

An interpretative phenomenological analysis investigation into men's experience of psychological change without psychotherapy

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**DOCTORAL PORTFOLIO IN
COUNSELLING PSYCHOLOGY**

by

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for the

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DECLARATION

The research dossier or any part thereof has not previously been presented in any form to the University or to any other body whether for the purposes of assessment, publication or for any other purpose (unless otherwise indicated). With the exception of any express acknowledgments, references and/or bibliographies cited in the work, I confirm that the intellectual content of the work is the result of my own efforts and of no other person.

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DEDICATION

I would like to dedicate this portfolio to my late grandmother Ruby May Carey, a very special person, who made the doctorate possible for me.

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**All work throughout this portfolio has been
appropriately anonymised and all identifiable
information removed, so no participant can be identified.**

Preface

Preface: An Introduction to the Portfolio

This portfolio encompasses a number of pieces of work which form several dossiers including an Academic Dossier, a Therapeutic Dossier and a Research Dossier. The work in these dossiers, in addition to the work in the confidential attachment submitted separately, has been produced for the Wolverhampton University's Practitioner Doctorate in Counselling Psychology. The confidential attachment includes a process report, a client study, personal journal summaries, feedback sheets pertaining to the assignments included in the portfolio, raw data relating to the research report (*the interview transcripts are provided on CD*) and the annual research progress reports. Information in the confidential attachment is not in the public domain.

The Academic Dossier in the portfolio includes an essay which was submitted for the Psychodynamic Approach module and another submitted for the Working with Couples module. The Therapeutic Dossier comprises a reflective essay regarding my professional development submitted for the Professional Issues module, in addition to the previously submitted essay for the Supervised Practice module, examining my placement experiences during the three years of training. Lastly, included in the Research Dossier is a literature review, a research report and a critical appraisal of the research process. All of the aforementioned work contained in the portfolio and in the confidential attachment adheres to the requirements of the British Psychological Society (BPS) and the Health and Care Professions Council (HCPC) regarding protecting the confidentiality of clients and research participants.

Preface

Throughout the last three years on the doctorate, I have developed in relation to my competences as a practitioner and regarding my professional identity, on my journey to becoming a Counselling Psychologist. I aim to demonstrate this in the portfolio and confidential attachment. In this preface, I will use a metaphor to describe how I have developed, based on a nickname that was allocated to me by a peer during our first meeting on the residential weekend at the start of the doctorate. The nickname my peer gave me, which she called me by throughout the course, is 'butterfly'. Hence, the butterfly, and its life cycle, is the metaphor I will use.

The butterfly is a symbol of change and transformation. I perceive 'butterfly' is a very appropriate nickname for me particularly with regards to being a practitioner, because as Carey, Carey, Mullen, Murray and Spratt (2006) state, change is the main quest of professionals who deliver therapy, and I perceive my role is to facilitate change and transformation. I also perceive it is apt in relation to my transition from practitioner to practitioner-researcher. Hence, I will address this towards the end of the preface, particularly with regards to my research report on psychological change included in the Research Dossier. Furthermore, I first became passionate about change and transformation as I battled to overcome Chronic Fatigue Syndrome (CFS), or M.E., a decade ago. I subsequently embarked on my new career in the helping profession, as I will briefly explain.

The life cycle of the butterfly includes four distinct stages: the 'egg', the 'caterpillar', the 'chrysalis' and the 'adult' butterfly. With regards to my own life, it is as though for the first 30 years of it I was in the 'egg' stage, surrounded and protected by a hard 'shell', until I

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became ill with CFS in the year 2000. This triggered the next stage, the 'caterpillar' stage, as I metaphorically broke out of the 'egg' and began to 'feed' and 'grow'. It was during this 'caterpillar' stage that my personal transformation began, described in my professional issues essay, as I embarked on a journey to overcome the illness. This encompassed a great deal of self-help along with receiving various psychotherapies. It also included obtaining an undergraduate degree in Psychology and Counselling and a diploma in Neuro-Linguistic Programming (NLP), hypnotherapy and coaching. Additionally, I wrote and self-published a self-help book (Buchan 2008) to share with others the lessons I had learnt on my healing journey about the self and relationships, and how I overcame CFS. I also began my role as a professional change facilitator with a small private practice. More recently, I delivered talks and workshops relating to my book and ran a meditation and personal development group too.

Having already developed a passion for change and transformation, I feel as though my previous identity has been 'dismantled' during the doctorate, allowing a new 'adult' or professional identity as a Counselling Psychologist to form. Consequently, I perceive that at the start of the doctorate I transitioned from the 'caterpillar stage' to the 'chrysalis stage'. This is because it is at the 'chrysalis stage' that the main transformation of the butterfly occurs, when the tissues of the caterpillar are dismantled and the structure of the adult insect develops. The professional issues essay, contained within the Therapeutic Dossier, particularly encouraged me to reflect on the personal challenges I had overcome and the training I had completed during the 'caterpillar' stage prior to the doctorate. Additionally, it helped me to gain an understanding of the importance of these aspects of my journey in regards to forming this new 'adult butterfly' and becoming a Counselling Psychologist.

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In spite of the self-reflection that I had carried out in the process of writing my book, the transformation I experienced during the 'chrysalis stage' on the doctorate also involved the skill of reflection. I now recognise that in relation to being a reflective-practitioner, this was one of the skills I needed to develop further. This is demonstrated in a number of pieces of work contained in the portfolio, particularly in the essays within the Academic Dossier and the Therapeutic Dossier. Furthermore, prior to the course, I considered myself principally a humanistic practitioner and had received personal therapy from humanistic and transpersonal therapists. Therefore, writing the psychodynamic essay, along with experiencing the module lectures, allowed me to reflect on change from other theoretical perspectives which I had not done previously.

Intuitively, and based on my own experience, I had formed the belief that emotions were important in regards to well-being and transformation. However, I had been unaware of how the main theoretical approaches differ in regards to the concept of emotions, particularly in relation to how they deal with emotions, the importance they ascribe to them and the corresponding techniques used to work with emotions, until I wrote the psychodynamic essay. I had been unaware that there were also some similarities regarding the treatment of emotions between the main theoretical approaches. Thus, considering how emotions are dealt with not only within the humanistic approach but also within CBT and the psychodynamic approach, contributed greatly to improving my competence levels as a reflective-practitioner. Hence, this is another example of the 'dismantling' of my previous identity that I experienced during the doctorate.

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Another very helpful aspect of the psychodynamic essay was that it afforded me the opportunity to not only deepen my theoretical knowledge but also consider the concepts of transference and countertransference from the three core therapeutic approaches taught on the doctorate. I had minimal knowledge, and lacked therapeutic experience, regarding working with transference or countertransference prior to the psychodynamic module. Hence, in the essay I reflected on this aspect of my development as a Counselling Psychologist, which included reflecting on my understanding of transference from a theoretical perspective. In addition, I reflected on these aspects of my clinical practice, particularly regarding my experiences of clients' projections of their emotions, and cognitions, the impact of this on myself and the therapeutic alliance for example, and how to manage these projections appropriately. Thus, I perceive my knowledge and competence levels regarding transference and countertransference have been significantly enhanced as a result of this process, along with the assistance of supervision.

Supervision, and personal therapy, have enabled me to address my own emotions in regards to countertransference too such that previously, I would have accepted full responsibility for any uncomfortable feelings or anger that the client expressed or displayed towards me in a session. I used to perceive that I was to blame for my client's reaction, believing that my actions or words were at fault. I now attribute this to an aspect of my own personal growth, relating to the underlying core belief I had at the start of the doctorate that I was not good enough. This has been an important aspect of my development personally and professionally over the last few years, which I have reflected on in my personal journal summaries. Although I have not used the psychodynamic approach with clients due to it not being appropriate, or permitted, in the services I have worked in, as demonstrated in the

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supervised practice essay, I am now very mindful of the dynamics of transference and countertransference when I work with clients. Consequently, I utilise these concepts in the appropriate manner in sessions, according to the therapeutic approach I am using at the time.

Additionally, I found writing the psychodynamic essay useful with regards to how other concepts used in the psychodynamic approach, and other approaches, are also considered, albeit in different ways. Due to my previous training in NLP and hypnotherapy, I subscribe to the belief in the existence of an unconscious mind for example. Researching this essay, I discovered that its existence is also accepted in the humanistic approach and that according to this approach too, it can be important to the change process. With regards to the CBT approach, when I wrote the psychodynamic essay, my viewpoint was heavily influenced at that time by the perspective of my placement supervisor. There are CBT therapist colleagues of Clemens' (2003) that seem to 'not believe in an unconscious mental life' (p463). My placement supervisor was in accordance with this perspective and consequently, my essay reflects this and my experience at that time.

Thus, in the essay I demonstrate how, when delivering CBT to a client who presented with OCD, I 'bracketed-off' the desire I had to work with what appeared to be the client's inner conflict regarding his religious upbringing and his growing sexual desires, as this seemed inappropriate at the time, and this was confirmed by my placement supervisor. In contrast, guided by my supervisor, I introduced the client to the Salkovskis (1985) CBT model of OCD, and using this model, we worked collaboratively to change the client's more easily accessible thoughts and alter his behaviour. Hence, the psychodynamic essay afforded me the opportunity to reflect on how I would have worked with this client if I had been using

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the psychodynamic approach, which demonstrates an aspect of my development as a Counselling Psychologist. Nonetheless, my thinking and therefore my knowledge regarding CBT has evolved in a number of ways, since the time of writing this essay. I reflect on these aspects of my further development as a Counselling Psychologist in the Critical Appraisal, which I refer to later in this Preface (*see p14*).

The other essay constituting the Academic Dossier, regarding working with couples, also demonstrates my development as a Counselling Psychologist. Before the doctorate, I most recently specialised in helping individual clients with relationship and self-esteem issues based on the concepts I discuss in my book. Consequently, I perceived that I would find the couples module, and essay, particularly easy. I also looked forward to sharing my relationship knowledge and experience with my peers. Nevertheless, during this aspect of the 'chrysalis stage' of my development as a Counselling Psychologist, I felt the painful effects of my 'caterpillar tissues' breaking down. This was caused by the rude awakening I experienced as I discovered what is really involved in delivering couples therapy and facilitating change, compared to working with only one of the individual's involved.

Examining the differences, in addition to the similarities, between working with individuals and couples, helped me to become knowledgeable about several important aspects of couple therapy. The differences and challenges I became aware of included the need to develop multiple alliances, having to deal with multiple transferences and countertransferences, the need to avoid colluding with either of the partners, and the challenge of working with individuals who may have differing levels of engagement or commitment to the therapy process. This permitted me to discover that facilitating change

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in couples is a much more complex process than working with only one individual client and thus significantly more challenging for me as a practitioner.

Furthermore, I perceive completing this module and essay has greatly improved my competencies as a Counselling Psychologist with regards to learning about the importance of considering gender in couples therapy too. I discovered heterosexual couple therapy is inherently imbalanced, for example, as one of the client's will be matched with the therapist on gender and the other will not (Shay, 1993). I became aware that in order for couple therapy to be effective and also a fair process, gender roles and how they relate to the presenting relationship issues must be included (Johnson & Lebow, 2000). Hence, along with my research into men's experience of psychological change, and this module and essay, I perceive I am much better informed about how the aforementioned factors can impact the therapeutic process and how to manage these more appropriately.

