that process, because actually the slow-down effect of it is that, now I get *me* more, I can totally now use that, put that to good effect in terms of my relationship. 15/10-20

She is happy now that she followed her therapist's advice and dropped her initial expectation. It is not clear how difficult this was for her or how long it took, but "through that process", in the course of the therapy, she was convinced. A new priority emerged for her, "to really understand my-*self"*. She appears to have learned a new mode, a "slow-down effect" that she felt important enough to subsume the

earlier expectation. This slowing down emerged as a new expectation about how therapy should work. It is not clear how explicitly this was discussed. Anna's expectation may have been changed through negotiation or because she saw how effective the therapy itself was.

Subtheme 4:2 Negotiation of process.

Theoretical orientation or approach was highlighted as crucially important by all of the participants. Where their expectations of process were not met this was linked to doubts over the value of therapy. Where it felt right, therapy was seen as worthwhile. Among those who appear to have attempted to change process, three felt they failed (completely or in part) to do so, one seemed ambivalent and only one was clearly successful. For these give, perceived success of therapy appeared to be closely linked with achieving process change.

Dirk was one of the participants who seems to have made the most regular, if sometimes oblique, attempts to negotiate his dissatisfaction with the process. He says he asked to be told what his therapist was thinking, but:

> She said, but this is not the way it works. I can't do that. Something like that. And it was, but I also didn't want to upset her by raising it too directly I guess. 20/7-11

His "I guess" here suggests uncertainty about whether being direct would have been better. Not wanting to "upset" his therapist implies an expectation that she may have found it distressing had he discussed her approach more firmly. The tension between this and his expectation of being fixed may have been implicated in their ongoing failure to agree a process and his resistance to his therapist's process. His solicitousness or deference might have been fertile ground therapeutically, but he gives no indication that it was discussed.

Through less direct means, however, Dirk sustained a pressure for change and felt that, to a degree, this paid off: He says: "I'd keep on trying to create situations which she had to intervene (22/7-10). Probably as a result of this, he says his therapist sometimes broke her own "rule" and shared more of her thinking:

> Researcher: And how was that feeling, when that happened?
>
> Dirk: That was great. This was exactly what I wanted. Those were the nuggets that I sort of hung on to. 20/9-26

A pattern of hanging on for nuggets seems to sum up Dirk's account of his therapy. It represents a modified expectation, that he would get the more obviously interventionist therapy he wanted, but only occasionally.

His account may also imply a feeling that his therapist was being inconsistent, that the sharing of nuggets, though welcome, betrayed a shaky conviction in her own approach. He seems to have found the pattern that evolved frustrating, meaning he could maintain his expectation of judgements or opinion-sharing even while, predominantly, it was being denied.

Struggle and frustration seem a sustained feature of Dirk's therapy and appear to have taken a toll. His lack of engagement has been illustrated (27/27-30), but he felt there was another cost - his therapist's engagement.

> I just got the impression that she, I don't know, towards the end generally I got the impression that she wasn't really that interested. That, and I was more trouble than it was worth. And that she couldn't really help me. 32/4-10

This new expectation, that he would get little commitment from his therapist and that she could not or would not "really help" seems likely to have been demotivating and possibly dispiriting. This sense of mutual rejection could not be more distant from the initial expectation that therapy would help fix things.

Serena too was dissatisfied with her therapist's style. She says: "I wasn't particularly happy with her constant acceptance or non-judgment" (52/8-9). As discussed in theme 1:3, Therapist will fix the problem, she said she challenged this approach repeatedly but was told she had to come to her own conclusions, but couldn't:

> I didn't because otherwise I would have done it before because I talked to a lot of people. 59/7-8

She seemed to feel her therapist was missing an obvious fact, that she needed help to be told what these conclusions were. Her explanation, "I would have done it

already" seems to underlie the firmness of her expectation, one of a therapist prepared to make and share judgements. Serena feels she has proof of the need for this approach because she had tried talking and it had not worked for her. She later adds: "I expected more input than I would get from my friends" (59/19-20). Again, disengagement followed, characterised by a detached curiosity similar to Dirk's. She says: "really every session that I just thought, let's see if anything happens" (61/2-3).

Unsuccessful attempts at negotiating a different process seem central to Serena's frustration, compounding the failure to agree on the goals she expected ("emotional management" and "patterns of thinking"). It appears to mean her disappointment was fairly comprehensive. She terminated after a short period in therapy. She summarises: "I would have wanted much stronger input. Definitely." (52/2-4).

In contrast, Natasha and Maia felt substantial initial doubts about the way their therapy worked, but when they raised these they did not describe being disappointed or rebuffed. Natasha only refers to trying to alter her therapy on one occasion. She describes mounting frustration at the her therapist's failure to meet her initial expectation of being fixed. This prompted a moment of apparent anger she feels changed everything:

> This experience happened which kind of I really strongly reacted to and then I sort of thought well I've got to bring that up. I've got to bring up what that made me feel, so I brought it up. 11/1-7

Her therapist, she says, was:

> Kind of encouraging, was ok, let's look at that and that response, then it became much clearer that we could talk about our relationship. 11/18-23

Her attempt to change process, she feels, was productive, with her therapy starting to work better. The apparent switch in process to one focusing on the relationship was not, however, one she says she suggested. Bringing up what the perceived lack of progress made her feel, appears to have been an immediate, emotional response rather than an attempt to negotiate any specific alternative. Her description suggests the outcome depended on her therapist's "encouraging" reaction and this seems to have involved steering the process to focus on their relationship. At this moment Natasha's initial expectation started being replaced. Her reaction to the therapist's

approach provided raw material for just that approach and she says “I then found it easier to kind of go back down that road” (17/6-10).

Maia’s experience was unique among the participants in that she told her therapist she wanted a major change in overall approach and got exactly what she wanted. Significantly it came after the therapist “asked for feedback” (38/6). Maia says she would have:

> Given feedback at that point anyway because I was getting a bit, sort of, I didn’t think that this is what I wanted really, this kind of therapy. 38/6-8

Her tact in not finishing “getting a bit...” may replicate what had been happening in therapy, a sense that she should not name the gap between her expectations and what was happening (like Dirk), not too soon at least. The phrase “didn’t think this is what I wanted” seems an understatement concealing something approaching despair at her therapy: She started out expecting to find it hard to talk and this expectation seemed a though it was being confirmed.

Maia puts a sense of lack of reciprocity at the heart of her unhappiness, saying it felt “a bit strange that it was just me talking with no input coming in” (12/20-21). Again, “strange” would appear to be an understatement as this led her to wonder whether the therapy was “wasting my time, wasting her time” (24/16-17).

These feelings could have led to early termination and must have been difficult to bear. Her therapist’s request for feedback was crucial, making it possible for her to reshape the process to one closer to her most optimistic expectation. She felt the process became more reciprocal and is to conclude, movingly, “that it does work, for me anyway, that therapy does work” (25/1-2).

Superordinate Theme 5: Agency and Constraint

The participants were not asked about the power relationship in their therapy, but many of the experiences they raised seemed to involve a an unexpected sense of disempowerment and a smaller number seemed to empower, also in unexpected

ways. Their accounts of these experiences related to four broad areas linked to expectancy; their inexperience of therapy, frame, lack of options and deference.

Subtheme 5:1 Inexperience of therapy.

Six of the eight participants named their lack of knowledge or experience of therapy as a significant dimension to their expectations. They seemed to feel this meant they had to give the benefit of the doubt to their therapists where therapy did not match their expectations. Sometimes they suggested it meant they were in no position to have firm expectations at all.

Maia had tried to give herself more certainty about what to expect by doing considerable research. Despite this, she seems to have felt going to therapy involved something like an act of faith:

> The thing is, I don't know what it is like until I am trying it (laughs), to be honest, so it is difficult just reading it. It's just an abstract definition of it and if you don't know what it's like during it then it's hard to judge. 16/8-11

Her laugh may be prompted by the very notion of doing something as serious as going to therapy without knowing what to expect, and may recall the nervousness she felt at starting out on this footing. She had "just an abstract definition" and the multiple use of "it" suggests she still lacks a meaningful label to use. This sense of lack of control or power, of having to expose herself without knowing "what it's like", is intense enough to leave an uneasy echo months after her apparent fear was allayed.

Maia appeared to feel this meant she was largely unqualified to steer the process or set the agenda:

> I mean I am not an expert on, um, psychotherapy, so I wouldn't, know you, know where to go or what I should be saying, I suppose. 11/20-12/1

Even Serena, who had a relatively strong sense of what she expected, appears to have been very aware of her inexperience.“I wasn’t clear, because I’ve never had therapy before”, she says (22/18-19). She seems to suggest this meant she had to put her expectations on hold until she knew more and goes on to say that by the end of therapy her doubts were replaced with a clear understanding:

> I wasn’t a hundred percent sure what to expect and I changed my expectation during therapy. But definitely, I’m sure now, I decided, okay, this is not helping me. 8/7-11

For Serena inexperience of therapy seems to have been central in keeping her from asserting her expectations at times. She did not do so during formal contracting or when she was unable to work on the goals and tasks she had expected. As she became more certain she did try address this but it may be that the opportunity for a co-constructed therapy had been lost because patterns had been established and trust and engagement lost.

Dirk, the other participant with notably strong expectations, also appears to have been prepared at times to sideline these because he was aware of his inexperience. He explains:

> Maybe it’s something I don’t understand, because I've never been through it and so once I've been through it, I'll understand it. 12/35-13/4

This stance is also consistent with the dental analogy he used. His therapist, he felt, was the experienced party, the expert, and as such should have told him how things would work. His expectation of being fixed by an expert professional appears to have been based partly on this sense of his own inexperience. When he is not helped in this way, he feels incomprehension and frustration.

Like Maia, Sinead felt her inexperience meant she was unable have very firm expectations:

> I didn’t really have any idea of how it would work specifically or like I don’t know how you would try to counsel someone with anxiety cos I guess if I knew I would just do it. But yeah, no, I wasn’t really sure how it would pan out. 22/11-17

Sinead was more satisfied than Dirk or Serena overall, but felt her inability to clarify goals was a disappointing gap in her therapy. Like the others, a sense of her own inexperience may suggest she did not feel entitled to pursue her expectations more effectively.

For Richard, lack of understanding or experience did not conflict with expectations regarding how therapy would work. His main assumption, that he would be shown the route to recovery, was fulfilled. He says:

> I was trying to analyse how was she doing it but by the end I was thinking you know what, I'm not a therapist. I did one module of psychology at university but I am never going to be able to understand all of that lot. It's not my domain. I come out feeling better. 24/8-12

He may have lacked understanding or specific expectations, but whatever his therapist did, it made him feel better. This appears to be because the therapeutic approached matched the few expectations he did have, such as being given coping mechanisms and that his therapist "would tell me why and how to deal with it" 2/3-4. The need for someone else to take care of process and the "magic" of therapy is again implied in by the uncomprehending "all of that lot".

Natasha seemed to feel that the fact she had not had therapy before may have influenced her throughout the process. Referring to her experience of having to wait while her therapist completed routines she felt ate into her 50 minutes (discussed in Theme 3:1 Formal contracting), she says: "Maybe if I had seen someone before her I might be going I really don't want to (26/4-7)". The implication is that without previous experience of therapy she was in a poor position to judge whether she should accept the situation.

Subtheme 5:2 Frame.

The way therapy was set up, its physical, interpersonal or institutional context, was raised by several participants. Some of them related this to feelings of disempowerment associated with lack of freedom, discomfort and stress.

Natasha speaks of a strong sense of being on someone else's territory. In an affecting passage towards the end of the interview she muses:

> I always felt a bit set free once I had finished. It was like I have done all this work, now I'm going to go and like live my life and I wondered if she was coming into my environment whether there would be less of a disconnect because I would take, it wouldn't be so like a place where I go to do that. 35/19-29

The disconnect she refers to appears to be between being able to "live my life", i.e., to be herself, and going somewhere else to "do that", something less authentic. Being "set free" implies a feeling of having been in someone else's control. Natasha links this very clearly to place, contrasting "my environment" with the place she goes for "that" (something perhaps unnatural or alien to her). The disconnect appears to have come as a surprise to her and one that she did not feel was helpful. In this way physical aspects of the therapeutic frame, the location itself, seemed to play a part in an unexpected kind of disempowerment.

Dirk is unambiguous about his dissatisfaction at the location of his therapy. He did not like the fact that to get to the consulting room he had to go through the entrance to his therapist's home. He says:

> I didn't like the notion that was her flat and all of that, it didn't feel it's just sort of official enough I think, I mean professional enough. 6/21-26

He explains his feeling in terms of a clear expectation that his therapy would be an "official" or "professional" matter without personal or domestic trappings, adding:

> Since I saw where she lived you know and her decorations, she was a human being, a person, another person not a professional. 11/17-21

The "notion that [it] was her flat" and that she was "a person not a professional" suggests an acute awareness of territory. His reluctance to "upset" his therapist may have been connected with not wanting to challenge her too directly in her own home. At the very least Dirk found the location uncomfortable enough to raise twice in the research interview, more than two years on from the start of his therapy.

Frame is an issue in a different way for Sinead. She felt it was the institutional context of the therapy that prevented the more "personal" therapy she expected:

> I kind of thought it would be more in depth but as I was going I realised it was not quite such a personal thing because I didn't hire her personally she is just like a service arranged by [identifying detail removed]. 1/8-14

Early in her therapy she blamed herself for failing to be clear about her goals. It is only later that she sees context as the reason:

> As I realised the use of the sessions to me, like knowing how sporadic they would be and the level or depth we would get into, I don't think if I had gone into huge detail that, I don't know that it would have made a difference. 17/6-12

Her shift from past to present tense ("I realised" to "I don't think") shows that she still holds this view that the opportunity to meet her expected goal (tackling her anxiety) was never there. She was disempowered not because she "messed up", but because the opportunity for this was never there. While the accuracy of these perceptions is not clear, Sinead felt the context of her therapy was the crucial factor.

When it came to experiencing frame as constraining there were, however, also contrasting descriptions. Three participants talked about valuing the special nature of the therapeutic space. For two of these frame had positive aspects as well as the negative ones discussed above. Dirk says "it was the structure that maybe was helpful more than anything else" (28/18-20). The word structure may imply he valued, and found, familiarity, space to think and reliability. He questions the value of much of his therapy, but here he seems to nod towards some sense of being helped.