These learnings described above were further enhanced by the use of case study material in the couples essay, including reflecting on my experience as the therapist in the assessed role-play aspect of this module. This enabled me to appreciate how much more complex couple therapy is compared to individual therapy, particularly with regards to attempting to balance the needs of each partner and their goals, along with managing the multiple interpersonal dynamics in the session. I was also able to reflect in this essay on the difficulty I experienced attending to the transference and countertransference issues, and managing the overt conflict displayed in the therapy room by the couple during the role-play. I considered the impact these factors would have on my ability to effectively facilitate

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the change process. I perceive being aware of, and considering these factors, further enhanced my development as a reflective-practitioner.

Reflecting in the essay on the complexity of working with couples, and on my experience of delivering couple therapy obtained during the module, has enabled me to recognise that my current identity as a Counselling Psychologist does not include the desire to work with couples. Although writing this essay has afforded me the opportunity to learn about the benefits of couple therapy too, such as helping couples through an impasse in their individual therapy, I recognise I currently prefer to facilitate change with one individual at a time, rather than with a couple. This is due to the added complexity and challenges of working with a couple, as outlined in the essay. However, I believe my thinking will change in the future, as I seek new challenges along my career path as a Counselling Psychologist and feel more prepared to take on the challenges that working with couples brings. At least now I have become more consciously aware that to work with couples, I require further professional development but that I have a foundation from which to build on.

Following on from the above, the transformation I experienced during the 'chrysalis stage' regarding my development as a Counselling Psychologist is also demonstrated in the two essays contained in the Therapeutic Dossier concerning my clinical practice. In my time working in private practice prior to the course, I generally felt competent in regards to my ability to facilitate change with my clients who presented with relationship and self-esteem issues. However, I felt completely de-skilled when a client also presented with depression. I recognised I needed further training, and particularly as the new HCPC regulations were

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coming into force. The professional issues and supervised practice essays enabled me to reflect on this and the experiences on my placements during the doctorate.

I was able to reflect, for example, on the increase in my knowledge of theoretical models, therapeutic approaches and techniques, along with my improved ability to apply these theories and techniques to my clinical practice. Furthermore, in preparing the many case studies (*not included in the portfolio*) which accompanied the supervised practice essay in particular, I had the opportunity to reflect on all the clinical experience I have gained working in such a variety of settings. This included reflecting on my work with clients presenting with many different issues, delivering both short-term and long-term therapy, carrying out assessments and formulations, in addition to learning how to appropriately manage risk. Contemplating my clinical experiences in the primary care settings, including an Improving Access to Psychological Therapies (IAPT) service, and secondary care NHS placements, along with the tertiary substance abuse charity placement which included working with a mandated client, I began to appreciate the breadth and depth of experience I have gained during the doctorate. I now understand the extent to which I was previously lacking in my clinical experience prior to the course.

In addition to all the clinical hours I have accumulated over the last number of years, and the doctorate course itself, a significant aspect of the progress I have made can be attributed to the clinical supervision I have experienced. Generally, my experience as a supervisee has been positive but I have had to face challenges in this regard too. The supervised practice essay, along with the professional issues essay, provided me with the opportunity to reflect on some of these challenges. One of the most difficult challenges I have had to overcome

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concerns my second year placement in a secondary care mental health service. My supervisor, a Clinical Psychologist, had the dual role of line manager. Furthermore, he valued CBT to the exclusion of all other approaches. Hence, due to our clash in values and his dual role, I struggled at times in regards to trying to act in my clients' best interests (HPC, 2008), which is demonstrated in my essays. Writing the Therapeutic Dossier essays enabled me to develop a more balanced perspective in regards to the challenge with the Clinical Psychologist supervisor, as I reflected not only on how the experience enhanced my professional identity but also how my basic CBT skills and techniques had improved as a result of my supervision with him.

Another challenge I experienced was that I found it difficult to take responsibility as a leading practitioner and implement any changes in policy during the first few years of training, due to the service constraints detailed in my supervised practice essay, along with my limited confidence as a Counselling Psychology trainee. Nonetheless, dealing with these challenges, and overcoming the aforementioned values clash with my supervisor, helped me to feel stronger and more confident, reinforcing my identity as a Counselling Psychologist. Consequently, I had the confidence in my third year to take responsibility and implement policy changes, which I reflect on in the essays in the Therapeutic Dossier.

An additional aspect of my transformation during the 'chrysalis stage' relating to my transition from working in private practice to working in the NHS, and a tertiary sector organisation, is in regards to the number of therapy sessions I was permitted to deliver. I was able to reflect in both essays in the Therapeutic Dossier, about the difficulty I experienced adjusting to working for services where the number of therapy sessions is

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limited and set by the service managers, to manage the demands on the service. The challenge for me included, at the start of the doctorate, perceiving that therapeutic change took quite a period of time. Thus, I have experienced a dismantling of my beliefs regarding the speed of therapeutic change during the doctorate. Hence, following the clinical experience I have gained, in addition to research support, I have formed new beliefs including that it is possible to facilitate therapeutic change in a brief number of sessions. Given these learnings and experiences, which I have been able to reflect on in the Therapeutic Dossier essays, I now appreciate how far I have travelled on my journey to becoming a Counselling Psychologist since starting the course.

In this portfolio, following on from the Academic Dossier and the Therapeutic Dossier, is the Research Dossier. The work in this last dossier demonstrates perhaps the most challenging aspect of the 'chrysalis stage' for me with regards to the development of my identity as a Counselling Psychologist, which concerns becoming a practitioner-researcher. I carried out what I now consider to be a relatively small piece of quantitative research for my undergraduate dissertation investigating the relationship between positive optimism and well-being and graduated from the course in 2003. Thus, having not carried out any research following my undergraduate course, I found the doctoral research process significantly challenged me both intellectually and emotionally.

The critical appraisal, along with my research diaries, afforded me the opportunity to reflect on the challenges I experienced and overcame regarding carrying out the doctoral research. This included having to deal with trying to find a research topic which was aligned with my interests and in an area of research that I could make a significant contribution to. I also had

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other difficulties recruiting and subsequently interviewing participants. Being a novel qualitative researcher, I experienced great difficulties regarding analysing the data I eventually managed to collect and I reflect on these in the critical appraisal too. Additionally, writing the critical appraisal enabled me to reflect on a number of individual differences regarding my participants, particularly how their prior learnings and experiences related to their change process. This also included reflecting on how I managed these differences during the analysis process.

My thinking has also evolved since writing the essays included in the Academic Dossier and Therapeutic Dossier, particularly with regards to CBT, as previously mentioned. Hence, I have taken the opportunity in the critical appraisal to demonstrate how my thinking has changed in this regard and to correct any possible perceived misrepresentations of the approach I may have made previously. Thus, it is in the critical appraisal that I provide a wider, more contemporary perspective of this approach focusing on certain aspects, including the concept of an unconscious mental life, because as Mansell (2008) pointed out, CBT 'acknowledges that unconscious processing clearly exists' (p19). It also includes my thinking in relation to the role of early experiences, defences, and the therapeutic relationship within the CBT approach, which help to demonstrate further my continuing development as a Counselling Psychologist.

Hence, on reflection I have been able to recognise how the pieces of work contained in the Research Dossier have positively contributed to my identity as a Counselling Psychologist and provided valuable, if uncomfortable, learning experiences. I perceive, for example, that the work contained in the Research Dossier in particular, has enabled me to enhance

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my critical thinking skills especially in regards to evidence-based practice, along with the ability to integrate psychological theory and research into my practice. I consider that these are aspects which prior to the course, were underdeveloped areas for me. Therefore, I perceive they have significantly contributed to my development in regards to my identity as a Counselling Psychologist.

Additionally, the pieces of work in the Research Dossier, along with my research diaries, have enabled me to become consciously aware of just how much the subject of my research, psychological change, is at the core of who I am and what I do as a Counselling Psychologist. They have also allowed me to recognise that psychological change is the main theme that underlies all my personal and professional interests since first breaking out of the 'egg' in 2000, when I experienced the fundamental change that eventually set me on the path to becoming a Counselling Psychologist.

I will now turn to the last stage in the lifecycle of the butterfly, the 'adult' stage, at which time the butterfly breaks free from its chrysalis, becoming mobile and moves on to pastures new. With regards to the future, I intend to leave Wolverhampton University and 'spread my wings'. I aim to contribute to the profession, in my capacity as a qualified Counselling Psychologist, raising awareness of what it means to be a Counselling Psychologist in the places that I work. This will include training to become a supervisor, as detailed in my professional issues essay, as I am committed to upholding the standards and ethics of the Counselling Psychology profession and helping future trainees to do the same. Furthermore, it is my intention to complete further training in CBT, as mentioned in the essays in the Therapeutic Dossier. The reason for this is because although I have been able

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to enhance my theoretical knowledge, skills and techniques regarding this approach during my time on the doctorate, and since then, working in the IAPT service in particular has helped me to understand that I require further professional development in CBT.

Another aspect of the process of 'spreading my wings' involves disseminating my research on men's experience of psychological change included in the Research Dossier, in addition to the knowledge and experience I have acquired in regards to working with male clients described in this portfolio and so forth, to current and future work colleagues. There appears to be a higher percentage of female than male practitioners in the helping profession for example. This imbalance of male to female practitioners was evidenced in the low number of male Counselling Psychology trainees on my course and the minimal number of male practitioners, or a complete absence of them in some cases, at my four placements. Consequently, I perceive it is important to disseminate my research findings and experience of working with male clients, because of the fact that female practitioners do not have the male socialisation experience to draw on when working with male clients, as previously mentioned. I also plan to present my research at a Counselling Psychology Conference in the future. Finally, I expect that I will be eager to pursue further research into the processes of psychological change, as expressed in my critical appraisal of the research process, once I have had a much needed break to fully recover from the demands of the doctorate!

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References

Buchan, C. A. (2008). *22 Boyfriends to Happiness: My Story and the Seven Secrets on How to Find True Love*. Triniti Press.

Carey, T.A., Carey, M., Mullan, R. J., Murray, L. K. & Spratt, M., B. (2006). Psychological change: What changes and how does it occur? A critical review. *Counselling Psychology Review*, 21, 4, 28-38

Clemens, N.A. (2003). Psychotherapy: Insight, Consciousness, Learning and Change. *Journal of Psychiatric Practice*, 9, 462-464.

Health Professionals Council (2008). *Standards of Conduct, Performance and Ethics, updated 1st July 2008*. Retrieved from <http://www.hpc-uk.org>

Johnson, S. & Lebow, J. (2000). The 'Coming of age' of Couple Therapy: A Decade Review. *Journal of Marital and Family Therapy*, 26, 23-38.