Sinead seems to make a similar point, highlighting the reliability of help:

> this space is for me to sort out my issues and I definitely have someone who is going to listen to me and always have someone there. 19/17-20

She clearly feels some ownership of what she has found ("this space is for me") and this seems to involve a sense of empowerment. The word "always" emphasises the value she puts on reliability. She and Dirk seem to have come to appreciate these aspects to frame, rather than to have known about or expected them beforehand.

The other contrasting perspective comes from Anna, for whom frame was experienced apparently entirely positively.

> There is no other space in my life where I'm able to talk to somebody who doesn't have any set of judgments or agenda about me. 2/16-19

She appears to have found this empowering, describing it as somewhere she could "make sense of things" (11/26) and do so "in a way that was quite freeing" (19/7-8).

She too emphasises reliability and acceptance, as well as the exceptional character of the time and place where sessions take place.

Subtheme 5:3 Lack of options.

An important sense of constraint suggested in the accounts was the participants' feeling that they had limited options but to make the best of their therapy rather than try to change it or terminate. Even when priorities like approach and goals failed to match their expectations and when disappointment and frustration became significant, they seemed reluctant to react. Options like strong insistence on what they expected or termination appeared to feel unavailable to them (or only became available after significant delay).

Maia had calculated that she would only have a small number of sessions, "as that was only so much as I could afford" (31/10-32/2). Despite this for her first two sessions she tolerated "just feeling uncomfortable really (laughs). Wasting my time, wasting her time" (24/15-17). This was because:

> She didn't really do much guidance so, and that was a bit of a surprise cos I thought there would be a bit more 12/7-8

Two sessions seems a long time to tolerate apparent discomfort and waste rather than the guidance she expected. It is not certain how much longer this would have continued had her therapist not asked for feedback. It may be that because it took time to realise she was "wasting" (24/16) her time she could no longer afford therapy elsewhere. Possibly starting therapy had demanded so much of her personal resources that Maia did not feel able to do it again. Whatever the reason, while in

theory she was free to raise the problem or even to terminate, she appears not to have felt able to do so.

Dirk uses a simile to explain why he stayed in therapy despite his disappointment (22/7):

> It's like watching a movie that you don't like, after you've reached the halfway point you just want to finish it, because you've invested so much time in it. 24/3-8

The image may reflect feelings of curiosity as implied above, or of simple inertia or of a perverse kind of determination. Most of all it seems to capture a sense of disengagement. Dirk also raises the fact that he had invested "so much time" in his therapy and the phrase seems to nod towards investment of emotional energy, effort and money too. The analogy also suggests a lack of any other options about what to do. Had he felt there were options this may have enabled him to move on. Instead he stayed with the therapy despite early disappointment, frustration and possible resentment.

Natasha also describes a sense of limited options, one that seems to have concerned autonomy. She explains:

> I had suggested ending the therapy, but I wouldn't actually, but I needed her permission to do it and it was that idea of like needing to be empowered I suppose to act on something. 13/22–14/5

She seems to have had a strong sense of being in someone else's control. Needing "her permission" to terminate could well result from such a relationship. Alternatively, Natasha may mean that limited agency or autonomy were what brought her to therapy in the first place and that once there, the same issues meant she needed to be empowered, permitted to take any meaningful action. Either way, acting "on something" did not appear to be an option unless or until permission was given. The role of expectations in this is uncertain, but her suggestion of ending therapy followed an unexpected sense of "feeling needed, like there were elements of, I felt, like needed by her" (13/15).

A final example of this theme concerns Serena's expectation of "managing to get out of this emotional mess" (9/9-10), discussed above (in subtheme 4:1, Negotiation of

tasks and goals). As discussed, she seemed to feel this goal was not one her therapist wanted to pursue with her and felt a session was “wasted” as a result. What is interesting is that as well as blaming her therapist, Serena blamed herself for insisting the expectation be met.

> I just felt you know, okay, I did something wrong. I need to collaborate a little more. Let’s give her the benefit of the doubt, let’s do what she wants. 35/3-6

She is chastened and she drops the idea of getting help to manage her emotions, i.e., she accepted that this was not an option (at least at that time). Expressing something she felt she had to say and as a result feeling she had done “something wrong”, unsurprisingly, appears to have been disempowering and Serena becomes passive, saying “let’s do what she wants”. She judges herself and her therapist harshly and this remains unresolved. This account is, of course, totally one-sided, but Serena’s subjective experience is the focus here (as it is with other participants throughout this study). For her it was an experience of expectations denied and a lack of any option to react to this, beside doing what her therapist wanted.

Sinead’s sense of a lack of options was attributed to the context of her contact with her therapist (this could equally have been discuss in Subtheme 5:2 Frame). She says: “I kind of thought it would be more in depth but as I was going I realised it was not such a personal thing because I didn’t her personally” (1/8-12). She felt there was no option of the type of “in depth” therapy she expected because the therapy service was ‘in-house’, offered through an institution rather than privately. She appears to accept this less “personal thing” as a given.

While lack of option but to accept (temporarily at least) disappointing aspects to therapy was described by half the participants, there was one contrasting account. Jacqueline appears to have felt herself free to choose to leave:

> I think I always had at the back of my mind the thought, well if this, if [therapist’s name]’s not right, I can always find somebody else. 19/6-8

This idea was not tested because Jacqueline felt her therapist did turn out to be “right”. However, it seems highly credible in light of the decisions she took not to follow her therapist’s recommendations on certain occasions (discussed in Theme 4:1 Negotiation of tasks and goals). Interestingly this was combined with a feeling

that her initial choice of therapist was one dependent on luck, and possibly that this can be the case in general. She says “I suppose I was lucky that I just hit on the right type of person” (18/24-25) and adds “I think it can be quite hit and miss, yes” (19/1).

Subtheme 5:4 Deference.

The expectation that a therapist would “fix” problems, common among participants, seemed perhaps inevitably to involve placing themselves to a degree in their therapists’ control. It could also mean relegating other expectations they held. Participants appear to have given up differing amounts of control, some deferring to the therapist as a generalised rule and others deferring in a more limited and controlled way. The latter maintained autonomy over some decisions, but still agreed to cede control of the process in important ways.

Natasha’s initial expectations fell into the first category. She describes assuming she would be fixed and this seemed to evolve quickly into an unconscious early feeling that her therapy was primarily about satisfying the therapist.

> There was this kind of element of wanting to please, wanting to feel, to show my therapist “oh look, my life’s improving, I’m doing all this work”. 2/4-10

The logic behind this may be that if her therapist was satisfied with what they did, it followed that she would be fixed. By trying to follow instructions (whether they were given or not), by “doing all this work” she expected this outcome. Natasha’s ability to influence her therapy during this phase appears almost to have disappeared as a result. The expectation that her therapist would control what happened also seems to have persisted in some forms throughout. This is illustrated, for example, by Natasha’s acceptance of her therapist’s routine despite her feeling that this wasted the time she was paying for (as discussed in theme 3:1, Formal contracting).

Dirk also started out expecting to be fixed and also appeared willing to suspend his own evaluation of the process. He explains:

> Maybe there’s some process and it will, in the end I'll look back and say okay now I understand it. It was great. Well done. 13/28-32

Deference to his therapist's expertise and experience is apparent as is the attempt to tolerate his own incomprehension. However his "well done" brings a note of irony, suggesting annoyance (possibly only in hindsight). He may feel he never did "understand it" because it was simply wrong. Deference also seems to play a role in the way he expressed his unhappiness at the time. He says: "I also didn't want to upset her by raising it too directly I guess" (20/9-10). Deference is also suggested in Dirk's solicitousness about "upsetting" his therapist (above).

Richard was happy with his therapy ("I am pleased with what we got done, yeah, it was really good", 32/13-14) and did not seem to feel any need to be involved in deciding how it would work:

> I did one module of psychology at university but I am never going to be able to understand all of that lot. It's not my domain. I come out feeling better. 24/10-12

The message appears to be that he was and is not able to understand how therapy works and did not want or need to, because it worked. Deference seemed to have no associated cost in his experience and allowed his therapist to do what he expected; to "tell me why and how to, how to deal with it" (2/3-4). Ceding control, he felt, was a natural attitude to take when consulting an expert. Just as patients do when they see a medical doctor, he feels clear this is "not my domain".

Anna too was happy to defer. In part, this stance appears to have worked because her therapist's effectiveness was so clear to her:

> It was quite amazing to me and humbling that someone else could actually just sort of hold up the mirror and I go, "oh good stuff!". And there were several things like that. 14/7-12

Anna's experience is an important qualifier to the idea of deference as disempowering. Like Richard's, it suggests that there are times when deference is appropriate – as it is with other expert or skilled professionals. Intuitively, this appears understandable; deference seems intrinsic to any experience of being helped.

The description is reminiscent of the “magic” Richard experienced. Because her therapy was so powerful and achieved so much, Anna seems to say, she was content to sit back in admiration and enjoy the benefits. Being humbled is perhaps the ultimate tribute to such effective help and on that basis she did not feel the need to be responsible for her therapy. She goes on to say this explicitly:

> Actually one of the pleasant surprises, and now I’m just getting back to your other question that I couldn’t think of, was giving away responsibility actually. 27/14-20

She did not expect this pleasure and looking back she sees it as unlikely or improbable, stressing it was true, that it “actually” was the case. She repeats this emphasis on truth, explaining: “I really was very happy to relinquish that because that’s been a feature of the thing, one of the things that really has caused stress” 28/4-7. It was precisely because it was so unlike her to give up responsibility, that this was what she needed, she seems to say. Deference, for her like Richard, was rewarded.

Maia explains the way she tolerated “wasting” two of her small number of sessions “talking to a wall” (27/13) with reference to her lack of knowledge:

> I am not an expert on um psychotherapy so I wouldn’t know, you know, where to go or what I should be saying. 11/23-12/1.

The implication is that she is not qualified to understand, but her therapist is. As such her therapist will know “where to go”. For Maia, though, this deferential stance does not work and she negotiates a more reciprocal process – but only after being invited to do so. In considering why her therapy was successful after this negotiation, she highlights an expectation of safety:

> You just have an instinct really about somebody and then you kind of know, this person’s ok, they’re not going to harm me. 7/15-17

She seems to say that initially this was “an instinct” but “then you kind of know”. In terms of deference this suggests that trust, something necessary for successful therapy, might even involve giving someone the power, as Maia puts it, to “harm

me". If this is true then she felt continuing deference was necessary for her recovery. The implication, that some measure of deference must be necessary in all therapy, is a powerful one.

Sinead emphasises the authority she expected her therapist to carry. She explains that her therapist's words would carry more weight than others':

> If a professional tells me, you need to do this, or whatever, I am more apt to listen, I guess. 3/5-7

For her the expectation of professionalism is central. Relevant skill, experience and/or qualifications mean she should pay particular attention. Again a form of deference seems evident.

Summary

In overview, the expectation of being told or shown what to do and how to think was in some way present, with variations of quality and strength, for all eight participants. For Dirk, Serena and (at first) Maia, the expectation was not satisfactorily fulfilled and for the first two disappointment, frustration or disengagement appeared to follow. For five participants (these three, as well as Sinead and Jacqueline) this expectation of therapist leadership extended to wanting to hear opinions and judgements, sometimes including uncomfortable ones. Four (Dirk, Maia, Serena and, somewhat less clearly, Jacqueline) expected fast progress and felt this meant there was little or no time for exploration in their therapy.

Serena, Dirk and at first Maia experienced the more exploratory space they were given as too weak and often without value or non-collaborative. They all felt their therapists were too reluctant to speak their minds. Even the participant who most valued space, Anna, felt space alone would not be enough and expected more didactic elements in the process too. None of the participants felt their therapists judged or instructed too much or were too opinionated and several complained that these elements were lacking. The apparent consequences of this substantial gap between participants' expectations and their therapists' actual approaches, including disappointment, frustration and disengagement, are illustrated.

Three participants (Anna, Maia and Sinead) said they experienced the therapeutic power of talk in itself, and valued this. Maia did not expect this, while Anna and Sinead did. The importance of this experience was emphasised very strongly by Maia and Anna, who felt transformed by the space they were given, and less so by Sinead. The ways facilitative approaches seemed to work are discussed.

All four participants who explicitly refer to formal administrative contracts (Jacqueline, Sinead, Serena and Natasha) expressed serious reservations about the process. Three out of the four (Sinead, Serena and Natasha) experienced aspects as disempowering and felt these marginalised their expectations.

Serena, Dirk and Sinead (and possibly Natasha) all felt their attempts to shape therapy to their expectations carried insufficient weight with their therapists or failed. The effect was disempowering and led to frustration or even resentment. Self-blame was described by these participants.

Jacqueline was satisfied with the outcome of her negotiation over some of the tasks suggested by her therapist. Anna was satisfied with a discussion over what her therapy would include, which took place at an early stage. Maia was the only participant who felt able to achieve a major change in the nature of her therapy and she felt this change was transformative.

Inexperience of therapy was strongly felt and named explicitly by six participants – Serena, Dirk, Natasha, Sinead, Richard and Maia. All felt this meant they were less able to argue that specific expectations be met or alternatively to have clear expectations at all. When therapy was not going well Dirk, Natasha, Sinead and possibly Maia too, appeared to feel their options were limited. Deference seemed to be an important strand in most participants' experiences – sometimes appearing to be a helpful element of therapy (for Anna and Richard) and at other times seeming unhelpful (for Natasha, Serena, Dirk, Maia and Sinead).

Potential opportunities to address the unfulfilled expectations above were identified, including devoting more attention to contracting and to negotiations about goals, tasks and approach. Times when a power imbalance played a major role were highlighted, suggesting opportunities for greater awareness of this issue. Finally,

important therapeutic opportunities were identified in participants' attempts to discuss process.

Discussion

The participants' emphasis on expecting to be led to recovery was perhaps the most significant finding to emerge in this study. Despite the importance they placed on this expectation there is a dearth of literature on the issue. This section considers therapist responses along the continuum from empathic to suspicious and the impact of these as perceived by participants. It discusses questions raised not just about therapist lead-taking, but about the use of acceptance, silence, negotiation and contracting, in that expectations of being led appeared to influence the therapeutic value of all of these. The importance of the power balance in responding to expectations of therapy is also discussed.

Expectations of being led

The fact that expectations of lead-taking were, to a greater or lesser degree, held by all eight participants, suggests that this may be common among clients. Despite this, while there is discussion of the related concept of directiveness, no literature investigating the broader notion of therapist lead-taking described above has been identified. This leaves therapists with scant information on the expectation. One explanation could be the historic dominance of quantitative research methodology, in particular the use of questionnaires to identify expectations (e.g., Hatchett & Han, 2006, and Kaknovets, 2011). Studies like these have relied on therapist-defined options including directiveness, concreteness and expertise, but not leadership as described by participants in the current study (subsuming directiveness, concreteness and expertise in a wider category including expectations of arbitration and opinion sharing by therapists).

Not only does research offer therapists little guidance; the dominant relationally-focused psychotherapeutic models also give therapist lead-taking little space. This is true of Rogers' client-centred approach (1951) and Freud's emphasis on therapist neutrality (outlined and critiqued by Lynn & Vaillant, 1998, and, more recently, Scaturo, 2005). This may help explain why six of the eight participants here described a gap between this expectation and the reality of therapy. Their accounts

support the idea that clients frequently want clearly visible interventions which have a tangible purpose, as suggested by Lane et al. (2002).

Certainly the evidence here indicates that clients can experience a lack of lead-taking as withholding or failing to contribute, with a negative impact on both alliance and outcome. There are recent studies supporting this view. Bedi et al. (2005) suggest that clients see therapist contributions as the main determinant of alliance quality. This could be in large part because of a perceived need for therapists to take a lead, especially when it comes to discussion of therapy rationale. Patterson, Anderson and Wei (2014) offer support for the idea that expectations of directiveness (which overlaps with lead-taking) are actually beneficial. They found that clients expecting directive therapy were likely to form better alliances and "will likely have better outcomes than clients who do not have these expectations" (p. 679).

This might be because such expectations reflect and allow the expression of client agency in that being shown *how* to work, clients can then get on with that work. If this is true it suggests therapist should give weight to expectations of lead-taking in the interests of engagement. It can be seen that the risks involved in failing to respond adequately to the expectation of therapist lead-taking are suggested by the current study and that previous research supports this view. Accordingly it is suggested here that greater recognition and connection with what may be a common starting point for many clients is important in improving engagement and accordingly alliance and outcomes in relational therapies.

Expectations concerning therapeutic approach

If therapists are to engage constructively with an expectation of lead-taking, they need a more specific idea of what this would mean in practice. A clue appears to lie in the strength of participants' reactions when they were disappointed with therapy. Six of the eight talked about feelings of dissatisfaction. Addressing this through open discussion and negotiation of therapeutic rationale appeared not just a reasonable response, but a necessary one. The current design did not aim to investigate agreement on modality, but it emerged clearly as a central participant concern.

Bachelor (2013) found that clients are more concerned than their therapists about agreement on salient issues. The descriptions here support this and suggest that one of the most salient is an understanding of the way therapy can help. Where this was lacking, it appeared extremely important to participants that this was addressed through explanation and negotiation, and that expectations of lead-taking be met in this way.

Langs (cited by Lane et al., 2002) warns against just the kinds of client experiences described if therapists pay insufficient attention to the nature of intervention their clients expect. In particular, he sees silence, while full of therapeutic potential, as also full of risk. He warns that it can be taken as a sign of inadequate sensitivity to clients' priorities. Similarly, when insights, guidance or opinions were offered by therapists, the participants interviewed here appeared reassured that they were getting the help they needed and that their therapists were fully involved. There are undoubtedly other ways therapists can show involvement (e.g., non-verbally) but on these occasions participants seemed to want clearer indications than they received. In this respect the study supports Langs' suggestions by highlighting the importance of addressing client expectancy.

Lane et al. (2002) make a similar point in their focus on the importance to clients of perceived reciprocity in the alliance, and how this may contrast with therapist attempts to create therapeutic space. Specifically, in considering psychodynamic neutrality, Lane et al. (2002) go as far as saying therapists need to examine whether their silence is "detrimental on the whole, an expression of countertransference retaliation and hate that takes the form of oral deprivation" (p. 1101). The participants here frequently complained (in more moderate language) about their therapists' failure to express themselves. This supports the idea that this is detrimental.

While clients may not know best when it comes to what therapists should provide, their accounts in the current study seemed generally reasonable and considered, supporting Dimcovic's (2001) finding that client expectations are usually moderate or realistic. While the therapeutic potential of negative emotion or transference (discussed, e.g., by Markin, McCarthy & Barber, 2013) is not denied, the accounts in question seemed to indicate occasions when the consequences were unhelpful, including disengagement and termination. This would be understandable in light of

participants explanations that therapist failure or refusal to disclose opinions and judgements sometimes appeared as withholding or even lacking in honesty.

Responses more in line with expectations of leading are not incompatible with major theoretical approaches, be they conceptualised as interpretation, working in the here-and-now, relational work or process identification and direction. These options, which can all link with explanation and discussion of rationale, may be demanding and less practised for some and this could explain the shortfall described by participants. However the need for therapists to take a lead by explaining (and if necessary negotiating) their rationale is recognised in the theoretical literature. Explanation of approach is conceptualised as "giving psychology away", by Cooper (2009):

> If counselling psychology, as a profession, strives to fully welcome our clients – supporting them to be more empowered in their lives – then finding ways of 'gifting' them our psychological knowledge and expertise, so that they are not dependent on us for it, should be at the heart of our psychological work. (p. 125)

This builds on the work of Rennie (1994, 1998) in which therapists are urged to tell their clients what they are doing and how it might help. Rennie (1998) writes:

> Depending on the particular moment, it may be useful to clients to let them know what we are up to so that they do not have to demystify us, and instead have a chance to influence us if what we are up to does not agree with them in some way. (p. 92)

While Rogers would have rejected the idea of clients as objects or the notion of a doctor-patient relationship, he did appear to prefer to let therapy evolve and unfold, rather than explain how he saw it working. It may be that this preference is shared by practitioners today.

While Rennie (1994;1998) focuses on deference in therapy and on metacommunication (discussion of communication) as a way to manage this issue, client expectancy offers an additional perspective. At times participants here made it

clear that they held strong expectations that their therapists would “demystify” what would happen. While this expectation was clear in at least six of the eight, it was those who did not feel their therapy was as helpful as they thought it would be, who stressed the point most strongly. The task of having to demystify the process for themselves was one they did not expect and one they seemed to experience as frustrating. For some this appeared to be a primary focus of disappointment, possibly leading to resentment in two cases.

Rennie (1998) argues that a lack of discussion concerning rationale can be explained by a tradition of one-way “metacommunication”. He includes person-centred counselling in this, saying of Rogers that:

> He was reluctant to ask for his impact on the client and to reveal his purposes... therapists in this tradition prefer to see themselves as subjects and clients as objects, themselves as agents and clients as patients. Also, going along with this is the tendency for therapists to assume that they have more cognitive privilege than the client. (p. 90)

Some therapists may argue that allowing clients to work things out for themselves fosters independence. Tallman and Bohart (1999) argue simply and convincingly that the client self-heals and Rennie (2006) highlights the importance of clients’ self-awareness and ability to manage their relationship with their therapists. An expectation of being led to understanding of therapeutic rationale need not, however, undermine or stand in opposition to these views of client-as-agent. In fact negative reactions expressed by participants may be the result of perceived blockages to the wish to take more responsibility, experienced as a restriction of client agency. Pluralistic approaches in particular emphasise responsiveness to the client’s perspective. Cooper and McLeod (2007), for example, see no contradiction between client agency and explicit therapist advice and explanation regarding process. They say “therapy is most likely to be effective when clients and therapists both draw on their particular bodies of knowledge and expertise and the methods and tasks of therapy emerge through a collaborative, negotiated dialogue”. (p. 140).

Therapists may at times have compelling reasons not to fulfil clients’ expectations of leadership or of negotiation over approach. This could include helping clients face issues like low tolerance of uncertainty or a lack of trust and prioritising these over

meeting expectations. However, the accounts here described occasions when this course of action led to manipulation, disengagement, and termination by clients. The stakes seem high where negotiation is neglected. Accordingly, a central implication of the current study is that more therapist attention to transparency and to negotiation regarding approach may be needed. Clients may go into therapy expecting their therapists to lead them through a problem or blockage so they are in a position to take the reins again. It may be that the best explanation is offered by de Shazer (1985), that clients look to their therapists to lead by supplying the "waypower" or route to recovery, while they themselves would supply the willpower once that route is clear. On the evidence here, the damage caused to the alliance and ultimately to outcomes when such process expectations are left unfulfilled can be greater than the benefit of any learning experience involved.

Psycho-education and information provision.

A need to understand their therapists' rationale for treatment, or to get proof that it worked, was described by six of the eight participants. They saw this as a function of their own lack of knowledge and inexperience of therapy. This uncertainty led to frustration, anxiety and disengagement when it was not allayed (in at least four cases). This implies that the need for better information may be commonplace, not just through accessible resources when clients are deciding whether to seek help and who to see, but also during therapy, through psychoeducation. The damage to alliance and outcome evidenced here, it is argued, mean that both therapy services and individual therapists should consider prioritising this need.

Research suggests the information available to potential clients considering having therapy is inadequate. Watsford et al. (2013) report that the majority of young people in their sample were unsure and ill-informed about therapy. This even included most of those who with previous experience of therapy. These authors make the point that clients' preparedness for therapy may in part depend on adequate information, however there is little detail about the kind of therapy their sample had ("treatment approaches varied", p. 77). Seligman et al. (2009) found fewer than one in twenty clients starting CBT knew what would they would be expected to do. The accounts here indicate that similarly vague expectations may be found among those starting

relational types of therapy. Expectations became clearer if they were not matched (expectation disconfirmation has been identified as worthy of special attention by Westra et al., 2010).

The responsibility of therapists to explain how they will work is emphasised in recent writing (e.g., Cooper & McLeod, 2007; Dreier, 2008; Gostas, Wiberg, Neander, & Kjellin, 2012). There is also evidence that psychoeducation, or "recruitment to the rationale", leads to better outcomes in CBT, as evaluated by clients (Westra & Ahmed, 2009). There is a dearth of research on the importance of psychoeducation in relational therapies. Despite this, the current study indicates that the importance given to explanation by those working relationally may be a major issue. The small sample here suggests clients may feel it is not always given appropriate priority – and that damaging levels of frustration and disengagement may result. The majority of participants in the current study saw therapists in private practice and it may be that better availability of information is especially important in this context, where a more individualistic or idiosyncratic culture may predominate.

However, it is argued here that taking a lead through psychoeducation per se is an inadequate response to clients' lack of information. Negotiation is also needed and attention to expectancy is a crucial part of this. As long ago as 1961, Frank argued that negotiation of a modality or plan that was acceptable to the client should be a part of all therapies and the point remains central in the common factors literature (e.g., DeFife & Hilsenroth, 2011; Goldfried &Davila, 2005; Lambert, 1992). Studies reviewed above of the association between positive expectations and therapy outcome (e.g., Price & Anderson, 2012) support this argument. Negotiation of approach is considered in more depth below.

Overall, the current study indicates that therapist lead-taking in the explanation of approach may frequently be needed so that negotiation in light of client expectations can follow. Explanation can maximise engagement and create a basis for a mutual alliance and a shared sense of direction, crucial components of successful therapy. It is argued that where therapy approach is not satisfactorily demonstrated quickly enough for clients, the alternative to explanation can be a damaging level of frustration. Importantly, there is no necessary incompatibility between lead-taking and an emphasis on the clients' subjective sense-making stressed in Counselling

Psychology. In fact by taking the initiative in ensuring elucidation of therapeutic approach, followed by negotiation and agreement on this, therapists can maximise outcomes by tailoring therapy for individual clients.

Implications regarding the use of acceptance

It is not intended to imply that a more subtle, less overtly active therapist stance is without value or that it is necessarily opposed to lead-taking. Acceptance, space and empathy were highly valued by participants. Their experiences resonated with the person-centred basis for acceptance, the view that "in a sense the client becomes contaminated by the counsellor's accepting attitude and little by little he begins to experience the same attitude towards himself" (Mearns & Thorne, 2007, p. 98). Five were explicit about their appreciation of a facilitative space in which to explore and 'be'.

However, the participants' emphasis on an expectation of being led highlighted limitations and risks involved in therapist over-reliance on acceptance. While the emphasis given to acceptance, primarily as understood by Rogers (1951), remains pervasively influential and was evident among the therapists in this study, the findings here are sometimes better explained by a less well-known strand of counter-argument (e.g., Kahn, 1999; Rennie, 2006) discussed above. This stresses that an overly exclusive focus on creating a facilitative space can be experienced as frustrating and without value – depending on when and for whom. While therapist empathy is a necessity in therapy, the accounts suggest that at times more suspicious therapist hermeneutics would have been appreciated.

The experience of participants made clear the risks involved in what they felt was an over-use of acceptance Five of the eight started out believing an excess of this quality was a distinct possibility and one they wanted to avoid. Four of the five described experiencing exactly this excess. One said he had come across the idea that people must be left to find their own conclusions before and found it "incomprehensible", another said she found a silent therapist "impossible" and another explained how she was grateful not to have had a "wishy-washy" therapist. They described being thrown and confused when they felt their therapists refused to

lead in the way they expected and alliance, agency and outcome all seemed to suffer thereafter. The four participants who prioritised pace of progress were most forceful in their rejection of therapeutic space. They explained their expectations of pace in different ways. These included being unable to afford more than a given number of sessions, feeling the extremity of their emotions was impossible to tolerate any longer, and being a personality type that needs to see fast progress. For them, space appeared not to be valued and instead to be experienced as deeply inappropriate, pointless or wasteful.

This ties in with previous research. It is in line with the suggestion that clients overestimate the likelihood of therapist directiveness and can be disappointed when this is not forthcoming, made by Tinsley et al. (1993). It also supports the finding of Bachelor (2013) that clients are more concerned than therapists with "therapist-specific contributions". In the same vein it supports and adds detail to the contention of Bedi et al. (2005) that clients stress "the activity of the counsellor with only minimal additions from themselves" (p. 83.). Further research into how often clients perceive an excess of acceptance and why they feel this way, would be valuable. Aspects of their experience could be ascertained by questionnaire, making results more generalisable than from qualitative work. One possibility is that some who could be seen for relatively brief therapies may approach therapists more inclined towards longer term work. If this is the case then early recognition of the fact could help therapists discuss and address potential problems.