Mansell, W. (2008). 'What is CBT *really*, and how can we enhance the impact of effective psychotherapies such as CBT?' in House, R., & Loewenthal, D. (eds.), *Against and For CBT: Towards a constructive dialogue?* (pp.19-32). PCCS Books Ltd.

Salkovskis, P.M. (1985). Obsessional-compulsive problems: a cognitive-behavioural analysis. *Behaviour Research and Therapy*, 23, 571-583

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Shay, J.J. (1993). Should Men Treat Couples? Transference, Countertransference, and Socio-political Considerations. *Psychotherapy*, 30, 93-102

Academic Dossier

**COMPARE THE PSYCHODYNAMIC, COGNITIVE-BEHAVIOURAL AND
HUMANISTIC APPROACHES IN COUNSELLING PSYCHOLOGY IN
RELATION TO THE CONCEPT OF EMOTIONS ILLUSTRATED BY EXAMPLES
FROM YOUR CLINICAL WORK.**

Introduction

Compare is defined as noting ‘the similarity or dissimilarity between’ (Pearsall, 1999; p290). There are both similarities and differences between the psychodynamic, Cognitive Behaviour Therapy (CBT) and humanistic approaches in regards to the concept of emotions. Therefore, this essay will make reference to some of the similarities in addition to focusing on some of the main differences between them.

The psychodynamic approach does not consist of one, single theory (Leiper, 2006). Similarly, CBT is based on a number of behavioural and cognitive therapies, including Ellis’s rational emotive behavioural therapy and Beck’s cognitive therapy (Corey, 2001). These were combined in the 70’s and CBT was born (Sanders, 2009). In addition, the humanistic approach also encompasses a variety of models which differ in theory and in practice (Gillon, 2007). Consequently, this essay will compare these approaches in relation to emotions, with reference only to some of their basic theoretical assumptions.

An overview of emotions and the similarities in the approaches in this regard will be provided, followed by a number of ways the approaches differ in their conceptualisation of emotions. Subsequently, how the approaches differ in regards to the treatment of emotions in therapy will be addressed, with reference to the unconscious, defences and transference specifically, as this is a psychodynamic module essay. Only a number of brief, rather than

in-depth, examples from my clinical work will be used to illustrate the aforementioned differences in the approaches, due to limitations of space.

The essay will conclude with a brief summary, in addition to my thoughts regarding the differences between the approaches in the conceptualisation and treatment of emotions, with reference to my clinical work.

An overview of emotions

As counselling psychologists, whatever our preferred theoretical orientation or choice of approach for each client, the nature of our profession involves dealing with emotions. Moreover, therapy has frequently been referred to as emotional training (Perls, Hefferline & Goodman, 1951). Furthermore, as counselling psychologists we also need to address our own emotions in personal therapy and in supervision, where we explore our emotional reactions to our clients and the therapy process, in other words transference and countertransference.

The emotions we most often deal with are distressing ones because it is these which usually lead people to seek therapy (Whelton, 2004). Additionally, irrespective of theoretical orientation, there is increasing agreement amongst therapists that emotions are central to mental health and change (Borum & Goldfried, 2007). Neuroscience also provides support for the importance of emotions in therapy, with research demonstrating that what affords beneficial therapeutic change is ‘emotional attunement, affect-regulation and the co-construction of narratives’ (Cozolino, 2002; p45).

Irrespective of this increasing agreement regarding the importance of emotions in therapy and their familiarity to us, the concept of emotions is a notoriously elusive one (Borum & Goldfried, 2007). An agreed single definition of emotion is still lacking. Hence, for the purpose of this essay, emotions will refer to ‘holistic constructs consisting of behavioural expression, physiological substrate, phenomenological experience, cognitive processes and a social context’ (Solomon, 2002). Furthermore, throughout this essay emotions and feelings will be used interchangeably.

How the approaches differ in regards to the concept of emotions

The psychodynamic, CBT and humanistic approaches differ in regards to the extent to which they deal with emotions, the importance they attribute to emotions and the methods used to work with them. The psychodynamic approach, being a developmental theory, perceives emotional and psychological problems as the result of issues in childhood (Howard, 2010). Therefore, the client’s feelings and experiences from the past which are negatively affecting their present are important to a therapist working psychodynamically (Jacobs, 2004). Furthermore, the psychodynamic therapist aims to help the client develop emotionally by stimulating their ability to self-heal and assist them to attain this ‘in an ongoing way so that he no longer needs our physical presence to continue and maintain his emotional development’ (Howard, 2010; p2).

In contrast, CBT, deemed to be a ‘disorder-specific, symptom-focused model’ (Gillon, 2007; p115), proposes that negative or dysfunctional cognitions cause emotional problems and unhelpful behaviour. Hence, CBT asserts that by altering our thoughts and beliefs, using specific interventions, it is possible to alleviate our emotional suffering (Curwen,

Palmer & Ruddell, 2000). Therefore, from the CBT perspective, thoughts drive emotions and so rational thinking produces health. Nevertheless, the Freudian perspective is feelings precede thoughts and there is evidence to support both view points, that is thoughts drive emotions and emotions also drive thoughts sometimes (Seligman, 2002).

Additionally, Beck (1995) states 'emotions are of primary importance to the cognitive therapist' (p94). Nevertheless, this is only in regards to the aim of relieving the client's symptoms and reducing the level of their distress, which is achieved by modifying their 'dysfunctional thinking' (Beck, 1995; p94). CBT aims to alleviate symptoms and thus help clients attain a 'generally more positive emotional state', which has led the approach being criticised as superficial (Jokic-Begic, 2010; p242). However, Jokic-Begic (2010) refers to research from neuroscience which highlights the importance of 'positive emotional states as facilitators of a neurobiological change' (p242).

In regards to the humanistic approach, psychological and emotional problems are the result of denying emotions and difficulty tolerating distressing but necessary feelings (Perls et al., 1951). This is also termed 'incongruence' (Rogers, 1961). Hence, humanistic approaches perceive change can occur by deepening the experience of 'organismic feelings in the present moment' (Davy & Cross, 2004; cited in Gillon, 2007; p101). Therefore, humanistic therapists aim to facilitate 'immediate experiencing' described as a 'continually evolving, dynamic synthesis of multiple emotion schemes organised around the person's key emotional states' in the present moment (Elliot & Greenberg, 2007; p242).

A further difference between these approaches has been observed by Burum and Goldfried (2007) who indicate that CBT therapists generally aim to diminish clients' negative emotions, for example depression and anxiety, whereas psychodynamic and humanistic therapists aim to increase emotional experiencing. Similarly, Whelton (2004) states that compared to the other approaches, CBT has demonstrated 'less interest in emotional processes' (p58).

Differences between the approaches regarding the treatment of emotions

The unconscious

The difference in the concept of emotions previously described has led to differences in the dealings of emotions in therapy to facilitate therapeutic change. One difference between the approaches is the concept of the unconscious. According to the psychodynamic approach, certain feelings (and thoughts) which were too painful or threatening to deal with at the time are denied, hidden in the unconscious mind, thus 'warded off' from the conscious mind (Leiper, 2006; p48). This denial causes great tension within. Hence, the psychodynamic approach aims to make the unconscious feelings and thoughts conscious and thus alleviate this inner tension (Jacobs, 2004).

The humanistic approach shares with the psychodynamic approach the notion of an 'unconscious dimension to human experiencing' (Wheller & McLeod, 1995; cited in Gillon, 2007; p100), where threatening feelings and thoughts are hidden from consciousness. However, the approaches differ in that within the humanistic approaches, the person-centred approach perceives it is possible for formerly 'denied or distorted

organismic experiencing’ to develop into ‘a full part of conscious awareness’ whereas the psychodynamic approach perceives ‘a significant and ongoing unconscious dimension in life’ is unavoidable (Gillon, 2007; p100). Hence, although the contents of the unconscious (eg. emotions) are central to the psychodynamic approach, any analysis of these is perceived in person-centred therapy as extraneous (Gillon, 2007).

Unlike the psychodynamic and humanistic therapists, CBT therapists are concerned with ‘the more obvious, surface level of thinking’ (Beck, 1995; p14) and feeling and in general, they do not accept the concept of the unconscious (Clemens, 2003). Therefore, they would offer ‘a behavioural explanation for the formation of schemata’ (Monaghan & Moorey, 1999; p41). However, in regards to more recent thinking within CBT, Bateman, Brown and Pedder (2010) state that, ‘there is a realisation that a simple focus on manifest behaviour and conscious thought is inadequate’ (p229). Nevertheless, the views of my main supervisor/line manager at my current placement, a clinical psychologist, are aligned with the traditional CBT perspective. Consequently, unconscious emotions and conflicts are not considered, which I find disappointing and limiting.

A 17-year old male client for example, was referred for CBT for low self-esteem and social anxiety. He had always been unconfident and shy but this escalated following the relatively recent death of his father. During our initial sessions, the client reported being unable to remember his life prior to the age of ten. Some sessions later we returned to his childhood and he suddenly remembered his parents separated for a period when he was nine. His mother moved out with him. His brother remained with his father. He reported remembering feeling powerless at the time. The client said he had ‘completely forgotten’

about this. I perceive this period was particularly emotionally painful for the client, who reported being very close to his father, that it became repressed in his unconscious. I perceive it could have been beneficial for the client to have explored this further.

Defences

Howard (2010) informs us that from the perspective of the psychodynamic approach, we develop defensive strategies to protect us and keep the threatening or painful feelings and thoughts hidden in the unconscious. Furthermore, in regards to their defence systems, psychodynamic therapists assist clients to utilise them more flexibly rather than completely stripping them of their defences, because ‘defences can be normal and adaptive as well as pathological’ (Howard, 2010; p103).

To facilitate the aforementioned process, psychodynamic therapists aim to ‘reach beneath the defence and anxiety’ to what is described as the ‘hidden feeling’ (Malan, 1979/1989; p14). Awareness of the hidden feeling evokes anxiety as ‘its expression is in conflict with another perceived need, and thus is feared to have catastrophic consequences’ (Leiper, 2006; p49). Psychodynamic therapists also aim to trace the client’s hidden feeling back from the present to its origins, which are usually relationships with parents. This is referred to as the ‘triangle of conflict’ (Malan, 1979/1989; p14).

According to Shedler (2010), the psychodynamic therapist explores clients’ efforts to evade painful feelings and thoughts by actively focusing on and exploring their defences. This also includes explaining and articulating conflicting, distressing feelings and ‘feelings the patient may not initially be able to recognise or acknowledge’ (Shedler, 2010; p2).

Therefore, the psychodynamic approach asserts that by adapting what are described as unhealthy defences, psychological change occurs, whereas in person-centred therapy it is the elimination of the defences rather than their adaptation that results in psychological (and emotional) change (Gillon, 2007; p101).

Furthermore, within the humanistic approach of gestalt therapy, it has been suggested that rational talking in therapy can be used as a defence mechanism by the client. Hence, 'direct confrontation between people' has been introduced and the physical expression of feelings has been encouraged more recently (Bateman et al., 2010; p101). However, these methods have been criticised for running the opposite danger of 'defensive doing and feeling'. Moreover, as Bateman et al. (2010) report, 'both feeling and talking are ultimately necessary for full expression' (p101).

In contrast to the psychodynamic and humanistic approaches, CBT, does not accept the concept of the unconscious (Clemens, 2003), as previously mentioned. Hence, if defences are considered at all in this therapy, a behavioural explanation would be given for them (Monaghan & Moorey, 1999).

Using CBT, I worked with a 19 year-old male client referred to the service for OCD, which he developed six months after starting university. He was having intrusive thoughts about harming others which he felt incredibly anxious about. He used to check the internet and local newspapers to verify whether or not the events he had thoughts about had actually taken place. According to Najmi, Reese, Wilhelm, Fama, Beck and Wegner (2010) it is the

'maladaptive beliefs about the need to control thoughts and their unrealistic expectations regarding the controllability of thoughts are the problem' in OCD and cause the anxiety. Hence, using the Salkovskis (1985) CBT model of OCD, I worked with the client to change his beliefs and expectations of control about the intrusive thoughts and eliminate his checking behaviour and thus reduce his feelings of anxiety.

If I had worked with the client from a psychodynamic perspective, I would have perceived the OCD as a defensive reaction to conflicting feelings that were not in his conscious awareness (Howard, 2010), possibly relating to his religious upbringing and his increasing sexual desires since beginning a relationship. Hence, in accordance with Malan's (1979/1989) triangle of conflict, at the appropriate time I would have considered offering the client an 'exploratory interpretation' regarding this because as Malan (1979/1989) states, 'the therapist makes the triangle of conflict explicit' (p81). Furthermore, as Bateman et al. (2010) state, 'defence should be interpreted with respect for the underlying anxiety or impulse' (p143). Moreover, as Carr and McNulty (2006) indicate 'defence mechanisms are used to manage the anxiety associated with the fears about expressing activating emotions' such as sexual desire, which could apply in this case (p118). Thus, I would have addressed the client's underlying, previously unconscious feelings and thoughts rather than addressing the symptoms of OCD.

Transference

Another difference in the approaches relating to emotions is the concept of transference, which concerns 'the client's attitudes, beliefs and feelings towards the therapist' (Coren, 2010; p78). The client projects these feelings and thoughts, which really concern significant

others from their past, onto the therapist and this impacts the therapeutic relationship (Jones, 2004).

Furthermore, Coren (2010) states that transference is ever-present but that it is specifically 'transference neurosis', that is transference of conscious and unconscious feelings, thoughts, and attitudes from the client's past onto the therapist, which is 'a specific illusion of the therapeutic setting' (p79). The transference neurosis provides the psychodynamic therapist with information regarding the client's problems which are still unresolved and is utilised 'to further the development of the relationship and the therapeutic process' (Jones, 2004; p14). Hence, the interpretation of this transference is perceived as the psychodynamic practice's 'gold standard' and the foundation for change (Howard, 2010; p91).

In practice, the repeating of the transference in the therapy setting facilitates the vivid experiencing of it and thus it can 'be mutually experienced and examined' by the client and the therapist (Bateman et al., 2010; p149). The experiencing of these intense transference feelings, according to Bateman et al. (2010) enliven the past, however because the therapist responds differently to the client than their parents did originally, this provides the client with a 'corrective emotional experience', also termed 're-parenting' (p149).

Although transference, as explained, is highly significant in psychodynamic therapy, within humanistic therapy whilst it may be acknowledged, it is regarded and treated differently. In person-centred therapy, for example, unconscious feelings and thoughts from the client's past which may be projected onto the therapist are not confronted or interpreted by the therapist (Bateman et al., 2010). Moreover, transference can be perceived as a problem, in

that the process could be perceived ‘to infantilise the client by undermining the legitimacy of her feelings in the moment’ (Rogers, 1987; cited in Gillon, 2007; p102). Similarly, gestalt therapy does not encourage transference and ‘dramatisation is used to explore and express fuller awareness of the self in the ‘here and now’ instead (Bateman et al., 2010; p214).

The CBT approach traditionally does not acknowledge the unconscious, as mentioned. Thus there is no examination of transference in this therapy and the therapist’s role is more one of support (Clemens, 2003). However, more recently, particularly with schema-focused CBT (Young, 1999), more attention has been given to the importance and need to make use of the therapeutic relationship. As Coren (2010) points out, whereas transference was previously an issue, now it is perceived as ‘a major part of the solution’ (p78), at least in theory. Nevertheless, this is not my personal experience on my placement, principally because my supervisor is an advocate of the more traditional ‘second-wave’ CBT.

A 25-year old female was referred for relationship problems. She wanted to clarify if her problems were caused by her confused sexual identity or issues with intimacy in general. Being permitted to use the humanistic approach, I chose gestalt therapy and we have been working with her two conflicting parts regarding her sexual identity using the two-chair experiment (O’Leary, 1992). Thus, the client has been able to ‘viscerally experience what they talk about and use their feelings to identify and solve problems’ which is necessary for change (Greenberg, 2002; p8). Consequently, we have discovered she has some unexpressed emotions, or ‘unfinished business’ (Joyce & Sills, 2007), particularly unresolved grief, regarding her mother dying when she was six.

Alternatively, if I were using the psychodynamic approach, using Malan's triangle of conflict, I would perceive the client has pushed her partner away, as a defence, thus attempting to avoid feeling the loss, grief and anger (the hidden feelings), at having been abandoned by her mother when she died, as she fears (the anxiety) being overwhelmed by them. To facilitate change from this perspective, I would focus on working through the transference within the therapeutic relationship, by exploring the client's defences and the previously mentioned hidden feelings and thoughts originating in her childhood (Corey, 2001). I would also intend to link the client's emotional insight with cognitive awareness, which is necessary for change (Howard, 2010). Thus the aim of these processes would be to facilitate a 'corrective emotional experience' for the client (Bateman et al., 2010) which, it could be suggested, is also the aim of the gestalt processes.

Conclusion

This essay has demonstrated the three approaches are similar in regards emotions in that they each deal with them and agree they are central to mental health and change (Burum & Goldfield, 2007). Nevertheless, as demonstrated, the methods used and the extent to which emotions are addressed in therapy differs across the approaches, with CBT focusing on surface level thoughts and feelings, whilst the psychodynamic and humanistic approaches work with deeper feelings and thoughts.

At my placement, I have had clients who have previously experienced CBT in the service and been re-referred within six months. Some of these clients have specifically requested

not to have CBT again as they felt it trivialised their problems and did not get to the heart of their issues. Furthermore, many of these secondary care clients' had several problems and/or enduring problems, which did not fit neatly into the 'second-wave' CBT models. Hence, I concur with Greenberg (2004) that CBT's aim of bringing difficult emotions 'into line with reasons dictates....denies human complexity' and trying to be completely 'rational can itself produce emotional distress' (p1). I also agree with Grant (1997) that 'multi-model, supportive and uncovering approaches are often necessary' (p60) because of human complexity.

Furthermore, I agree with Corey (2001) that 'some painful early experiences need to be recognised, felt fully, re-experienced and worked through' (p330). This emotional arousal and processing in addition to thoughtful reflecting on the meaning of the emotions experienced is what produces the 'deepest therapeutic transformation' (Whelton, 2004; p58) but this is not aligned with 'second-wave' CBT either.

I personally find working with clients who desire deep therapeutic transformation, when I am permitted to use approaches other than 'second-wave' CBT, more fulfilling than using CBT to relieve symptoms. However, I recognise, and have experienced, that some clients wish for symptom relief whilst others desire deeper transformation. Therefore, I perceive it is very important to be able to be flexible in regards to the therapy approach, to meet the needs of the client, and work at the emotional level that they desire. I perceive that therapeutic integration may be very beneficial in this regard, and as Burum & Goldfield (2007) state, advances in emotion research will hopefully facilitate discoveries in the

mechanisms of change, in addition to promoting 'greater psychotherapy integration' (p142). Nevertheless, organisational constraints such as those I have experienced at my placement may have to be overcome first.

References

Bateman, A., Brown, D. & Pedder, J. (2010). *Introduction to Psychotherapy: An outline of psychodynamic principles and practice (4th ed.)*. Routledge.

Beck, J.S. (1995). *Cognitive Therapy: Basics and Beyond*. The Guilford Press.

Burum, B.A. & Goldfried, S. (2007). The Centrality of Emotion to Psychological Change. *Clinical Psychology: Science and Practice*, 14, 407-413

Carr, A. & McNulty, M. (2006). 'Psychodynamic Therapy' in Carr, A. & McNulty, M. (eds.) *The handbook of Adult Clinical Psychology: An Evidence-based Practice Approach* (pp.108-156). Routledge.

Clemens, N.A. (2003). Psychotherapy: Insight, Consciousness, Learning and Change. *Journal of Psychiatric Practice*, 9, 462-464.

Coren, A. (2010). *Short-term Psychotherapy: A Psychodynamic Approach (2nd ed.)*. Palgrave Macmillan.

Corey, G. (2001). *Theory and Practice of Counselling and Psychotherapy (6th ed.)*. Wadsworth Publishing Co Inc.

Cozolino, L. J. (2002). *The neuroscience of psychotherapy: Building and rebuilding the human brain*. W.W. Norton & Company, Inc.

Curwen, B., Palmer, S. & Ruddell, P. (2000). *Brief Cognitive Behaviour Therapy*. Sage Publications Ltd.

Davy, J. & Cross, M. (2004). *Barriers, Defences and Resistance*. Milton Keynes: Open University Press.

Elliott, R. & Greenberg, L.S. (2007). The Essence of Process-Experiential/Emotion-Focused Therapy. *American Journal of Psychotherapy*, 61, 241-254

Gillon, E. (2007). *Person-Centred Counselling Psychology: An Introduction*. Sage Publications Ltd.

Greenberg, L.S. (2002). *Emotion-Focused Therapy: Coaching clients to Work Through their feelings*. American Psychological Association.

Howard, S. 2010. *Skills in Psychodynamic Counselling & Psychotherapy*. Sage Publications Ltd.

Jacobs, M. (2004). *Psychodynamic Counselling in Action (3rd ed.)*. Sage Publications Ltd.

Jokic-Begic, N. (2010). Cognitive-Behavioural Therapy and Neuroscience: Towards Closer Integration. *Psychological Topics*, 19, 235-254.

Jones, A. C. (2004). Transference and Countertransference. *Perspectives in Psychiatric Care*, 40, 13-19.

Joyce, P. & Sills, C. (2007). *Skills in Gestalt Counselling & Psychotherapy*. Sage Publications Ltd.

Leiper, R. (2006). 'Psychodynamic Formulation: A prince betrayed and disinherited' in Johnstone, L. & Dallos, R. (eds.). *Formulation in Psychology and Psychotherapy: Making sense of people's problems* (p47-71). Routledge.

Malan, D.H. (1979/1989). *Individual psychotherapy and the science of psychodynamics*. Butterworths & Co.

Monaghan, M.T. & Moorey, S. (1999). Bridging the Psychotherapy Divide. *Psychiatric bulletin*, 23, 40-42.