One implication of this study is that, especially where clients expect short term therapy, acceptance needs to be used with care and flexibility. Silence can be seen as particularly unhelpful, as discussed above. At worst, participants expecting fast progress and unable to see the value of space sometimes experienced their therapists as condescending or even dishonest in their perceived refusal to match this expectation. The differing needs of individual clients as expressed in their expectations appeared crucial in the current sample. Expectations of therapist style need to be elicited and considered and it is argued that it is not enough to rely solely on theoretical allegiance to acceptance to guide approach.

It is also argued that explanation of the treatment rationale is not incompatible with more relational approaches to therapy. Divergence between participants and even

within participants suggest the value of a broad spread of therapist approaches, drawn on responsively. Participants described their pre-therapy expectations as including acceptance, but also tools for change; that they would find warmth, but also objectivity and arbitration on wrong and right; and that they would be given space but also be fixed. It is suggested that variation and flexibility were appreciated, and that the balance between acceptance and lead-taking is a critical example. It is also worth stressing that none of the participants expressed dissatisfaction with therapist lead-taking, but five clearly felt unvarying acceptance to be inadequate. Balance and flexibility are recommended and it is suggested that over-reliance on empathic hermeneutics and therapeutic approach may impede clients' progress.

Engaging with expectations: Elicit and negotiate.

So far, this discussion has focused on what the participants expected and on their feelings and interpretations when these expectations were matched or disconfirmed. These experiences are seen here as pivotal to perceptions concerning the value of therapy, strongly influencing the degree to which client agency is engaged and accordingly whether engagement and attendance are sustained. However, in some respects this is only the start of the story. Once the degree of match with expectations became clear, at least seven of the eight participants tried to make changes to the process, tasks or goals. These attempts at influence were critical events for the participants. They expected to be able to influence process, and where they experienced therapists as inflexible this was imbued with negative meanings taking a toll on the perceived value of the therapy. A key implication of the current study is that practitioners should be willing to engage flexibly with client concerns at these times and to recognise their importance in terms of agency.

Critically, only one participant was happy with the outcome of her attempt to change her therapist's approach. Four described being unable adequately to influence the process and felt strongly that this was unhelpful and affected the value of their therapy. Not only does this finding add to the literature arguing that therapists must show flexibility of approach (e.g., Cooper, 2009; McLeod, 2012 & Orlinsky, 1994), it also supports the view that they should elicit and then discuss clients' expectations to enable this flexibility (Swift & Callahan, 2009; Safran, 2011). Dreier (2008) frames

the point convincingly in terms of belief, stating that it is inappropriate to ask clients to stay in therapy out of blind faith in their therapists' expertise. The current study adds evidence to these arguments and suggests they should be more influential than they are in clinical practice and that an important opportunity for improvement exists in this area.

Further research using quantitative methods could help establish the extent to which difficulties identified in the small sample here apply more generally. It could compare the views of matched pairs of clients and therapists, asking whether clients had tried to influence process and what response they received. The match between the perceptions of clients and therapists would be an important guide to practice. If the client experience identified here is shown to exist more widely, it would support and add urgency to the argument for greater engagement with expectancy. Qualitative methods could add depth. It would be valuable to hear from clients whether they came to accept aspects of a process they at first resisted. Conversely would therapists report changing their views of what approach was appropriate? Detail about how and why these conversations occur and their perceived outcomes would also be valuable.

Balancing the need for flexibility with the participants' desire to be led can be complex. It is possible, however, to envisage transparent conversations about this issue. Clients who want their therapists to arbitrate or express opinions, for example, could be helped to make clear when and why they want this. Therapists can oblige or explain why they do not think this is helpful. In this way clients can feel they have influenced the process or, alternatively, that their concerns have at least been seriously considered in a collaborative fashion. Either outcome would be likely to facilitate engagement and thus contribute to positive outcomes.

This idea may need to be qualified when it comes to longer term therapy. Negative and unexpected client experiences may be welcomed for their therapeutic benefit and the opportunity for clients to learn, as discussed above. Overall more time can be allowed for such learning and for engagement to develop or recover. In shorter term therapy this way of thinking might well be seen as an unaffordable luxury – and sometimes as one that is unnecessary. Crucially, in therapy of any duration, the potential cost when expectations are marginalised seems apparent.

Participants' courage when they raised matters of process was significant. Safran et al. (2011). consider the client experience with some sensitivity, warning that: "Practitioners should be aware that patients often have negative feelings about the psychotherapy or the therapeutic relationship that they are reluctant to broach for fear of the therapist's reactions" (p. 86). Taking the initiative in difficult conversations of this kind is one of the most significant forms or responsibility-taking a client can show and one that should be encouraged as a model of interacting within as well as outside therapy.

Times when clients questioned their therapists' approach in the current study were full of therapeutic potential. They revealed participants' deeper feelings and internal beliefs or models. One's apparent view that she (Maia) was unable to express herself, seems to have been overturned as a result of a discussion of process. For another (Jacqueline), raising a concern over a task seemed to help identify an overriding need for distress tolerance and acceptance of what she had seen as intolerable circumstances. As such, attention to expectancy appeared not only to avoid damage to engagement, alliance and outcome, but to offer insights into a therapeutically rich vein of client sense-making.

This reinforces but also broadens the conclusions of Safran and Muran (2001) in their work on ruptures in therapy, that:

> Ruptures in the therapeutic alliance are the royal road to understanding the patient's core organizing principles. Accordingly, the therapist should attend, on an ongoing basis, to the ways in which patients respond to their interventions. The exploration of the factors underlying the patient's construal of an intervention as hindering can provide a rich understanding of the patient's idiosyncratic construal processes (p. 166).

The current study suggests such thinking is relevant more widely than during ruptures alone and that any instance when clients initiate discussions of overall approach are important therapeutic opportunities. It indicates that these chances may be missed by therapists and it is suggested that therapists prioritise engagement with client attempts to question or change the process.

Allegiance and negotiation

A crucial factor determining the way process did or did not take account of expectancy appeared to be practitioners' theoretical allegiance. It is argued here that the contingency of individual client needs should not be overridden by therapist modality and that this latter can amount to what Safran and Muran (2001) refer to as a "inflexible and idealized criterion" (p. 166). Therapists are at times faced with a difficult balancing act between theoretical allegiance and appropriate flexibility. At least five participants here felt therapist adherence to psychotherapeutic principles was at times profoundly unhelpful. They felt these principles were much less relevant than their own autobiographical knowledge in determining what process was appropriate. The participants' feeling that their knowledge about, for example, what they had tried before was relevant when shaping therapeutic approach is seen here as entirely reasonable. Descriptions of the strain on the alliance when this did not happen support this view. It is argued that this level of respect is owed to clients. The humanistic principles underlying counselling psychology stress the importance of subjective meanings and of negotiation between therapist and client. The findings here suggest adherence to these principles may at times be lacking.

The view that taking account of clients' expectations when shaping process is beneficial has received empirical backing. A meta-analysis by Swift et al. (2011) found that when therapists modified their approach to fit better with client preferences, this was associated with improved outcome. The current study supports this conclusion in that participants tried to move process closer to what they expected and described this as crucial for outcome. Three of the four who were most satisfied had expected the kind of therapy they had. Three who did not expect what actually happened were dissatisfied (two very dissatisfied).

The one case where process was clearly modified to match client expectancy was notable. The individual who felt she successfully negotiated this change spoke of transformative progress as a result and of wasting time beforehand. In her eyes, she knew what would work *for her* and this was proven when the process changed. In contrast, when negotiation was felt to have failed, participants reactions included disappointment, self-blame and possible resentment. Results of this during therapy

included attempted covert manipulation of process, withdrawal and termination of therapy.

However, the opposing argument that therapists should hold fast to what they know in the face of client pressure to change approach, was also reflected in the accounts. Four participants accepted aspects of their therapist's approach even though it did not match their expectations and spoke eloquently of the way they benefitted as a result. Cooper and McLeod (2007) stress the need for practitioners to involve clients meaningfully in decisions about their therapy but to do this without sidelining their own skills and learning. The current study reflected this complexity, indicating that appropriate practitioner flexibility is likely to depend on individual and situational factors.

It would clearly be simplistic to dismiss either practitioner flexibility or reliance on existing expertise. The current study strongly indicates how therapist hermeneutics of empathy and suspicion need to be balanced according to individual client context. The indication from the data is that it may only be a minority of clients who are able to influence their therapeutic process meaningfully. Further research asking therapists whether (and when) they depart from their theoretical allegiances and asking them and their clients how this was experienced would help establish whether this is a widespread problem. What does seem clear in light of the participant accounts is that if it is not critically considered, theoretical allegiance has the potential to undermine therapist responsiveness and reduce flexibility. It would be unsurprising if at times of uncertainty or tiredness therapists rely on the training and theory to the detriment of a more spontaneous, empathic response. The results here highlight the risks involved, including actually suppressing clients' engagement and undermining the alliance.

Contracting

Any impact of expectations during therapy frequently follows an attempt to contract for and clarify goals, process and other matters at the outset. By establishing what can be expected in advance, the hope is that a strong alliance is facilitated and that this in turn makes favourable outcomes more likely (as outlined by, for example,

Asay & Lambert, 2002). Notably, formal agreement of a contract was not mentioned at all by half of the participants in the current study. It may be that a contract was discussed but was not felt to be significant or relevant enough to mention, but it seems more likely that in a discussion about expectancy it would have been mentioned had it taken place. On this basis the study suggests explicit contracting at the outset of therapy may be completely absent for some clients. Further research could confirm whether this finding applies more widely. If it is replicated, a pivotal process in addressing expectations is being neglected in relational therapies.

In indicating potentially serious and negative consequences where process expectations are not investigated and discussed, this study backs literature arguing that contracting is indispensible. Sills (2006), for example, believes that clients must be involved in agreeing contracts, stating “it is essential to invite them to be active in designing the counselling relationship, deciding on their goals and meaningfully pursuing them” (p. 5). Tryon and Winograd (2011) go as far as saying work should not start until both goals and process have been satisfactorily negotiated.

This needs qualifying. Some clients may have strong views on what to expect and benefit from discussing these. Others, however, may have little idea what to expect. The participants here were divided and some individuals fell into both camps at different points in the process. Five described firm expectations, but at least six at times expected their therapists to simply lead and to prove their expertise and helpfulness in the process. Contracting is clearly not the only way forward. There is much that cannot be known about where therapy may lead and it is impossible to contract for all possibilities in advance.

It is clear, however, that where contracting takes place it is sometimes a difficult and unsatisfactory process for clients. Of the four participants who said explicitly that they had formal contracting, three felt their expectations were not adequately addressed or found the process inadequate. Two experienced aspects of contracting as imposed. For the individuals concerned a sense of disempowerment possibly arsing from this can be traced throughout their therapies. It appears that therapists may at times treat contracting as a vehicle for telling clients how therapy will work, rather than eliciting expectations about process and discussing these. This study indicates that lasting damage to engagement and alliance quality can follow.

The participants' experiences of contracting (or its omission) lends support to recommendations for practitioners in the recent literature on client preferences (including Swift et al., 2011; Harrison, 2013; Tryon & Winograd, 2011; Cooper & McLeod, 2011). In overview, this advocates equality of client and therapist influence, transparency and decision-making regarding process and goals. Therapists are encouraged to outline their own ideas about what may be helpful – but also to negotiate about these. Harrison (2013) stresses that the therapist "needs to be transparent about their specific approach and the limits it has" (p. 113). Swift et al. (2011) argue that therapists should: "Address client preferences throughout the therapy process. Clients may change their preferences after starting treatment or clients may feel like their preferences are not being addressed despite therapists' attempts to do so" (p.164). These recommendations are strongly supported here.

In the absence of responsive contracting and negotiation, half of the participants felt important expectations they brought were marginalised. When this happened they described a perceived lack of options but to accept this reluctantly. Such cases reflect and help explain what Rennie (1998) described as a pervasive deference in therapy. The participants who accepted contracts obliging them to pay even if they gave notice and good reason for cancellation, is a clear example (payment in these cases implied reciprocity but not an equality of power). This sense of deference seems in part at least to reflect a power imbalance inherent in the therapy, where one party is asking the other for help with problems they struggle to cope with.

If an inequality of power is inevitable, and if therapy still sometimes helps, then equality cannot be essential. Indeed, some participants spoke in positive terms about ceding power and about expecting their therapists to decide what was rational or what approach would be helpful. All arrived with assumptions about being fixed and this surely reflects expectations that their therapists would wield a benign power that they would welcome. The fact that some continued therapy despite feeling unable to influence the process – and that even the participant most unambiguously happy with her therapy talked about "giving away responsibility" – gives clear support for the notion that power imbalance is acceptable to clients under certain conditions (Bachelor, 2007). However, the current study indicated that the context in which therapist power was experienced seemed critical and that individuals' expectations appeared to be a powerful determinant of this.

By eliciting and discussing expectations, it is argued, therapists can empower clients to be involved on as equal a footing as possible in agreeing how their therapy should work. Formal contracting is a major opportunity to do this. However, regularly revisiting the match with client expectations throughout therapy is at least as important. Engaging with expectations offers a way to foster the expression of client agency and to work with rather than against a client's autobiographical narrative as argued by Cooper (2009). The suggestion from the data here is that therapists may at times neglect this imperative. It is proposed that service providers, training courses, supervisors and regulatory bodies should do all they can to promote engagement with expectations and the use of contracting in particular, among therapists.

Summary

In summary, the key finding here was that participants expected to be led by their therapists and that this has important implications. The expectation took several forms, but the most important in terms its impact on engagement, the alliance and the perceived success of therapy was that practitioners would demystify their approach. For the participants this required either explicit discussion of process, or that the helpfulness of the approach became apparent early on in the course of therapy. Strong emotions and judgements were attached to the fulfilment of this expectation. Where it was met, participants described their therapy as valuable, even inspiring. Where it was not, a sense of frustration, disappointment or non-collaboration appeared to result, accompanied by low expectations of outcome. No participants indicated their therapist had taken too leading a role. It is argued that therapist decisions for or against lead-taking could be usefully informed by the expectation that approach would be made understandable – and by the negative consequences when this expectation was not met.