Najmi, S., Reese, H., Wilhelm, S., Fama, J., Beck, C. & Wegner, D.M. (2010). Learning the futility of thought suppression enterprise in normal experience and in obsessive compulsive disorder. *Behavioural and Cognitive Psychotherapy*, 38, 1-14.

O' Leary, E. (1992). *Gestalt Therapy: Theory, Practice and Research*. Chapman & Hall.

Pearsall, J. (ed.) (1999). *The Concise Oxford Dictionary*. Oxford University Press.

Perls, F., Hefferline, R.F. & Goodman, P. (1951). *Gestalt Therapy: Excitement and Growth in the Human Personality*. The Guernsey Press Co. Ltd.

Rogers, C. R. (1961). *On Becoming a Person: A therapist's view of psychotherapy*. Constable & Robinson Ltd.

Rogers, C.R. (1987). Transference. *Person-Centred Review*, 2, 182-188

Salkovskis, P.M. (1985). Obsessional-compulsive problems: a cognitive-behavioural analysis. *Behaviour Research and Therapy*, 23, 571-583

Sanders, D. (2010). 'Cognitive and Behavioural Approaches' in Woolfe, R., Strawbridge, S., Douglas, B. & Dryden, W. (eds.), *Handbook of Counselling Psychology* (3rd ed.) (pp.105-129). Sage Publications Ltd.

Seligman, M. E. P. (2002). *Authentic Happiness: Using the new positive psychology to realise your potential for deep fulfilment*. Nicholas Brealey Publishing, London.

Shedler, J. (2010). The Efficacy of Psychodynamic Psychotherapy. *Psychotherapy in Australia*, 16, 38-51.

Solomon, R.C. (2002). Back to Basics: on the very idea of 'basic emotions'. *Journal for the Theory of Social Behaviour*, 32, 115-144.

Wheller, S. & McLeod, J. (1995). Person-Centred and Psychodynamic Counselling: A dialogue. *Counselling*, 6, 14-20

Whelton, W.J. (2004). Emotional Processes in Psychotherapy: Evidence Across Therapeutic Modalities. *Clinical Psychology and Psychotherapy*, 11, 58-71

Young, J. E. (1990) *Cognitive Therapy for Personality Disorders: A Schema-focused Approach*. Sarasota: Professional Resource Exchange

**COMPARE AND CONTRAST THE SIMILARITIES AND DIFFERENCES
BETWEEN COUPLE THERAPY AND INDIVIDUAL THERAPY.**

Introduction

This essay will compare and contrast the similarities and differences between couple therapy and individual therapy. It will encompass general aspects of the process of therapy, rather than particular therapeutic models, due to word count limitations. The essay will begin with an overview of an aspect of therapy which is fundamental to all therapies, that is, the concept of change. Three features of individual and couple therapy will be compared and contrasted, demonstrating their similarities but principally focusing on the differences between them. The three features of therapy will include the relational factors of the therapeutic alliance and the processes of transference and countertransference, in addition to the aspect of gender.

In order to illustrate the similarities and differences between couple therapy and individual therapy in the aforementioned aspects of therapy, supporting evidence will be provided. This will include material obtained from the couple therapy role play assignment (*used with permission*) in addition to an example from my work with an individual therapy client. The essay will conclude with a brief summary of the similarities and differences between the two modes of therapy and some personal thoughts based on my clinical work.

The Concept of Change

Counselling psychologists and other professionals who deliver therapy, whether it is to individuals or couples, work with people who are experiencing psychological distress.

Furthermore, regardless of the mode of therapy the professional delivers, change is their 'central pursuit' (Carey, Carey, Mullan, Murray & Spratt, 2006; p7). Similarly, as Carey et al. (2006) state, the change work which is carried out is deemed to be effective when the client (*or clients*) psychological distress alters 'in an ultimately positive and beneficial direction' (p1). Furthermore, other similarities are that people who come to individual and couple therapy bring with them their own 'internal world representations, attachments and ways of dealing with others' (Jenkins, 2006; p120). Additionally, they will have their own formative experiences, core beliefs, thoughts, feelings and patterns of behaviours.

Hence, it could be argued that individual therapy is greatly similar to couple therapy, except as Donovan (1998) states, couple therapy involves 'inevitably treating two persons simultaneously' (p116). Additionally, in couple therapy each member will bring not only their own beliefs and so on, but also their 'day-to-day experiences of each other' (Jenkins, 2006; p120). Donovan (1998) therefore poses the question as to whether couple therapy is 'therapists engaging in individual therapy in double focus or in family work with a very small family or in some third unique enterprise?' and reports that 'no one seems able to decide' (p116).

Nevertheless, irrespective of some similarities, given that there are more people involved than in individual counselling, the change process in couple counselling appears a more complicated process. Gurman (2010), for example, invites us to consider whether change in couple therapy is facilitated more 'via the therapist-client (partner) relationship or via the client-client (partner-partner) relationship' (p102) as this will impact counselling psychologist's role as a change facilitator.

Additionally, there can be advantages to couple therapy over individual therapy in facilitating change. If, for example, the two members of the couple are in individual therapy but their distress is not diminishing, such as when they reach an impasse in the process of change, couple therapy can be useful to assist them to move beyond the impasse (Braverman, 1985). However, it is acknowledged there are also limitations to couple therapy. Although clients may present with relationship problems for example, not all clients and their partners can be treated conjointly in couple therapy for a number of reasons such as one partner may not want change and 'refuse to participate' (Carriger, 2009; p246).

The Therapeutic Alliance

One of the perceived fundamental features according to almost all schools of therapy is the therapeutic relationship between therapist and client (Jacobs, 2004). Hence, this relationship, also referred to as the 'therapeutic alliance', is a crucial element of both couple and individual therapy. Cooper (2008) defines the therapeutic alliance as 'the quality and the strength of the collaborative relationship between therapist and client' (p103). Moreover, he asserts that 'a strong therapeutic alliance' is essential for effective therapy (Cooper, 2008; p119).

Thus, a strong therapeutic alliance is important not only in individual therapy but also in couple therapy, as Treadway (2010) explains 'the heart of a successful couple therapy is developing a nurturing, compassionate alliance with each member of the couple in the presence of each other' (p430). Furthermore, the therapeutic alliance in couple therapy is

similar to that of individual therapy in that it also involves developing ‘a strong emotional bond as well as negotiation of goals and tasks with the therapist’ (Friedlander, Escudero, Heatherington & Diamond, 2011; p26).

However, despite the aforementioned similarities between these two modes of therapy there are important differences between them regarding the therapeutic alliance. In individual therapy for example, the therapist has only to be able to form a therapeutic alliance with one person. However, in couple therapy, they must be able to form ‘multiple alliances’ (Rait, 2000; p211) which is more complex than forming a therapeutic alliance with only one individual. This is because as Celano, Smith and Kaslow (2010) report, in couple therapy both partners have different ‘personalities, developmental needs, and clinical issues’ in addition to often having ‘competing perspectives on the problem’ (p37).

An additional challenge exists for the couple therapist in forming a therapeutic alliance. Gurman (2010) explains that the couple therapist must be able to ‘find stylistically different ways to start to establish a bond with each partner’ in that one member might be ‘responsive to a solid dose of empathy’ where as the other ‘seeks guidance, structure and explanation’ (p240).

Mr. and Mrs Denton were referred for an assessment by Mrs Denton’s GP. Mrs Denton mentioned to her GP that she and Mr Denton had recently been arguing a great deal over his unusual hobby of ghost hunting. The referral stated that the couple had been married for two years and have no children. Mrs. Denton (‘Jane’) is 26 years old. Mr Denton (‘Steve’) is 30 years old. During the assessment, I asked the couple to tell me in their own

words what had brought them to therapy. Steve looked at Jane and indicated that she should tell me. Jane proceeded to disclose her dissatisfaction with her husband's hobby, which she perceived was the cause of their problems due to the cost of the hobby and because she did not participate in it as it was of no interest to her. Consequently, she reported she felt rejected by Steve due to the time he spent on his hobby without her. Steve reported he did not see the hobby as a problem and that he is happy for her to join him ghost hunting, whenever she wants too. He also stated that he perceives the money he spends on his hobby as an 'investment' as he described it, rather than a waste. Furthermore, he expressed he would attend therapy as he wanted to make the relationship work but he does not perceive his hobby as a problem.

Hence, I could immediately recognise one of the differences of developing a therapeutic alliance in couple therapy compared to individual therapy, in that as Rait (2000) indicates 'not every family member comes to treatment with equal motivation, similar goals, or agreed-upon beliefs about how to change' (p212). It was apparent during the assessment that although Steve and Jane both wanted to make their relationship work, they had different levels of motivation and differing perspectives on the problem.

Although they had a mutual goal of wanting to make their relationship work, Jane also disclosed that she had given Steve an ultimatum and it appeared that if Jane had not issued the ultimatum, Steve would not be attending therapy. This is another example of a challenge and difference between couple therapy compared to individual therapy in that the former is frequently carried out with clients who are to some extent reluctant (Rait, 2000).

At points during the assessment Jane was very critical of Steve and his hobby, blaming him for a number of things. She appeared to portray herself as the victim in their relationship and seemed to want me to side with her against Steve. In contrast, Steve tried to defend himself and put his point of view across, seeming to want me to see things from his perspective. They continually interrupted each other.

This appears to demonstrate another difference regarding the complexity in the therapeutic alliance in couple therapy, which is the necessity for the therapist to ‘dance’ backwards and forwards freely, between each individual ‘always attending to invitations to join one against the other’ (Rait, 2000; p214). Furthermore, it seemed to be an example of what Tudor (2006) describes as the possible ‘ulterior transactions or hidden agendas of both parties’ in couple therapy, such as ‘B may want the couple therapist to tell A to get off their back’ (p132). The couple therapist needs to attend to this during the course of therapy, unlike the therapist in individual therapy.

Consequently, I found it very challenging trying to manage this aspect of the couple ‘dance’, with Jane perceiving Steve as the one with the problem and thus dominating the assessment. Hence, it became apparent that the couple therapist needs to be mindful of a tendency to collude with either of the partners because, as Gurman (2010) reports, ‘when one partner in couple therapy continually or repeatedly feels the therapist is on the other partner’s side, the likely helpfulness of the therapy is severely limited’ (p77).

During the assessment, Jane reported that her father died when she was 15 years old and that she feels she does not understand men. She also disclosed that her relationship with

her husband is her first serious relationship, unlike Steve, who it was revealed had had other serious relationships in the past.

The therapeutic alliance also involves ‘the negotiation of goals’ (Friedlander et al., 2011; p26), as previously mentioned. Hence, when Jane disclosed this, I found myself questioning whether an implicit therapy goal for her would be to improve her understanding of men. I also wondered if she had any unresolved grief. Therefore, I wondered whether it would be helpful for Jane to have individual therapy to address these areas, because as Gurman (2010) points out, ‘it is common for one or both couple partners to be in individual therapy during the course of joint treatment’ which can be ‘initiated after the couple work has begun’ (p72).

Furthermore, it demonstrates an additional difference between these two modes of therapy. This concerns the need in couple therapy to prioritise the ‘marital distress’ and for this to be the main treatment focus rather than the individual issues, as by doing so it will ‘solidify the therapeutic alliance’ (Garfield, 2004; p457). I struggled with this aspect in the couple assessment due to Jane’s disclosure of her issues. It was only with extreme effort that at the end of the assessment I managed to verify that they both wanted the relationship to work and enquired about their mutual therapy goals. In order to manage this challenge of couple therapy, I would adhere to Lawrence and Brock (2010)’s practice and have two or three conjoint sessions, followed by one individual session with each partner separately, to complete a more thorough assessment of the issues and agree the appropriate way forward.

Transference and Countertransference

Following on from the above, another relational factor of therapy irrespective of the therapeutic mode is the concepts of transference and countertransference. Although transference and countertransference occurs in both individual and couple therapy, not all therapists address these aspects of the process, as some counsellors ‘do not attach any value to the concept’ (Jacobs, 2004; p17). In order to adhere to the word limitation, the differing levels of value placed on these concepts in therapy will not be explored further in this essay.

Corey (2001) defines transference as ‘the client’s unconscious shifting to the analyst of feelings and fantasies that are reactions to significant others in the client’s past’ (p94). In both couple therapy and individual therapy, what transference does is permit clients to comprehend and settle ‘unfinished business from these past relationships’ (Corey, 2001; p89).

In contrast, countertransference is described as the ‘therapist’s reactions to clients that are based on therapists’ unresolved conflicts’ (Cooper, 2008; p112). Hence, whether delivering individual therapy or couple therapy, ‘powerful countertransference reactions are unavoidable’ (Shay, 1993; p98). Furthermore, it is important to attend to countertransference in both modes of therapy because failing to do so will negatively impact the therapy, reducing its ‘vitality, robustness and excitement’ (Melnick, 2003; p41).

Although transference and countertransference occurs in both individual and couple therapy, there are differences in how these concepts are experienced. Unlike individual

therapy, in heterosexual couple therapy, two of the three people involved will be the same gender. Consequently, this will result in ‘an inherent imbalance with important transference and countertransference consequences and dilemmas’ (Shay, 1993; p93)

Moreover, couple therapy involves an additional transference element in that the individual members of the couple will react to the therapist and experience a particular transference but they will have this reaction ‘in the presence of the partner who has a correlated reaction’ (Shay, 1993; p97). Shay (1993) describes this aspect of transference in couple therapy as ‘triangular transference transactions’ (p97), which adds to the complexity of this mode of therapy.

Furthermore, unlike in therapy with one individual, couple therapy can involve a heightening of ‘relational intensity’ as a result of how easy it is for the therapist to become ‘triangled into the couple’s relationship and by the influence of the emotional triggers from their respective internal worlds’ (Jenkins, 2006; p113)

In regards to transference issues during the brief assessment with Steve and Jane, I sensed that Steve may be experiencing Jane as a parental mother figure, someone who seemed to be spoiling his fun. Hence, I wondered if we had longer together, whether Steve may also begin to experience me, being a female therapist, in this way. Additionally, I wondered if it may have been useful for Jane to see a male therapist individually, to work through transference issues regarding the loss of her father and I would seek to have an assessment with them individually, as previously mentioned, to explore these items further. *(The issue of gender in couple therapy will be explored further at a later stage).*

Couple therapy also differs to individual therapy regarding countertransference, because in couple therapy 'for every intense transference, there is an equal and correlated countertransference' (Shay, 1993; p98). Hence, it is therefore more complex than in individual therapy, particularly because there are a greater number of 'countertransferential' opportunities (Melnick, 2003, p45).

During the assessment, Jane stated she was unemployed and unhappy not having a job. She stated this was something she wanted to change. Steve was the bread-winner of the family and although he spent their money on his hobby, he perceived this as an investment (as previously mentioned), rather than something detrimental to their relationship. Furthermore, he felt because he worked hard all week, he deserved to be able to spend time on his hobby, which he later described as a passion, not just a hobby. It was how he relaxed after his hard work.

My father was the sole wage-earner in my family. He frequently reminded my mother and I how hard he worked to provide for us and hence, he had the right to spend 'his' money however he wished. Logically, this seemed to make sense to me. Nevertheless, emotionally I felt uncomfortable with the elevated status this earning power afforded him. Consequently, I grew up feeling powerless and vulnerable, until I was old enough to earn my own money.

In regards to countertransference during the assessment with Steve and Jane, I was very surprised to find myself over identifying with Steve. I felt conflicting emotions, as a result

of the childhood experiences described above. I experienced Steve as 'right' in that as the wage-earner, it did seem appropriate that he was free to spend 'his' money as he wished. I also experienced Jane as powerless and weak with her unemployed status. This seems to support Shay's (1993) argument that it is possible in couple therapy for the therapist to over identify or take the side of the client 'most like an idealised parent or different from a devalued parent' (p98). Therefore, I was very aware that I would need to attend to this particular countertransference if we were to begin therapy together, otherwise it would impair the therapeutic alliance.

A further difference in couple therapy is that countertransference can be so powerful that the therapist can find themselves easily becoming 'emotionally engulfed' (Jenkins, 2006; p119). I had some sense of this during the assessment, as I found my own childhood emotions triggered by the individual experiences they recounted, as described previously. It was difficult to attend to what was being triggered in myself, due to the fact that I was hearing the experiences of two people, unlike in individual therapy. Moreover, I found the addition of the conflict between the couple and my need to manage this conflict, further impaired my ability to monitor my own countertransference responses.

Gender Issues

An additional similarity in both individual and couple therapy is that it can be affected by the gender of the therapist, that is, there is a possibility in both of therapist gender bias. In individual therapy and same-sex couple therapy, if the client (*or clients*) and therapist are of the same gender, the individuals involved will have experienced a 'common socialisation process' which will have helped to create who they are (Shay, 1993; p97). Therefore, a

male therapist will be accustomed to the 'male epistemology' and thus understands how a male makes sense of the world (Shay, 1993; p97), just as I as a female therapist know how a female makes meaning of the world.

Being matched on gender and thus have an understanding of the client's perspective could be perceived as an advantage of delivering therapy to an individual of the same gender (or to same-sex couple clients who are of the same gender as the therapist). Hence, it can be problematic in both modes of therapy if the therapist and client's gender are not matched. Shay (1993) gives an example of this, explaining that as a male therapist, there are times when he will not be able to connect with the female client as 'there are some experiences I cannot share....related to growing up as a female in this society' (p97). This can equally apply for a female therapist in regards to a male client (or clients).

'John' was a 50 year-old divorcee. He was referred to the primary care service for short-term counselling by his GP to help him overcome the break-up of his recent long-term relationship which was affecting his mood. John openly expressed his disbelief and anger about the relationship break-up and wanted to win his partner back. Furthermore, in our first session he asked if his ex-partner could attend, so that he could be helped to 'make her see', as he described it, how wrong she was to end it. I informed him that as a service, we were unable to provide couple therapy and that if he wished to pursue that route he would need to contact Relate. Additionally, he disclosed that he had 'paid a visit' as he described it, to his ex partner's new boyfriend and given him 'what for', stating that he had threatened him. Consequently, the police were called and the new boyfriend ended the relationship as he did not want to have to deal with John's aggression. I carried out an

assessment session with John. He then attended two counselling sessions. During our second session, John declared he would not be continuing with the counselling as he did not need it reporting that 'this should be sorted out between me and her and no-one else'.

I have experienced being rejected by a partner in my own life. I drew on my experience in order to try and begin to empathise with John. Nevertheless, throughout our few sessions, I struggled to relate to his experience of reacting so angrily to being rejected by his partner. I felt relieved when he terminated the therapy. I felt our differences in gender impacted the counselling relationship. I experienced John as intimidating and I perceive that had I been a male therapist, the same issues would not have occurred.

Although there are similarities regarding gender, as previously described, there are also great differences in heterosexual couple therapy compared to individual therapy (or same-sex couple therapy). Heterosexual couple therapy is profoundly different because there are two people involved in the process who share the same gender, and one who does not, which represents 'an inherent imbalance' (Shay, 1993; p93)

A further example of the imbalance in heterosexual couple therapy is when the member of the couple who is the same gender as the therapist seeks 'gender solidarity' in an argument with his or her spouse' (Garfield, 2004; p458). Similarly, I perceive that if I had been able to offer John a couple therapy assessment, gender would have been more of a significant factor (in addition to more complex transference possibilities) given his overt anger towards his female ex-partner. Additionally, I had some sense of this with Jane during the

assessment and I perceive this would be more of an issue if we were to begin couple therapy.

Furthermore, it was apparent to me during my sessions with John, that he was very uncomfortable with emotional intimacy, which as Garfield (2004) indicates is a common problem for men and one that 'therapists regularly encounter in working with heterosexual couples in therapy' (p457). I also experienced this with Steve as he continuously avoided articulating his emotions, despite what I perceived as my creative questioning. Hence, it is even more important to consider gender in couple therapy because 'couple therapy cannot be fair and effective if it does not include an understanding of the role of gender and the part it plays in the issues of concern' (Johnson & Lebow, 2000; p30).

Conclusion

In this essay, the similarities and differences between couple therapy and individual therapy have been compared and contrasted. Consequently, it is apparent that whilst there are some similarities with these modes of therapy, such as that a strong therapeutic alliance is necessary in both; transference and countertransference factors also impact both modes, as does gender, there are significant differences between them. These differences have been discussed, including how much more difficult it is to develop multiple alliances in couple therapy and the increase in transference and countertransference possibilities which make couple therapy more complex.

Furthermore, it has been demonstrated that one of the profound differences is that in heterosexual couple therapy, the therapist will share the same gender with one of the

partners but not with the other. This presents an important imbalance in the dynamics of the therapeutic relationship, which needs to be managed as effectively as possible, as explained.

Although I have only limited experience regarding couple therapy and I perceive it has strengths, such as helping a couple through an impasse in their individual therapy as previously stated, as a counselling psychologist I prefer to facilitate change via individual therapy. The reason for my preference is due to the complexity and difficulties which feature in couple therapy previously outlined, particularly including trying to develop multiple alliances and manage the needs and goals of two individuals, in addition to managing their interpersonal conflict.

References

Braverman, S. (1985). One couple, three therapists: therapeutic overdose or collusion breaker? *Journal of Marital and Family Therapy*, 11, 179-186.

Carey, T. A., Carey, M., Mullan, R. J., Murray, L. K. & Spratt, M. B. (2006). Psychological change: What changes and how does it occur? A critical review. *Counselling Psychology Review*, 21, 28-38

Carriger, R.M. (2009). The Cognitive-Behavioural relationship record. *Journal of Psychotherapy Integration*, 19, 246-268.

Celano, M.P., Smith, C.O. & Kaslow, N.J. (2010). A Competency-Based Approach to Couple and Family Therapy Supervision. *Psychotherapy Theory, Research, Practice, Training*, 47, 35-44

Cooper, M. (2008). *Essential Research Findings in Counselling and Psychotherapy*. Sage Publications Ltd.