An important corollary to the expectation of therapist lead-taking is that acceptance alone can be seen by clients as problematic. Participants described expectations of an excess or empathy or space in therapy and felt these fears were sometimes confirmed during therapy. Therapist positions that seem likely to have been motivated by acceptance and empathy appeared to be experienced negatively.

Three of those interviewed described them as clearly unhelpful and a fourth described relief at not having a “wishy-washy” or over-accepting therapist. These participants suggested variously that such interventions were irrelevant, withholding, patronising or lacking in honesty. Accordingly it is argued that relying too heavily on acceptance and eschewing a more active or lead-taking role can be counter-productive. A responsive flexibility and breadth of practitioner repertoire, including more leading methods like congruent self-disclosure, psychoeducation and process direction is advocated as more reliably therapeutic.

The need for flexibility in response to expectations was at its most plain when participants attempted to discuss or negotiate the approach in their therapy, either at formal contracting or informally later in therapy. The possibility that contracting is neglected, and that when it takes place it is experienced as imposed, emerged unexpectedly from the data and practitioners are encouraged to contract and to do so with flexibility. It is suggested that trainers, supervisors and service managers need to ensure a focus on contracting is maintained. Some of the most intense experiences participants described related to these attempts and it is notable that only one felt able to change therapy as she had intended. They described disempowerment, self-blame and blame of the therapist when such attempts failed.

Perhaps the core point made here responds to these participant experiences by suggesting that pluralistically based counselling psychology best prioritises responsiveness to clients’ expectations, by placing the client experience and sense-making at centre stage. In this way the discipline can reduce the risk of a therapist over-emphasis on suspicious hermeneutics . In professional terms, Cooper (2009) suggests that such an emphasis offers counselling psychologists a “virtually unique place in the landscape of psychological therapies” (p. 124). A focus on expectations as a route to ensuring the client perspective is given the importance it deserves is in line with the model of pluralistic therapy outlined by Cooper and McLeod (2011) in which therapists encourage clients to collaborate in creating a process compatible with their individual needs and expectations. It also chimes with the existential perspective. Yalom (2001), for example, writes that “the therapist must strive to create a new therapy for each patient” (p. 34). The dangers of the alternative, a more rigid adherence to a theoretical approach, are highlighted in the current study and it is suggested that responsiveness must at times trump allegiance to theory.

These arguments arise from the view that a practitioner focus on subjective meaning-making (expressed through expectations) admits clients' autobiographical narratives into a collaborative construction of therapy. In this way it can ensure therapy makes sense to clients. It is argued that this is the best way to engage client agency – because expectations are a reflection of that agency. It is recognised that this is something of an idealised stance and real-world constraints like the unavailability of long term therapy, pressure for measurable results and service protocols have to be factored in. However, the humanistic values underlying counselling psychology can enhance the effectiveness of therapy in a variety of service contexts. If the underlying aim of practice is to address client needs, then responding to the expectations expressing those needs is a priority.

The participant accounts suggest that many clients may start therapy ill-informed about what to expect and better information on how the process will work is emphasised as one obvious way to remedy this. Knowledge about therapy is likely to mean clients less anxious, less confused and as a result more able to engage in therapy. However, those with only vague initial expectations knew what they wanted and what they did not want from therapy once it was in front of them. As suggested by McLeod (2012) such (sometimes implicit or unconscious) expectations appear to be based on self-understanding, on personal narrative as well as on experience and knowledge regarding what they may already have tried. Participants had a view about what would work *for them* and nothing in the present study gives cause to doubt that this needed to be treated seriously.

A concluding point is that the findings here emerged through the use of IPA as a qualitative methodology intended to access the client perspective as closely as possible while maintaining a constructive critique of this. This distinctive hermeneutical balance between suspicion and empathy allowed a form of triangulation through contrasting perspectives on the data. Suspicion involved stepping back from the text by use of researcher reflexivity, the literature and comparison across participants. Empathy involved getting as close as possible to the participant's perspective. This broad approach uncovered the role of a similar dialectic operating within therapy itself. The need for a greater therapist emphasis on empathic understanding through a focus on client expectancy, balanced with a

questioning stance derived from training and experience, was the overarching finding here.

If subsequent research suggests the experiences of participants in this small sample are empirically generalisable, the implications would be relevant to professional standards and to training courses across the range of psychological disciplines. Even without proof of external validity, it is believed the issues raised by participants are relevant to clinical practice and address important but neglected aspects of therapy. It is hoped the discussion of clients' experiences will have face validity for practitioners. Suggestions have been made for further research and for specific ways therapists might find the material here useful.

Limitations

This study excluded cognitive behaviour therapy and focused on relational and non-directive therapies. In this respect the findings need to be treated cautiously. It may be that had the participants received CBT instead, the findings would have been very different. The presence of therapist qualities associated with CBT approach (e.g., directiveness) could have led to their being taken for granted so they did not emerge as themes. In the same way expectations associated with acceptance, empathy or warmth in the current study could have been downplayed or excluded from the accounts because they were satisfied, skewing the results towards unfulfilled expectations. Further research is needed about the way expectations are experienced in non-relational approaches to give a fuller picture than this study captured.

The possibility that expectations which were satisfied were not discussed by participants and were therefore not represented in the study is real. The overall emphasis on a need to elicit and discuss expectations may have been, to an extent, a product of this phenomenon. These limitations qualify the findings here rather than negating them. The descriptions still refer to real experiences, but the possibility that these were less than the whole truth is recognised.

The research is also limited by the fact that it gathered retrospective data from participant accounts after therapy was complete. Had interviews been conducted at

different times during therapy instead, the accounts may have been different. The use of a post-therapy interview gave a snapshot at one point in time only, albeit one aiming to give an overview. Participants' mood at the time of the interview may have affected what they said, as could conversations since therapy, reading or events in their lives. Asking clients about their experiences at multiple times before, during and after therapy could have given a more complete picture (though the ethics of such a procedure would be an issue).

A different design might have given a more complete picture than the study's focus on just one side of the therapist-client dyad. Both therapists and their clients (in matched pairs) could have been asked for their descriptions and experiences of what happened in therapy. Comparison between the two sources could have added a useful extra dimension to the findings. Had resources been available, sessions could have been audio or video recorded and independent observers or raters could have given a third, more objective perspective on what happened. A baseline for expectancy could also have been established through pre-therapy interviews, giving a reference point from which to ascertain changes. While these alternative designs would all come with problems of their own, each offers a distinct lens on the subject of expectancy.

It may also be that individuals with a particular experience of therapy outcome were disproportionately attracted through the recruitment process. A biased level of satisfaction or dissatisfaction based on perceived therapy outcome may have introduced a corresponding bias into the findings. Of the eight participants, two were very satisfied with the outcome of their therapy, a further three moderately satisfied, one ambivalent and two strongly dissatisfied. This broadly matches current estimates that about two thirds of all clients experience successful outcomes (Lambert, 2013), suggesting that this bias may not have been present, but not excluding it.

The phrasing used in the recruitment flyer may also have attracted a sample with a particular set of expectations or a particular motivation for participating that is atypical of clients. By raising the issue of satisfaction in its headline, the flyer may have appealed to those who were dissatisfied, while those who were happier with therapy felt no need to revisit the subject. Dissatisfied individuals might have been motivated by ongoing frustration at unresolved issues from their therapy or a desire

to complain or have their complaints affirmed. In contrast, it may also be that those who felt therapy met their expectations nonetheless wanted to recall their experiences for the opposite reason, to be reminded of valued insights or experiences. Any of these biases may have operated and accordingly the findings could have been skewed as a result. Greater neutrality in the phrasing of the flyer along the lines of “what was your experience of therapy” could have mitigated some of these problems.

The recruitment procedure could also have biased the sample and therefore the findings. Therapist-referred participants might have been chosen because they were more satisfied with therapy than average and as a result felt expectations had been met. Those recruited through flyers may also have introduced bias into the sample for the reasons discussed. However, some indication of participant motivation is available from the level of satisfaction with therapy they expressed at interview. The two who responded to flyers were positive about their experience. The five selected by therapists (and then agreeing to take part) were spread fairly evenly along the continuum from satisfied to dissatisfied (two were positive overall, two ambivalent and one negative). The one participant recruited by word of mouth was strongly negative about his experience. Taken overall these experiences do not indicate the introduction of significant bias in terms of the motivations they could reflect, though again this possibility remains.

The role of payment offered for participating also needs to be considered. On balance it does not appear likely that this would have attracted people with particular types of expectations. Three participants were recruited by the version of the flyer that did not offer payment, two declined payment and three were paid. While the three out of eight who were paid appeared to speak congruently and openly about their therapy, it is possible that they were motivated by payment. They may have given answers purely to reciprocate payment by giving the researcher what they perceived he wanted. The validity of the data and findings are therefore open to question on this point. A greater lead time for recruitment would have negated any need for payment.

The severity and diagnoses of the problems participants had is another way the sample may have been unrepresentative. The data suggests that five struggled with

anxiety and three with low mood, but the degree of comorbidity is difficult to know as is the presence of other problems. Two appeared to have had severe problems and six moderate. Certainly anxious clients in general (and severely anxious in particular) may be predisposed to post-hoc anxiety about whether their therapy met expectations. As such negative interpretations could have predominated in the sample. However, because many in the general population of clients are anxious, this does not necessarily amount to a bias. Rather it offers one potential explanation for negative client experiences considered above.

The sample interviewed was made up entirely of white, articulate, high functioning individuals from a large conurbation in England. These characteristics jointly or separately could have introduced bias. One possibility is that it might have meant a particular sense of entitlement among participants, resulting in harder-to-meet expectations than among therapy clients in general. This could have been reflected in a disproportionate level of complaint in their accounts, biasing the findings.

Finally, the method used, IPA, has inherent limitations as discussed in the methodology section above, including its reliance on language and its inclusion of cognition rather than pure experiencing (or eidos) as a focus. Perhaps above all it relies on the researcher's imperfect attempt to recognise his own preconceptions and to prevent these from influencing or obscuring the data. This could have meant that the research was more receptive to experiences reflecting the researcher's own. The size and nature of the sample and the purposive, non-random recruitment method used in IPA mean the research has forgone any claim to provide generalisable evidence on which conclusions about a wider population can be based. Instead, theoretical transferability was the aim.

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Appendix A - Participant characteristics questionnaire

(you are free to decline to answer any of these questions, though the information will be useful and may help with understanding of what you say.)

1. Age: years

2. Sex: Male Female (please lick the appropriate answer)

3. How would you describe your ethnic background?

4. Do you have any children? If so, how many?

5. What is your highest educational qualification?

(please tick the appropriate answer)

No educational qualifications

GCSE or equivalent

A-level

Diploma

Degree

Postgraduate

5. What is your marital / relationship status?

Single

Live separately to partner

Live with partner and unmarried

Married

Divorced/separated

Widowed

6. Who do you live with?

7. How long was the therapy you have just completed?

8. Was it the first time you have ever had counselling or any kind of psychotherapy?

(please tick the appropriate answer)

Yes No

Appendix B - E-mail to Heads of University Counselling Services

Dear Colleague,

I am writing concerning a study I am carrying out into client expectations of therapy and how these expectations play out during therapy. Below is a brief summary of the research, which is part of a thesis for a Doctorate in Counselling Psychology at City University London and which I am hoping you can support.

My intention is to interview clients shortly after their last session, to avoid interfering with therapy.

The interest in the subject arose because there is little qualitative research into expectations from the client's perspective, into what they expect and how it is for them as those expectations change. There has been some work looking at clients who received CBT, and interestingly, the evidence is that many expected something far closer to psychodynamic therapy. The intention here is to find out about client expectations in relational therapies such as psychodynamic or person-centred approaches, in terms of both process and outcome.

The research aims to allow clients to give their own version of their experience of expectations, being as non-directive as possible in the interview.

I would be very grateful if you would consider supporting this research by passing a brief description of the study including my contact details (attached) to clients who will finish therapy during the next six months. This can be done before therapy begins and, if you already send forms after completion, a reminder might be included then, subject to your agreement.

If the client consents and gets in touch he or she would be sent an information sheet and if they wish to participate telephone contact would be made.

The research has been passed by the Ethics Committee at City University London and follows BPS ethics guidance and is supervised by Dr. Susan Strauss [redacted]. I have attached the flyer for clients and am happy to answer any questions you have or to provide a full research proposal if that is helpful. I am also more than happy to do a short presentation of the results to you and your staff if this is of interest.

Many thanks for considering this proposal.

Best wishes,

Paul Lewis
[redacted]

Appendix C - Recruitment flyer.

Was therapy what you expected?

Finding out about your point of view is the goal of this study by a City University doctoral student. The aim is to understand your experience of therapy in the light of the expectations you had.

The interview will take about 45 minutes (travel expenses will also be covered). Talking about your experience might also be interesting or helpful. Anonymity is guaranteed.

If you would consider participating, please get in touch and we can arrange to talk soon after you finish therapy.

Many thanks,

Paul Lewis

[redacted]

[redacted]

The research is part of a City University Counselling Psychology Doctoral thesis, supervised by Dr Susan Maise Strauss, C.Psychologist. susan.strauss.1@city.ac.uk). It study has been approved by the City University London Ethics Committee and will be in accordance with British Psychological Society guidelines.

Appendix D - Information sheet

Title of study: How do clients' expectations of therapy play out during psychotherapy? An Interpretative Phenomenological Analysis.

Thank you for your interest in taking part in this study of clients' expectations about therapy. Below is information to help you decide whether or not you are willing to take part in the study.

Researcher:

My name is Paul Lewis and this study forms part of City University's Counselling Psychology Doctorate on which I am in my second year. This study is supervised by Dr Susan Strauss, a Chartered Psychologist and member of City University's staff in the School of Arts and Social Sciences.

Aims:

The aim of this research is to understand the experience of clients undergoing therapy in terms of what expectations they bring to therapy and how these are experienced during therapy. It is hoped that a better understanding of that experience will inform future attempts to improve therapy in the interest of clients.