Corey, G. (2001). *Theory and Practice of Counselling and Psychotherapy* (6th ed.). Wadsworth Publishing Co Inc.

Friedlander, M.L., Escudero, V., Heatherington, L. & Diamond, G.M. (2011). Alliance in couple and family therapy. *Psychotherapy*, 48, 25-33.

Donovan, J.M. (1998). Brief Couples Therapy: Lessons from the history of brief individual treatment. *Psychotherapy, 35*, 116-129

Garfield, R. (2004). The Therapeutic Alliance in Couples Therapy: clinical considerations. *Family Processes, 43*, 457-465.

Gurman, A.S. (2010). *Clinical Casebook of Couples Therapy*. The Guilford Press

Jacobs, M. (2004). *Psychodynamic Counselling in Action (3rd edn.)*. Sage Publications Ltd.

Jenkins, H. (1996). Inside out, or outside in: meeting with couples. *Journal of Family Therapy, 28*, 113-135.

Johnson, S. & Lebow, J. (2000). The 'Coming of age' of Couple Therapy: A Decade Review. *Journal of Marital and Family Therapy, 26*, 23-38.

Lawrence, E. & Brock, R.L. (2010). 'The North Going Zax and the South Going Zax: from impasse to empathic acceptance in Integrative Behavioural Couple Therapy in Gurman, A.S. (ed.) *Clinical Casebook of Couple Therapy* (pp.67-89). The Guilford Press.

Melnick, J. (2003). Countertransference and the gestalt approach. *British Gestalt Journal, 12*, 40-48

Rait, S. D. (2000). The Therapeutic Alliance in Couple and Family Therapy. *Journal of Clinical Psychology, 56*, 211-224.

Tudor, K. (2006). 'Contracts, Complexity and Challenge' in Sill, C. (ed.) *Contracts in Counselling and Psychotherapy* (pp.119-136). Sage Publications Ltd.

Shay, J.J. (1993). Should Men Treat Couples? Transference, Countertransference, and Sociopolitical Considerations. *Psychotherapy, 30*, 93-102

Treadway, D.C. (2010). 'Happily Ever After: A Couple Therapy from Three Perspectives', in Gurman, A.S. (ed.) *Clinical Casebook of Couple Therapy* (pp.427-440). The Guilford Press.

Therapeutic Development Dossier

**A REFLECTIVE ACCOUNT OF MY PROFESSIONAL DEVELOPMENT
AS A COUNSELLING PSYCHOLOGIST**

Introduction

The British Psychological Society describes counselling psychologists as being involved with ‘the integration of psychological theory and research with therapeutic practice’. Additionally, it states that Counselling Psychology needs ‘a high level of self-awareness and competence in relating the skills and knowledge of personal and interpersonal dynamics to the therapeutic context’ (BPS, 2011). Hence, in this essay, I will provide a reflective account of my professional development as a counselling psychologist, particularly in regards to the aforementioned areas.

This essay will incorporate my personal development, including the events which led to me choosing the practitioner doctorate, in addition to my personal therapy and P.D. group experience. This will be followed by a reflection of the development of my professional practice. This will encompass my experience of different professional contexts and some of the issues relating to the change process, in addition to how I have attempted to develop the Counselling Psychology profession. Furthermore, this essay will include a reflective account concerning how I have integrated theory and research and made use of supervision in my practice, as part of my development.

The above has resulted in the development of a personal philosophy in relation to my practice and this will be included, along with a plan of my continued professional development. A brief summary will conclude the essay.

My Personal Development***Why I chose Counselling Psychology***

I have always been described as a ‘good listener’. My early experiences of ‘listening’ included as a teenager being asked by my parents to facilitate the resolution of their numerous arguments. Having felt somewhat rejected following the birth of my brother, mediating for my parents briefly gave me the attention I sought. It made me feel valued. Nevertheless, counselling and psychology were never mentioned as possible career routes during my childhood and with work experience spent at nearby Heathrow Airport, I was drawn to a career in the travel industry, culminating in the role of Press Officer for a European tourist board.

Nonetheless, the excitement and challenge of the role faded over the years. Suddenly I found I longed to make a difference in the world. I had always had an interest in people and wanted to understand why they behaved the way they did, particularly my parents and boyfriends. Additionally, I wanted to help others and Counselling Psychology met both these needs because as Frost (2012) reports ‘as a counsellor I want to help my client. As a psychologist, I want to know what works and why’ (p53). This led me to take an evening class in Psychology and Counselling with Birkbeck College, and it sparked a thirst for more. Although I discovered a Psychology and Counselling undergraduate course at my nearest university, I felt too afraid to relinquish my travel PR identity and salary. Additionally, I felt afraid I would not be good enough, a belief I have battled with over the years, particularly as I was nearly 30.

I ignored the inner longing and my personal problems. Instead I overworked and became ill. Consequently, although I had applied to start the degree, I was diagnosed with M.E. (Chronic Fatigue Syndrome). The GP's prognosis, according to the medical model, was that I may never recover as there was no cure. I felt devastated, helpless, hopeless and powerless. Unable to work or socialise, I also felt worthless and alone. This led me to feel depressed for weeks, until I read how someone had cured themselves of the illness. Hence, I chose to reject the medical model and become my own health 'expert', discovering the benefits of nutritional therapy, acupuncture and psychotherapy. Additionally, I discovered meditation and Reiki, and developed a belief in spirituality that was previously non-existent, which was transformational.

Following graduation, and other trainings, I set myself up in private practice offering a variety of services ranging from complementary therapies, spiritual counselling to psychological coaching. I felt extremely uncomfortable having to promote myself and struggled with this. Observing what my peers were doing, wanting to reach more people and also have something tangible I could promote rather than myself, I decided to write a self-help book based on my experiences and what I had benefited from on my personal development journey. I self-published my book and subsequently promoted it. Additionally I ran workshops and coached people on the principles I had written about.

However, I was still struggling with the discomfort of promoting myself. Furthermore, I had a client who had been diagnosed with depression and was on medication. I felt de-skilled and unqualified to help, even with the support of a coaching supervisor. I was

approaching 40 and feeling afraid of getting older. I also longed to belong to a proper profession. Prompted by these experiences, in addition to the new Health Professional Council's (HPC) regulations, it felt right to pursue the practitioner doctorate in Counselling Psychology training.

Personal therapy

I experienced nearly two years of therapy between 2000 and starting the doctorate as part of my healing journey and an increasing passion for personal growth. Consequently, I did not start the (mandatory) therapy like Simms (2008) and many trainees unsure of whether I had a need for therapy or not, and thus 'sceptical about the extent to which it would be of any value to me' (p71). In contrast, having moved to the Midlands, I felt more concerned about whether I would be able to find a therapist who would be 'good enough' for me, which I now recognise was a projection of my feelings about myself.

Personally, I have continued to find therapy very useful during the course. I have felt relieved to have a safe space to regularly unburden myself and process the issues that have arisen for me during this time. I have found therapy particularly helpful in supporting me through my health challenges, including suddenly having to deal with frightening levels of exhaustion again for the first time in years, as the course progressed. It has been especially difficult in this final year as we re-located to Middlesex. This was because of my husband's work, but also so I could be close to my family, because as Papadomarkaki and Lewis (2008) found in their study with Counselling Psychologists, 'the presence of compassion and security inside the family circle helped them re-charge and carry on' (p46).

Nevertheless, this has meant that each week I have had to make a seven-hour round trip to university and back, in addition to managing all the other work which has caused further stress to my body. Hence, after having three years of such an extreme workload, the travelling and the insufficient time off to fully rest and re-charge, I now feel physically drained and find myself struggling to complete this final assignment. I have often felt alone with my struggle, but therapy has helped me keep going in spite of these challenges.

I feel that therapy, along with supervision, has been equally important in regards to my Counselling Psychology practice. It has given me a greater insight into the experience of being a client in therapy, as initially I felt vulnerable as a client, uncertain about the therapist and the approach she used. Later on in our relationship, I felt angry when the therapist became directive, giving me advice when what I had needed was empathy. Furthermore, as Simms (2008) reports, it has also enhanced my capability to 'distinguish between personal issues and those of the client' (p73) and helped me to become more adept at appropriately bracketing off my issues when delivering therapy.

Personal development groups

My undergraduate degree included an 'experiential' group. There was no structure to the sessions and the facilitator took a passive role. Additionally, there was a continual overt conflict between two group members, which I felt powerless to stop. I felt incredibly stressed and at times emotionally upset in the sessions. Consequently, when I ran my own P.D. group, as part of my private practice, I ensured there was structure by devising weekly modules based on spirituality, particularly Buddhist philosophy. Thus, I felt some

trepidation at becoming a member of a P.D. group again on the doctorate, until I discovered the sessions would be more structured than the experiential group.

In the first year I found P.D. quite frustrating as my fellow trainees had much less experience and interest in personal development at that time. I felt frustrated, not wanting to upset my new peers, consciously holding myself back to allow others space to express, particularly when they did not then follow through. Additionally, I struggled each year with wanting to be in control and explore the topics that I felt were particularly important (such as the Existentialist topics of meaning and loneliness). I am aware this is partly due to my past experience and a desire to want to be in control and found therapy a helpful safe space to address what the P.D. groups triggered in me.

However, aside from learning to manage these issues, I have found the P.D. groups to be integral to my development as a Counselling Psychologist, particularly in the third year. The safe space that I felt the facilitator and the group were able to create made me feel safe enough to push myself further than I have ever felt able to previously, particularly in regards to being congruent and openly expressing my thoughts and feelings, even when they were contrary to others'. I perceive that this has had a positive impact on my client work because as Lewis (2008) states, what sets counselling psychology apart is that it does not involve only 'a technical application of psychological theory' but rather it puts 'the practitioner's use of self in the therapeutic process' in the foreground (p63).

Consequently, being able to take risks in expressing my true thoughts and feelings in the P.D. group, and with other areas of my personal development during the course, has

enabled me to improve my practice. I am aware that until this year, I may have held myself back in client sessions as I felt afraid to take a risk and make a mistake, and thus my clients are now getting more of me.

The development of my professional practice

The different professional contexts and some issues relating to the change process

In my previous private practice, I worked with clients for as long as they wanted to work with me. The longest client contracts were with the psychological coaching clients, who I worked with for six months on average. Hence, another significant aspect of my development as a Counselling Psychologist has been experiencing different professional contexts and their related issues regarding the change process.

The first issue that I experienced working in the NHS was working with service limitations, such as only being able to offer clients a maximum of eight sessions. I felt a great weight of responsibility to help the client and overwhelmed by what felt like an impossible task. This was difficult because as Deyoung (2003) reports ‘therapists who come from such families [like mine], are likely to repeat their histories in their work – feeling at first both stimulated and overwhelmed by responsibility’ (pxix). I feel supervision and therapy has helped me a great deal in working through this issue and be able to manage responsibility more appropriately, as described in my supervised practice essay.

Additionally, I initially felt incredibly overwhelmed attempting to make the transition from private practitioner to scientist-practitioner, particularly in regards to the areas of

assessments and formulations. Again, this triggered my lack of belief in my abilities, but I have found my confidence in these areas has grown with clinical practice, supervision and completing case studies.