Procedure:

If you are still interested in participating in the research after reading this, please reply to me to give me a contact phone number and, if possible, an indication of suitable times when you can talk on the phone. The phone call will mean any questions you have can be answered and that if there is any reason that the study is inappropriate for you, this can be identified. The phone call should take 5-10 minutes.

What is involved if you go ahead:

If you agree to participate, we will arrange a 45 minute audio recorded interview where I will seek to find out as much as possible about your thoughts and feelings concerning your experience of therapy. We could meet in a room at City University London or another venue convenient for you at an agreed time.

You will also be asked to fill in a demographics a questionnaire, giving basic information about yourself such as your age, gender and ethnicity and taking about 5 minutes to complete. You do not have to answer any of these questions if you do not want to. If you do decide to participate you will also be asked to sign a consent form. There is also 20 minutes

set aside after the interview so you can say anything you want to about what it was like to take part or ask any questions on your mind.

Anonymity:

All information you give in writing or verbally will remain entirely anonymous. The study will be available in the university library after completion, but any details you mention that could identify you will be omitted or changed. If you change your mind about involvement in the two weeks following the interview you can request that any records are deleted and withdraw.

Possible risks:

If during or after the interview you feel unhappy about your involvement or distressed at any aspect of the process, you are free to say you no longer wish to participate and withdraw from the study at anytime in the following two weeks (that is until time has been spent transcribing and analysing the interview). No attempt will be made to persuade you otherwise. One reason that this is possible, though unlikely, is if something you find distressing comes to mind as a result of the interview. While this cannot be ruled out it is considered unlikely because in the nature of this study the interviewer intends to minimise his influence on what is discussed and the focus will be on what you choose to raise in response to open questions (within a "semi-structured interview").

Ethics:

This research will be carried out in accordance with guidelines laid out in the British Psychological Society's Code of Ethics and Conduct. It has been approved by an Ethics Committee at City University, London, on the basis that no risk of harm greater than would be expected in life in general is expected, that you will be treated with respect throughout the process, that you will be given the information needed to make informed consent and that any risk is minimised.

Thank you very much for taking the time to read this information. I hope to hear from you soon at this e-mail address – [redacted]

Appendix E - Second recruitment flyer

Was therapy what you expected?

Finding out about your point of view is the goal of this study by a City University doctoral student. The aim is to understand your experience of therapy in the light of the expectations you had.

A payment of £25 will be made if you agree to a 45 minute interview (travel expenses will also be covered). Talking about your experience might also be interesting or helpful. Anonymity is guaranteed.

If you would consider participating, please get in touch and we can arrange to talk soon after you finish therapy.

Many thanks,

Paul Lewis

[redacted]

[redacted]

The research is part of a City University Counselling Psychology Doctoral thesis, supervised by Dr Susan Maise Strauss, C.Psychologist. susan.strauss.1@city.ac.uk). It study has been approved by the City University London Ethics Committee and will be in accordance with British Psychological Society guidelines.

Appendix F - Informed Consent Form

Researcher: Paul Lewis, Counselling Psychologist in Training. [redacted]

[redacted]

Supervisor: Dr Susan Strauss, School of Arts and Social Sciences, City University London

[redacted]

Study title: Clients' Expectations of Therapy: An Interpretative Phenomenological Analysis.

This form is to give you information about the purpose of this study and your entitlements as a participant. The study aims to understand better the experience of clients undergoing therapy in terms of the expectations they bring to therapy. This includes whether clients believe their expectations affect any aspect of therapy and what it is like if this happens. It also aims to understand more about whether expectations change as a result of the actual experience of therapy and how this is experienced by clients. It is hoped a better understanding of your experience as the client will inform future attempts to improve therapy in the interest of clients.

The study also fulfils the requirement of the Counselling Psychology doctorate at City University.

The method used for these purposes is a semi-structured interview taking about 45 minutes which, along with other interviews, will form the basis of the completed study. You are encouraged to ask any questions at any time about the nature of the

study and the methods used. Your suggestions and concerns are important to me and I can be contacted on the address and phone number above.

I guarantee that the following conditions will be met:

Your participation in this study is entirely voluntary and you can withdraw consent at any time and for any reason with no impact on your interests. In this instance all records about you will be deleted.

You have the right to a copy of the completed study if requested.

The research may be published in a psychological journal or reported to psychological institutions, however, no details identifying you will be revealed. Your name will not appear anywhere in the completed work or any published or reported form of this. Any identifying details such as places or persons known to you will be changed or omitted from the completed study.

The research will be conducted according to the Code and Conduct and Ethical Principles of the British Psychological Society.

If you give permission for audio recording, this recording will not be used for any purpose other than for this study. It will be kept securely and deleted once the project is completed.

Do you agree to be quoted?	Yes	No
Do you agree to being audio-recorded?	Yes	No

I agree to participate under the terms described above.

Participant _____

Date _____

Researcher _____

Date _____

Appendix G - Debrief for participants

Thank you very much for taking part in this study, the information you have given will be invaluable and I am very grateful for your help. I hope the research will help psychologists better understand the way clients' expectations are relevant to what happens in therapy.

If there is anything you would like to ask about the interview or about the research as a whole please simply contact me and let me know.

If you change your mind and want to withdraw your consent to take part at any time within the two weeks following the interview, please just get in touch and I will delete all records pertaining to you.

If you wish to discuss any aspect of this study with someone other than myself, please contact my supervisor, Dr Susan Strauss, at [redacted] or at The Department of Psychology, School of Social Sciences, City University London, Northampton Square, London, EC1V OHB.

Were you to have any difficult or distressing concerns thoughts or feelings as a result of taking part in this study, you can contact any of the organisations which offer personal therapy, given in the resource list below.

I hope the experience of participating in the research was a good one for you and would like to thank you once again for taking part.

Paul Lewis

[redacted]

[redacted]

Appendix H - Interview Schedule: (potential follow ups in brackets)

Initial expectations

What were your expectations of therapy? (pre-therapy, but open to consider changes during therapy).

What did you want to get from therapy? (open to hopes/best outcome and realistic expectations?).

Can you describe any worries or reservations you had about the process?

Expectations of process/roles.

What were your expectations of what would happen in therapy/how it would work?

What did you think it would feel like sitting with the therapist?

What did you think your role would be? (eg. responsibility/investment/openness).

How did you expect the therapist to behave? (presence, directiveness, warmth, challenge/judgement).

What did you think your relationship with the therapist would be like? (eg relational work expected,collaboration, challenge, trust, comfort level)

Potential follow ups for each question: How aware of these expectations at the time? How they felt/influenced process? Accuracy? Changes to expectations?

Expectations of content

How much did the things you discussed match your expectations? (include level of disclosure)

Can you tell me any ways that you were favourably surprised?

How did that come about?

How significant was that? How did it feel?

Were there any ways you were disappointed by your therapy?

How did this come about? (What prevented expectation being met - process, therapist or client)

How significant was that? How did you feel/think about that.

What kind of emotions/feelings did you expect to come up during therapy?

How accurate was this expectation? Can you describe any unexpected feelings that come up? What was this like?

How much did new expectations replace old ones?

What were they? How did they arise? (eg explicit challenge by therapist to expectancy)? How that felt? What happened to any new expectations / how important this felt?

Is there anything you would like to add, or that you think I have not covered but is important?

Appendix I - Excerpt from transcript for Dirk

Shows pages 12

	1	Interviewee: So that's.	
	2		
	3	Interviewer: And, and then you've been	
	4	expecting some of this dialogue	
	5	and you didn't get it, and like it,	
	6	there must have, there must have	
	7	been a point where, where you	
	8	realized. What was it like as it, as it	
	9	dawned on you, "Oh, this isn't	
	10	what I thought."	
Frustration at process	11		
	12	Interviewee: I, I was a bit frustrated with it and I	frustrated
	13	was, I was going like oh jeez	"jeez" – surprise, unexpected re-evaluation. Implies disappointment?
demotivation	14	should I continue and ah you know	"Is it worthwhile" Demotivated when expectation of dialogue disconfirmed, led
	15	is it really worthwhile? And um,	to question overall value of therapy. Sigh may recall loss of hope/energy.
Doubt re value of therapy	16	(sighs) um you know, I was going.	Early consideration of ending therapy.
	17	these were the thoughts running	
	18	through my head, and, um, I'm	Forgetting the question may parallel uncertainty over how to react at the time.
	19	sorry what was your question	
	20	again?	
	21		
Pace	22	Interviewer: How you felt when you. You said	
	23	frustration,	
	24		
	25	Interviewee: Yeah, because I wasn't moving	Lack of pace central to frustration and doubt about value.
	26	along fast enough.	"Enough" suggests there may have been movement, but too slow.
	27		
	28	Interviewer: Right.	
	29		Confirming that pace was the issue for him.
Struggling to retain faith.	30	Interviewee: You know I, I mean from, what,	
	31	yeah I, yeah I wasn't moving along	Repetition x3 of "process", "must be" more like hopeful insistence than belief.
	32	fast enough. I mean, you know, I	
	33	felt okay so we're going through a	"must be" - self-reassurance/effort to hold on to faith/trust in his therapy.
	34	process, obviously there's some	Unfinished thought at "otherwise" may reflect reluctance to move to conclusion
Deference	35	sort of process otherwise, you	

Shows page 13

Inexperience of therapy	1	know, there must be a process that we're going through here. And you know maybe it's something I don't understand, because I've never been through it and so once I've been through it, I'll understand it and I could say okay, I understand why I came in so many times and just spoke. Um. And so, so I kept on going, because I was hoping to get the end result. But if I look at my own experience of being a mentor or a coach in any kind of way I guess which is quite different from what I was doing, and maybe I'm too kind of direct. But you know for example I worked at a, a sort of a, what is called? It's a part of the job sector where people who are chronically long term unemployed, go to when the jobs and when they've been registered with the job center for more than a year. And they have mentors and various other support mechanisms, I can't remember what they're called the name is, anyway I acted as a mentor there for a while. And I found it extremely frustrating, because we'd have meetings with the other mentors and counsels and some of them are qualified psychologists in whatever and whatever. And you know I'd say to	that he should terminate due to lack of any point he could grasp? Maybe I don't understand – willing to defer. Also importance of understanding. I've never been through it – implies *she/therapist* has been? Contrasts therapist's experience to his lack. Inexperience would explain why process not clear to him so feels he has to wait. Felt this was the (only?) way forward. So many times – feeling that amount of talk seemed excessive? "Just" spoke – speaking in itself feels like only a small thing? Kept on going like soldiering on. But what options? Doubt in process seems to have weighed heavy. Hoping to get the end result: Process required trust from him. Meant doing something that didn't make sense, staying with it, giving it a chance.
flexibility as no other option	7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29		It may be his failing/fault that he doesn't understand – suggests his willingness to learn? Implies expected more direct approach from therapist? Recalls his own work as a mentor for long term unemployed.
Telling is effective in therapy	30 31 32 33 34 35		Extreme frustration: of similar type to that felt in therapy, experienced before - in his work. Suggests his preferred process applies generally, not just to himself. Suggestion that he finds methods of psychologists in general frustrating and that overall this is not personal, it is about logical comprehension. I want to tell them – echoes wanting his therapist to tell him (p9)

Appendix J - Collated emergent themes for Dirk

Therapist as responsible (for making it work)
Expected to be given insight 2/1
Put myself in their hands/trust 17/25
I'm not responsible / money. 9/17
To be changed/fixed 3/26
Must tell and fix 19/26
Not professional enough (setting) 6/20
Task focus in therapy (as necessary) 34/27
Friendship not wanted 38/15
Pre-knowledge 3/4-25
Having the keys, showing me things 1/35
Illuminate 2/6, 3/30
Therapist suggests 5/30
Telling is effective 13/32
Therapist to instruct 18/2
Therapist to normalise 18/7
Thpt points out the road 18/17
Professional=almost paternal 19/11
Therapist has tools 2/4
Information expected 3/30
Found feedback helpful 3/20
Deference 6/6, 12/35
Must be some kind of process, I don't understand 12/30-13/7. 14/28
Inexperience of therapy 13/1
Exchange of money for making therapy work 9/19
Therapist to show way of living 1/12, 1/25
Pre-knowledge, lack of 5/17, re couch 6/9
Judgement important/inevitable 44/18, 44/25
Ambivalent re dream analysis 39/3
Dreamwork accessed emotions 41/9

Excitement and motivation
Excitement, Motivation 2/26
Expectant hope 17/1
Excitement at confirmed expectation 17/12
Hope (for new way of living) 1/23
Hope justifying investment 24/25
Pre-knowledge 3/4-25
Hopeful enough to start 2/13

Exploratory talk vs directiveness
No faith in talking 14/22
Client role inappropriate (re 'talk') 33/29
Thpst input created engagement 41/1

Frame
Didn't like location 6/18-32
Not like media, discomfort 10/8

Restricted choice re leaving 24/3-27
Habit 24/34-25/4
Discomfort at location/setup 10/15
Not professional enough 11/9-31
Symbols (including money), trappings 17/20
Frame as primary 28/17
Excited at couch, meat 17/1-18
She could have been sleeping 16/26
Impact of frame breach (personally) 31/15
Actually lay on couch 7/2
Routine was helpful 28/2

Lack of progress/disempowerment
Therapy as stuck 24/3
Feeling abnormal as a client 36/26-37/18
Pace 12/23
Impact of frame breach (personally) 31/15
Expected more emotion 47/27
I should have said 8/27
Responsibility *for* therapist 20/10

Process was disempowering
Incredulity 6/7-12,
I didn't know what she wanted 33/20
Nothing to say, silences 7/22-8/9
'Code' of not telling 8/19. 21/8-35. 23/8-27
Self-blame 8/25
Frustration at process 12/11
Demotivation 12/13
Doubt re value 12/15
Struggle to retain faith 12/31
Flexibility as no option 13/7, 21/32
Wouldn't tell me, just talk, why not? 14/14
Hanging on for nuggets 20/24
Diminished expectations 47/9
No engagement with process 27/23, 28/26
Pace (insufficient) 12/22
Wandering in nebulous maze 29/28
Should be intervention not crutch 15/5-23
Therapist rejection 32/29
Disappointment 15/2

Negative view of therapist
Therapist as helpless, dishonest 32/1-31
Judgement of therapist 16/13
Anger 14/32, 21/15
Indignation 18/8
I was concerned re her judgement 45/1
Lack of relationship 16/27
She should have solved process 9/1-10
Who knows how useful the feedback was 39/18

Content/it was all garbage 38/24
Therapist as inflexible 23/17
Oppositional relationship 23/8
She's not going to help, I'll do it. Identify change 26/25
conflict, unresolved 37/25, 23/8

changing process
I should have said 8/28
Failed negotiation re process 20/4, 32/34
Client appeal re process 2015
Therapist concession re process 7/10, 20/13
Therapist concession 33/2-36/12
Manipulation of process 22/7
Those were the nuggets 20/24

Other
Denial of emotion 42/4 and 41/29
Stuck pattern, I'd got myself depressed 1/26
Therapy as crutch 15/13
Uncertain re origin of recovery 25/10
Support/caring (purportedly) 26/6
Don't care what she thinks/not friend 38/15
Stigma (social) 45/17
Expected more emotion 47/23-48/34
Real financial impact of therapy 46/9

Appendix K - Table showing all superordinate and subordinate themes

superordinate theme	sub-theme	illustrations of theme. Line/page numbers
1. Therapist as leader	**1:1 Therapist as arbiter of reason/objectivity**	Jacqueline: Somebody who I could talk over the problem with who could say, oh, either that was rational or irrational. 1/5-2/2
		Sinead: That was really helpful that I had someone who was not afraid to be like well I think you can approach this better or something like that so I was like really grateful for that because I think if I was left to my own devices I think I would have made a huge mess out of the whole thing. 9/9-16
		Serena: Maybe I expected the fact that she was this professional, she was actually objective enough to actually tell me when I was talking rubbish or doing or thinking something wrong. 28/1-8
		Dirk: My role would be to explain a situation, a dilemma, a feeling, and for her to say well this is how you can put it in perspective or this is how you should have felt or you know, something like that. Or these are the range of things and here is your range, it's not too bad. 18/1-4
		Richard: I wanted someone I didn't know who had no idea about me or my history or my situation or anything, to judge it on the facts. 1/11-13
		Maia: A bit of clarity I suppose in my life to know that there is a way out really and this is not the way I should be (inaudible) should be thinking. 4/1-3
	1:2 Therapist as instructor and guide	Dirk: I thought how long are we going to take for this person who probably may never reach the conclusion that we want them to reach, without telling them: This is what you should be thinking about, this is the route. It's clear to anybody. It may even be clear to you but you want knowledge, that kind of thing. And so that was in my opinion the way to deal with these kinds of things. And that contrasted strongly with the counsellor's approach and my counsellor's approach in situation I guess which was more similar to the let's let it roll, hopefully this person will come to the right conclusion just by talking about it. I find that very difficult to comprehend. 14/2-22
		Richard: I needed to have some form of, um, discussion really and getting things off my chest in a way that would let the therapist know when, what, tell me why and how to, how to deal with it really. 1/20-2/4

		Anna: I wanted there to be enough kind of talking and compassion around the human condition rather than not you know plus ok well then this is what you should aim for 5/2-6
		Sinead: Like I wouldn't be like wow, just because she said this, I wouldn't like just because she said this I really need to do it, but I would always like, well, she is trained to deal with these kinds of things so that means that her opinion should have some weight. 26/12-18
		Maia: I wanted to talk to someone neutral who could give me some spin or some positive way of getting out of what I was, what rut I was in. 2/7-11
		Serena: I need someone to help me sort out my thoughts a little bit and figure out what's going on. 1/21-22
	1:3 Therapist will fix the problem	Natasha: I think on a conscious level it was someone else would fix where there were problems in my life. 4/10-14
		Richard: The way she did it, it was, it wasn't possible for me, maybe because of the way I was being led, whatever, I wasn't consciously thinking about well that's a breakthrough or that's something I want to get out. It was just a kind of, this is going to sound a little bit twee, but it was kind of like magic. 22/18-23
		Anna: I think she was very, very good at what she did. So, and that also was one of the, actually one of the pleasant surprises and now I'm just getting back to your other question that I couldn't think of, was giving away responsibility actually. 27/14-17
		Serena: She said to me: "I'm not here to judge to you, so you have to you know, you have to come to a conclusion yourself". And I just didn't, I didn't, because otherwise I would have done it before, because I talked to a lot of people. 59/4-8
		Dirk: I don't expect him to say tell me what's wrong or where is the pain coming from, can you feel it and discuss the pain in immense detail and then eventually for *me* to say oh, look I've got decay on my tooth. I was there for her to look at my tooth and say there's decay there, let's fix it. 19/21-28
	1: 4 Therapist will provide tools.	Jacqueline: I suppose being helpful and constructive and you know giving me maybe some coping mechanisms, that kind of thing. 4/5-7
		Anna: I also knew from my friend who had recommended her that there would be some kind of tangible, practical sort of tools given to me through that process as well 3/15-18
		Maia: Practical ideas and what I should be doing. 23/1
		Richard: Probably coping mechanisms was the most important to be able to erm cos I tried, I mean I tried lots

		of things coming into this. (1/15-17)
		Serena: I didn't expect to have everything solved at the end of the therapy, but to derive some valid methods to actually work by myself. 19/13-15
		Sinead: It would be more directed about like specific like techniques I could do instead of just like telling her how I am feeling. 35/7-10
2. Therapist as facilitator	**2:1 Appreciation of space/being heard.**	Maia: So that was a surprise. Especially to, a, more or less a stranger, to, to speak so much about things. I was really worried that I wouldn't have enough to say as well, so (laughs). 24/8-11
		Anna: It's, yeah, just a reflective approach that I can immediately appreciate how healthy that is, but because of the speed at my usual life I don't get that space really, to do that. 11/7-12
		Richard: She guided me so well it was, it was, it was you know I was almost, I found myself talking about things that I had been much more guarded about 21/9-11
		Serena: Even though she didn't give me much input you know, it's still, the little bit that she gave, even if most of it was actually just acceptance and everything and I wasn't particularly pleased with that, but, er, it was still good. 50/13-18
		Jacqueline: some people may be judgemental and think well there is nothing wrong with her life, why is she here complaining, but [therapist's name removed] was never like that. 22/2-6
	2:2 Expected more intervention.	Maia: I would have preferred some kind of comment even if it is you know, slightly, um, negative towards me I don't mind. But I don't know, I just wanted someone being a bit more honest. Like "this is how I see things about your life, about what's going through, what's going on in your mind". 42/10-43/1
		Serena: She wouldn't want to give me any opinion and she wanted just to be totally understanding and accepting over anything. 12/3-6
		Sinead: I expected her to be, I don't know what the word I am looking for, but not, really wishy-washy, like "you might want to do this or you might", like I expected her to be like "this is my opinion on what you should do but by no means do you have to". 27/5-11
		Dirk: I used to wrack my brains before I was going there, going like, "What the fuck am I going to talk about", you know, "What am I going to say to her today". And you know and I would talk and then there would be long silences and I talk some more and then she would say, "Okay, time's up, thank you" and I'd leave and go like,

		"What was the value of that?" 7/29-8/5
		Jacqueline: I had had this bad experience of this woman [identifying detail removed] before who never uttered a word during the entire session and I found that impossible. 18/3-6
3. Contracting	**3:1 Formal contracting**	Natasha: I would have liked to know more about ok, how does, how does therapy wind, what about the end, how do you know when it's the end? Or maybe, maybe it would have been nice to get a handout which would literally have been about boundaries, timings, expecta-, something that just, you know, makes it feel like the service that it is. 30/8-22
		Serena: She didn't know about the therapy, how it would work, she didn't have a fixed plan. It depends, you know, how things go and how the person manages, which again, didn't really make me happy as an answer. (Laughs) 37/18-23
		Sinead: I think she assumed that I knew that it was only a certain amount of time. I didn't really understand why it had to be every two weeks either. 38/11-14
		Jacqueline: I wanted to go to somebody who I felt was giving something back, so that's something that I discussed with [therapist] from the beginning. 3/16-4/2
	3:2 Informal contracting	Dirk: I don't like, I don't like fiddling around with people's processes and she had a particular process. I was going to go through the process. Presumably she was old enough, she's been through this long enough and done enough, so she could advise me rather than other way round. 9/2-10
		Richard: Tell me why and how to, how to deal with it really. 2/3-4
		Anna: I was recommended this particular therapist [identifying detail removed] and I was told in a lot of detail about the processes. 2/1-6
		Maia: You know, if there was anything that I don't want to talk about that would be fine. You maybe go back into it in another session but whatever I want to do. 11/7-9
4. Attempting to change therapy	**4:1 Negotiation of tasks and goals**	Jacqueline: I said to her I don't really want to talk about, that's why I don't want to talk about [identifying detail removed] because I am not here for [identifying detail removed]. And she was perfectly okay with that. 23/4-9
		Sinead: I think the second session I came back I did, like I didn't go into super detail, but I was like I feel like I maybe wasn't honest about at least this one thing and we talked about it a little more but I didn't just go into detail about

		like everything. 16/16-17/4
		Serena: I said no, now I'm going to talk about [identifying detail removed]. She didn't say a word and I felt like, oh! I wasted a session because of you. So she didn't really want that. 31/11-15
		Anna: I was expecting like a kind of relationship counselling kind of thing and she very quickly realised that it was (pause), I needed the space to really understand my-self much more. Researcher: I see. Anna: And I agreed with her through that process, because actually the slow-down effect of it is that, now I get me more, I can totally now use that, put that to good effect in terms of my relationship. 15/10-20
	4:2 Negotiation of process	Dirk: She said, "But this is not the way it works. I can't do that". Something like that. And it was, but I also didn't want to upset her by raising it too directly I guess. 20/7-11
		Serena: And she was just, she really told me "I'm not here to judge to you, so you have to you know, you have to come to a conclusion yourself". And I just don't. I don't because otherwise I would have done it already because I talked to a lot of people. 59/5-8
		Maia: Given feedback at that point anyway because I was getting a bit, sort of, I didn't think that this is what I wanted really, this kind of therapy. 38/6-8
		Natasha: This experience happened which kind of I really strongly reacted to and then I sort of thought well I've got to bring that up. I've got to bring up what that made me feel, so I brought it up. 11/1-7
5.Agency and constraint	**5:1 Inexperience of therapy**	Maia: I mean I am not an expert on, um, psychotherapy, so I wouldn't, know you, know where to go or what I should be saying, I suppose. 11/20-12/1
		Dirk: Maybe it's something I don't understand, because I've never been through it and so once I've been through it, I'll understand it. 12/35-13/4
		Richard: I was trying to analyse how was she doing it but by the end I was thinking you know what, I'm not a therapist. I did one module of psychology at university but I am never going to be able to understand all of that lot. It's not my domain. I come out feeling better. 24/8-12
		Serena: I wasn't a hundred percent sure what to expect and I changed my expectation during therapy. But definitely, I'm sure now, I also decided, okay, this is not helping me. 8/7-11

		Sinead: I didn't really have any idea of how it would work specifically or like I don't know how you would try to counsel someone with anxiety cos I guess if I knew I would just do it. But yeah, no, I wasn't really sure how it would pan out. 22/11-17
		Natasha: Maybe if I had seen someone before her I might be going I really don't want to. 26/4-7
	5:2 Frame	Natasha: I always felt a bit set free once I had finished. It was like I have done all this work, now I'm going to go and like live my life and I wondered if she was coming into my environment whether there would be less of a disconnect because I would take, it wouldn't be so like a place where I go to do that. 35/19-29
		Dirk: I didn't like the notion that was her flat and all of that, it didn't feel it's just sort of official enough I think, I mean professional enough. 6/21-26
		Sinead: I kind of thought it would be more in depth but as I was going I realised it was not quite such a personal thing because I didn't hire her personally she is just like a service arranged by [identifying detail removed]. 1/8-14
		Dirk: It was the structure that maybe was helpful more than anything else. 28/18-20
		Sinead: This space is for me to sort out my issues and I definitely have someone who is going to listen to me and always have someone there. 19/17-20
		Anna: there is no other space in my life where I'm able to talk to somebody who doesn't have any set of judgments or agenda about me. 2/16-19
	5:3 Lack of options	Maia: [specific number of] sessions as that was only so much as I could afford. 31/10-32/2
		Dirk: It's like watching a movie that you don't like, after you've reached the halfway point you just want to finish it, because you've invested so much time in it. 24/3-8
		Natasha: I had suggested ending the therapy, but I wouldn't actually, but I needed her permission to do it and it was that idea of like needing to be empowered I suppose to act on something. 13/22–14/5
		Serena: I just felt you know, okay, I did something wrong. I need to collaborate a little more. Let's give the benefit of the doubt, let's do what she wants. 35/3-6
		Sinead: I kind of thought it would be more in depth but as I was going I realised it was not such a personal thing because I didn't her personally. (1/8-12)

	5:4 Deference	Natasha; There was this kind of element of wanting to please, wanting to feel, to show my therapist “oh look, my life’s improving, I’m doing all this work”. 2/4-10
		Dirk: Maybe there’s some process and it will, in the end I'll look back and say okay now I understand it. It was great. Well done. 13/28-32
		Richard: I did one module of psychology at university but I am never going to be able to understand all of that lot. It’s not my domain. I come out feeling better. 24/10-12
		Anna: It was quite amazing to me and humbling that someone else could actually just sort of hold up the mirror and I go, “oh good stuff!”. And there were several things like that. 14/7-12
		Maia: I am not an expert on um psychotherapy so I wouldn’t know, you know, where to go or what I should be saying. 11/23-12/1 Sinead: If a professional tells me, you need to do this, or whatever, I am more apt to listen, I guess. 3/5-7

Appendix L - Notation used in analysis

Page and line references locating excerpts taken from participant transcripts are formatted as in the example 24/3-5 which indicates page 24, lines 3 to 5.

Italics in the verbatim transcription of participants' words denote an emphasis in their tone or volume of voice.

[Square brackets] used in transcripts indicate explanation added to participant account by researcher.

(Round brackets) in participants' accounts indicate a description of non-verbal communication.

... indicate that some of the participant's words have been omitted.

Italics used in descriptive and interpretive comments in right hand column of transcripts denote researcher's interpretive comments.

Plain text in descriptive and interpretive comments in right hand column denote researcher's descriptive comments.

Appendix M – Ethics Release Form

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:

BSc ☐ M.Phil ☐ M.Sc ☐ **D.Psych** ☐x n/a ☐

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

1. Title of project

How do clients' expectations of therapy play out during the therapeutic process? An Interpretative Phenomenological Analysis.

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

Paul Lewis [redacted]

3. Name of research supervisor

Dr Susan Strauss

4. Is a research proposal appended to this ethics release form? **Yes** No

5. Does the research involve the use of human subjects/participants? **Yes** No

If yes,

a. Approximately how many are planned to be involved?

8 people.

b. How will you recruit them?

Participants will be recruited from private practices, counselling services and charities. It is intended that therapists will agree to pass on a flyer (at Appendix 1) to clients of theirs who complete therapy. As the research will look at relational therapies, the flyer will be passed to clients who have received these types of therapies. Contact details for clients to get in touch with the researcher are included in the flyer.
Prospective participants who reply to the flyers will then be sent an information sheet enabling them to make an informed decision about taking part and ensuring they are familiar with their rights as under the British Psychological Society Code of Human Research Ethics (BPS, 2010). If they decide to proceed, they will be asked for a contact telephone number so a telephone call can be arranged (see 'c' below). After this call prospective participants will be informed whether or not they are being asked to participate.
A letter to the Heads of University Counselling Services requesting participants is also attached (appendix 8 to the Research Proposal at appendix 5).

c. What are your recruitment criteria?
(Please append your recruitment material/advertisement/flyer)

To be included, participants will need the ability to articulate the experiences arising from or impacting on their expectations of therapy once that process is underway. The study is looking for rich data from the client perspective, meaning detail is sought about the way participants made sense of what happened in therapy in the light of their expectations, including how they felt and what thoughts they had about this, how their reactions and sense-making impacted the therapeutic process and relationship as well as when and in what way their expectations played out during therapy. For this reason a telephone call will be arranged to assess whether individuals have the ability to articulate their experiences in a detailed and rich way (this does not exclude speakers of English as a second language as long as they are able to communicate appropriately). This will be assessed during the call by asking them the question "what is it about this research subject that interested you"? This call will also be used to reduce the risk that anyone who is not sufficiently emotionally stable for the interview is not recruited. Signs of greater than usual difficulty tolerating emotion or of unstable affect or sense of self would be treated as indications that a prospective participant may not be suitable for inclusion.

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

d1. If yes, will signed parental/carer consent be obtained? Yes No

d2. If yes, has a CRB check been obtained? Yes No
(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).*

Participants will be asked to attend a 45minute interview as soon as possible after their therapy is complete (interview schedule appended to attached research proposal). The interview will be audio recorded and conducted by the researcher. Participants will be asked to sign a consent form agreeing to this (appended to research proposal) and to the use of the interview for the thesis and for its supervision and marking. The interview schedule will reflect the approach taken in the study (Interpretative Phenomenological Analysis), so they will be able to determine the agenda of the interview within a flexible framework of a semi-structured interview. They will be asked to travel to and from the interview and travel costs will be reimbursed.

Participants will also be asked to spend up to 10 minutes filling in a short demographic information questionnaire and a post interview debrief is expected to take around 20 minutes. Before selection for participation they will be asked to take part in a five to ten minute phonecall to answer their questions and as screening for recruitment.

7. Is there any risk of physical or psychological harm to the subjects/participants?
Yes No

If yes,
a. Please detail the possible harm?

Participants are of interest because they have been in therapy and therefore are or have been in distress due to a mental health condition and this is seen as constituting vulnerability and as such can involve an element of risk of harm. It is not expected that the interview will include any unduly difficult or challenging questions that could occasion any harm as it is the participant's experience that is being asked for and it is likely that in the main this will be familiar material for them or at least not shocking in impact. Despite this it is possible that there may be instances when unexpected or distressing thoughts or emotions arise.

There is also a risk of harm if more prospective participants come forward than can be interviewed or if any potential participants are not felt to be suitable for the study, in that they may feel rejected if their offer of participation is declined. Because the study's approach will sacrifice numbers of participants for richness of material, it is essential that interviews yield this depth of information. Were a participant not of the mind-set or capacity to talk in this way the interview would be inappropriate from their point of view as well as the researcher's, hence the possibility that not all offers of participation will be accepted.

There is also a risk that participants may see the research as a way of getting further therapy or as an outlet for disagreement or dissatisfaction with their therapist and in these instances may not get the compliant response they hoped for, which could be upsetting for them.

b. How can this be justified?

The possibilities for harm are likely to be relatively remote and minor and can be mitigated (see below) and

the potential benefits of the study, ie that it could contribute towards improvements in the support offered to people through psychotherapy, are felt to outweigh the risk, if the risk is handled with care. Participants are not considered to be extremely vulnerable and the process is not thought to be include a large element of risk of harm.

c. What precautions are you taking to address the risks posed?

A pilot study will be carried out before the interview schedule is finalised and this will give some indication of any likely distress that may be experienced by interviewees.

As part of the chosen research methodology, care will be taken not to direct the content of the interview any more than minimally and this should help avoid any area a participant could find difficult to tolerate. Attempts will be made to remain empathic at all times and alert to any sign of distress and, if this arises, to contain it and steer the interview onto safer ground, while remaining prepared to abandon the interview if that is appropriate. Any distress that is apparent will be contained using counselling psychology skills and a non-judgemental, accepting stance will be maintained. Participants will, if necessary, be advised that any issue that seriously concerns them which arises is something they can take to further therapy and a list of contacts to access therapy will be provided.

Anyone who expresses willingness to participate but is not asked to take part will be contacted by telephone and informed of this sensitively and again counselling skills will be used to help contain them at that time because of the feeling of rejection that could result. An explanation of the exclusion will be offered which emphasises that the decision was based on resource limitations and the fact that sufficient numbers had been recruited.

If any serious allegation against a therapist are made, participants will be directed to the appropriate professional contact for expressing this and it would be explained to them that continuing the research interview would no longer be appropriate as resolving their complaint should take priority and the study could interfere with this. Complaints of this type are thought to be highly unlikely as the staff at practices to be contacted will be accredited professionals working to high ethical standards.

All participants will be told they have the right to withdraw their consent at any time within the two weeks following the research interview and that in this instance all records about them will be deleted, without any adverse consequences and if this desire becomes apparent it will be given priority. Debriefing will be available to answer any questions participants have after the interview. This will also be an opportunity to engage with any concerns or anxieties resulting from the research and to ensure any necessary steps are taken to minimise any negative impact of it.

A screening call will be made to prospective participants before arranging any interview and this will also reduce any risk of harm. Attention will be focused in this call on whether an individual who is willing to take part in the study lacks emotional stability (or the ability to give a rich account of their experience of their own expectations during therapy). Attention will also be paid to the possibility that a prospective participant is looking for a way to make a complaint about their therapist. If any of these risks are thought likely, that participant will not be included in the study as explained above.

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 see Appendix 2

(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?

Yes **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 No

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).

Please see Appendix 3

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

Digital audio recordings, transcripts of these, transcripts annotated with the researcher's interpretations, thoughts recorded (in text) by the researcher, contact details for participants, e-mails exchanged, demographic questionnaires filled in. All hard copies will be scanned and stored digitally and the originals destroyed.

12. What provision will there be for the safe-keeping of these records?

All records will be kept in a password protected computer.

13. What will happen to the records at the end of the project?

Records will be kept as above for seven years and then deleted.

14. How will you protect the anonymity of the subjects/participants?

Contact details will be kept separately from other records on a second password protected computer. Any details that could be used to identify a participant, such as names or places they mention, will be removed from transcripts and analyses/write-ups. All names will be changed when discussing in any way (supervision, viva) or writing about the participants (eg names will be changed in transcripts, discussion of results). Hard copy information will be scanned and then shredded.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

All participants will be given a 20 minute debrief after they are interviewed (see Appendix 4) during which any questions they have will be answered. They will be given a list of telephone numbers, e-mail contacts and websites for organisations through which further therapy is available (below) if this is appropriate.

British Psychological Society (BPS)
www.bps.org.uk Tel: 0161 797 4484
British Association for Counselling & Psychotherapy (BACP)
www.bacp.co.uk Tel: 01455 883300
United Kingdom Council for Psychotherapy (UKCP)
www.ukcp.org.uk Tel: 020 7014 9955
British Association of Behavioural & Cognitive Psychotherapies
(BABCP) www.babcp.com Tel: 0161 797 4484
British Association of Sexual & Relationship Therapy (BASRT)
www.basrt.org.uk Tel: 020 8543 2707
Mind
www.mind.org.uk Tel: 020 8519 2122

(Please append any de-brief information sheets or resource lists detailing possible support options)

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 [redacted]

Date 12 June 2013

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 No

If yes,

a. Please detail possible harm?

There is a remote risk of an untrue accusation against the researcher because he will be in a private room with one participant at a time with no independent witnesses present.
There is also a remote risk of material distressing to the researcher coming up in the course of the interviews or the debrief process.

b. How can this be justified?

The potential value of the research justifies these very remote risks.

c. What precautions are to be taken to address the risks posed?

The risk of bogus accusations cannot be eliminated but the room itself will be in a public-facing organisation rather than a private home so the location is not as susceptible to this risk.
Any distressing material arising in the interview or debrief process is unlikely to be of impact on the researcher, but if it was, the researcher would have support available from personal counselling and university staff (personal tutor and thesis supervisor).

Section C: To be completed by the research supervisor

(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)

Please mark the appropriate box below:

Ethical approval granted ☑

Refer to the Department's Research and Ethics Committee ☐

Refer to the School's Research and Ethics Committee ☐

Signature [redacted] ---------- Date-------- 12 June 13

Section D: To be completed by the 2nd Departmental staff member *(Please read this ethics release form fully and pay particular attention to any answers on the form where **underlined bold** items have been circled and any relevant appendices.)*

I agree with the decision of the research supervisor as indicated above ☐

Signature [redacted]

Date 12 June 2013

Appendix 1 – recruitment flyer

Have your say – talk about your experience of therapy.

Student No: [redacted] Module PSD206 Ethics release form for research project 20.1.13

This research aims to understand your experience of coming to therapy with certain expectations and asks your impressions of the therapeutic process in this light. Finding out about your experience is the goal because this research values the client's perspective. A better understanding of what clients experience in therapy could help improve counselling in the future. Talking about your experience might also be interesting to you or help you to put things in context.

The research will consist of a 45 minute interview after your therapy is completed. All interviews will be confidential. There is also a debrief of about 20 minutes after the interview where any questions you have will be answered. There is also a short questionnaire that should take 5-10 minutes to fill in.

Taking part is entirely voluntary and participants can withdraw consent at any time during the two weeks after the interview, without any consequence. The study has been approved by the City University London Ethics Committee and will be in accordance with British Psychological Society guidelines. Any receipted travel expenses will be reimbursed.

If you would consider participating, please get in touch and I will send you more information.

Many thanks,
Paul Lewis
[redacted]

This research is part of a City University London Counselling Psychology Doctoral Thesis supervised by Susan Maise Strauss, PhD, C Psychologist. [redacted]

Appendix N - Reflexive diary excerpt.

July 6th (After interviewing “Natasha”).

Natasha came across as strong, confident and self-aware, at first in any case. The story she told was of having worked on things, overcome difficulties, learned lessons. I was impressed. She talked fast and fluently, seemed to have clear opinions and to be familiar with the subject.

I did not sense any hidden agenda with her. She works in PR, so her apparent confidence could have been habit for her, a well developed front. Overall I feel sure she was trying to be honest throughout the interview, but I also had a strong sense of not following, of confusion at what she was talking about during interview and I felt anxious I might not have done a ‘good’ interview.

I felt during the interview that there seemed to be incomplete ideas, opinions expressed that seem to change half way through, non sequiturs and contradictions. I may need to manage a tendency to doubt my comprehension or my skill in this kind of situation and to treat to the discomfort as data.

I have a sense from the interview that it can hard to criticise one’s therapist because it suggests you have been misled, mistreated, failed and the like, or been weak. I sensed strong loyalty to her therapist however, that seemed to have its roots in part at least in her sense of achievement.

As with my feelings about my epistemology above, the best route to ‘truth’ seems to lie in combining the objective and subjective, the rational and the emotional – triangulating gives more than the sum of its parts.

Having conducted the interview I am concerned to be clear in my mind about how far the word ‘expectations’ can extend. Anything that a client finds surprising must be included as relevant, in that on some level it was unexpected. Similarly anything that is not surprising could be seen as confirming pre-existing expectations. So together this could mean anything is relevant - which is unfocused, to say the least. I think that a surprise does inevitably speak to the subject of expectancy, but that where something is unsurprising it does not mean it was expected – not necessarily. In these cases I have to look within a participant’s account for signs that expectation was or was not a felt issue in the participant’s experience. Satisfaction or dissatisfaction is one indicator in that it links to the client’s perception and understanding of therapy and this understanding might be at the root of expectancy. It also links to whether or not something matters to the participant. I need to focus on moments of emotion in the interviews.

Having said that surprise is critical – especially negative surprise. It represents a clash with understanding, a break with ‘self-narrative’. Expectations are so important because they arise out of a lifetime’s construction of internal models. Any mismatch between these and what happens in therapy must surely be critical to that therapy.

Section D: Paper for publication

Balancing empathic and questioning hermeneutics in therapy: Client and practitioner perspectives

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Abstract

Interviews were conducted with eight adult psychotherapy clients about their expectations of therapy. The participants were self-selected or therapist-selected and all were seen by therapists taking more relational as opposed to structured approaches. Interviews took place within four weeks after therapy termination. Data collection and analysis relied on qualitative methods and were in accordance with recognised Interpretative Phenomenological Analysis practice. This methodology supplemented the predominantly quantitative literature, adding distinctive data accessing the client perspective on expectancy and seeking to balance suspicious and empathic research hermeneutics. A key finding to emerge was that an expectation of various forms of therapist lead-taking was pervasive. In particular practitioner elucidation of therapeutic approach was critical to participants if frustration and disappointment were to be avoided. Dimensions of meaning attached to such experiences and their impact on client engagement, therapeutic alliance and outcome are explored. Implications for practice and the therapeutic alliance are discussed.
Keywords: Client expectations, experience, therapy, roles, therapy process.