Following on from the above, another challenge I initially had to overcome working in the NHS, was working within a medical model and the NICE guidelines. In regards to CBT, Fairfax (2008) reports for example that ‘it may be highly appropriate for some individuals, but not for those in secondary or longer term environments. It is this group of clients, the complex and the co-morbid, that is missing from NICE’ (p30). Hence, I found myself feeling particularly angry, and initially powerless, in my secondary care placement when my then supervisor continued to insist I deliver CBT to some of my clients with complex issues, and those who expressly wished to have an alternative approach.

However, I perceive that the placement challenges described, along with others to numerous to mention here, in addition to my previous experiences working in private practice, have enhanced my development as a Counselling Psychologist, particularly in the area of facilitating change. Consequently, I perceive that I have developed the ability to be versatile, which as Shorrock (2011) confirms, ‘is a particularly valuable therapist competence when working within resource stretched settings such as the NHS’ (p69).

Additionally, I have also benefited on my placements from working as part of a team, particularly within the NHS placements and their multidisciplinary teams. I felt, and continued to feel, working as part of a team has made a difference to me personally. It has also helped me feel supported in my client work too, particularly regarding working with

clients with complex issues and risk. Moreover, working in these different settings, along with what I have learnt and experienced at university, have also enabled me to become conscious of my own limitations in regards to my Counselling Psychology practice. I now know, for example, that I am not 'cut out emotionally' (Whitton, 2008; p58) to work in a psychiatric in-patient setting, having shadowed the team's psychiatrist there in my first year. This also applies to working with children under the age of 16.

Helping to develop the Counselling Psychology profession

Following on from that above, another aspect of my professional development as a Counselling Psychology includes working with clients with complex issues and chaotic lives in the substance abuse setting. In this setting I have felt grateful for my previous practice experience within the NHS, particularly in regards to structure, boundaries and mandatory training. This, in addition to the knowledge I have gained at university regarding being a professional and ethical practitioner, helped me feel equipped to address an issue I identified.

The entire team shares one office. The team's project workers, the main care-coordinators for my clients, deliver psychoeducation and some other CBT interventions but are not qualified clinicians. A weekly team meeting is held, during which time clients are discussed appropriately, particularly issues of risk. Nevertheless, I noticed at other times, the project workers would openly discuss clients and their issues in the office, particularly if there had been an incident which could be described as dramatic. Additionally, project workers would regularly try to engage me in conversations about our mutual clients' pre and post my counselling sessions with these clients.

I felt very uncomfortable with their regular discussions about clients and their issues. Every time they would begin disclosing, or would try to engage me in a discussion about my clients, I would feel a gut-level reaction to it. Initially, aside from discussing the issue and what it triggered in me with my clinical supervisor, I felt powerless to take action beyond maintaining my own boundaries. Additionally, I had already proposed other improvements to the service, as described in the supervised practice essay.

However, I eventually felt unable to tolerate the situation any longer and addressed the issue with my line manager, explaining the client confidentiality issue from my perspective as a Counselling Psychologist. My line manager explained these discussions were the staff's method for coping with the stress of the work. Although I felt empathic in regards to how difficult it is for the staff to manage such challenging work without the clinical training, the resources and in-house clinical supervision, I felt more needed to be done to protect the clients. Consequently, I proposed (supplementary to the existing service risk management protocols) that if any of the staff feels the need to discuss a client, and feels unable to withhold the information until the weekly team meeting, they should no longer discuss the client with colleagues. Instead, they should find an alternative appropriate outlet, such as having a private meeting with the line manager or her deputy.

Additionally, I recommended the line manager also request staff to have confidential meetings with the volunteer counsellors, should they wish to discuss issues pertaining to mutual clients, or communicate via private emails as usual. Hearing the line manager state that one of the key attributes the team valued about me during my time at the placement

was my professionalism made me feel I had significantly contributed to the service and I felt relieved I had finally addressed this issue.

How I have integrated theory and research into my practice

My professional development as a Counselling Psychologist during the last three years has also included greatly enhancing my ability to integrate theory and research into my practice. However, initially this was very challenging. I felt very uncomfortable using the CBT approach having been principally used to humanistic approaches such as person-centred therapy (Rogers, 1961) and Gestalt therapy (Perls, Hefferline & Goodman, 1951). It felt very unnatural using paper tools during a counselling session. I felt they acted as a barrier in the therapeutic relationship because I felt unable to listen as deeply to my clients as I can when using a humanistic approach. Additionally, using CBT with my clients triggered my feelings of not feeling good enough.

Nevertheless, having a regular meditation practice and having participated in the Breathworks 'Mindfulness for Stress' eight-week course prior to the doctorate, I felt more at ease and competent following the NICE (2009) guidelines, to help a client with depression relapse prevention using the Mindfulness-Based Cognitive Therapy (Segal, Williams & Teasdale, 2002) in my second NHS placement. Furthermore, learning about specific CBT models in clinical supervision, such as the Salkovskis (1985) OCD model and subsequently using the approach with a client, helped improved my confidence as a counselling psychologist.

Therefore, I have felt surprised by the difficulties I have experienced adapting to my placement within an Improving Access to Psychological Therapy (IAPT) service. In this service, when clients are referred for CBT, therapists have to follow the Roth and Pilling (2007) specified CBT models for anxiety and depression, such as Foa, Hembree and Rothbaum (2007) for Post Traumatic Stress Disorder. Consequently, I have found myself feeling de-skilled and experiencing 'conscious incompetence' (McKimm, 2009) again, which feels very uncomfortable. Exploring these issues along with others, such as some discomfort as a Counselling Psychologist using manualised treatments, with my supervisor has been very helpful.

Supervision

Following on from the above, I perceive that in addition to placement supervision, my practice as a Counselling Psychologist has also been enhanced as a result of the supervision I have experienced at the university, particularly the lecturer/peer group supervision during the psychodynamic module and the informal peer supervision in the P.D. groups. I feel I gained a great deal from hearing about the issues others experienced, and how they dealt with them, in addition to being able to discuss my own practice issues.

Over the last three years, I have received clinical supervision from a variety of professionals. I feel that each one has helped me develop personally and professionally, but in different ways, because as Rowan and Jacobs (2002) contend 'there are different levels of supervision as there are different notions of the use of self in therapy' (p98). The Counselling Psychologist, the Counsellor and the Psychotherapist who supervised me all employed the Hawkins and Shohet (2000) supervision model, for example. Thus, I felt that

in addition to ensuring suitable standards of practice were maintained, they also created ‘a permissive environment in which strong feelings are acknowledged, respected and thought about’ (Smith, 2003; cited in Papadomarkaki & Lewis, 2008; p45). Consequently, I felt able to be my authentic self in the sessions and address issues relevant to my practice as a counselling psychologist, which also helped me to receive valuable feedback in regards to my use of self in the therapy.

In contrast, I felt it was more of a struggle to be my authentic self in my supervision sessions with my Clinical Psychologist supervisor (who had the dual role of department head). The focus in the sessions was on diagnosis, theory and skills. Consequently, I perceive these sessions helped me integrate CBT theory into practice in particular. However, I felt as though my ‘self’, my personal history, my attitudes my emotions and my issues, were irrelevant. I felt disregarded. Furthermore, in these sessions it also felt that the client was not particularly relevant either, rather their diagnosis and treatment, and level of engagement with the treatment, appeared most important. Thus, I experienced these sessions as technically useful but unsatisfying because as Whitton (2008) confirms ‘it is the recognition of this last factor (*the personal characteristics of the therapist*) that makes the difference in humanistic therapy’ (p58).

Towards the future

My personal philosophy

I am passionate about positive change, personal growth and helping others to improve their well-being and develop, hence my chosen research topic concerning the process of

psychological change. This means I am committed to taking responsibility for myself (my thoughts, feelings, behaviours and development), particularly as this impacts on my practice, as previously described. Consequently, the personal philosophy I have developed in relation to Counselling Psychology is articulated by Whitton (2008) who states that for a humanistic practitioner, being humanistic is not purely a professional practice, but it is also 'a way of life' (p58). Thus, in addition to continuing with my personal therapy in the future, I will continue to take responsibility professionally, through supervision and ensuring I adhere to the professional and ethical codes of conduct of the HPC and BPS.

My personal philosophy has changed during my time on the course, particularly in regards to the medical model, which I previously rejected, as explained. This is as a result of increased knowledge and the need to consider information such as that reported by Hammersley (2010), that 'combining medication and psychotherapy may involve using drugs sensitively and intermittently to support extreme distress and symptoms' (p641). I found support for this at the substance abuse placement, working with newly abstinent clients who were on medication for anxiety and depression, which enabled me to help the clients with their goal of relapse prevention.

Nevertheless, following the recent lecture by Dr. Hammersley, my personal philosophy now also includes challenging the status quo regarding this, because as she states 'Counselling Psychologists have an ethical responsibility to ensure that any treatment benefits the client and minimizes harm and risks to safety' (Hammersley, 2010; p650). Consequently, I have since begun to address this issue with my IAPT clients who have been prescribed medication by their GP's, including exploring the option of managed

withdrawal during the therapy contract, and I will continue to address this issue with clients.

Following on from the above, I have recently begun to include a pluralistic approach where possible, with my counselling clients at my IAPT placement, because pluralism, according to Frost (2012) 'can provide a bridge between humanism and the medical model'. This ensures clients are given a therapy which 'is tailored specifically to their needs' (p61), which is aligned with my philosophy as a Counselling Psychologist.

Furthermore, my philosophy also includes a consideration for the power of the unconscious particularly because of my previous NLP and hypnotherapy training, in addition to the doctoral psychodynamic module, because as Gilbert (2003) states the unconscious is 'a feature of human experience that has sometimes been glanced over in humanistic therapies' (p140). Thus I aim to adhere to the recommendation by Gilbert, who advises 'against a surface acceptance of visible phenomena and ask for a more thorough exploration of underlying dynamics (Gilbert, 2003; p140).

Continuing professional development

I have been committed to continually developing personally and professionally during the last 12 years and I will continue to do so, as I recognise the importance of this in relation to my practice as a Counselling Psychologist. I perceive I am currently in a transition phase, with psychological obstacles yet to overcome and several academic goals still to achieve. Consequently, I plan to focus initially on addressing my health issues and creating a better work/life balance, in addition to completing the doctorate. Once this is achieved and I am

able to become a member of the HPC, I will adhere to their standards for continuing professional development (HPC, 2011).

This will include pursuing further training in CBT, because it is my intention to reach the level of 'conscious competence' (McKimm, 2009) with this approach. Furthermore, having experienced the benefits of meditation and mindfulness, and witnessed the benefits of this in my clinical practice, my CPD plan includes training to teach Mindfulness Based Cognitive Therapy (MBCT) with the Oxford Mindfulness Centre, and thus formalise my existing mindfulness training. Similarly, in the long-term, I plan to attend a workshop in Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 1999), with a view to exploring training in this area. My CPD plan also includes training to become a supervisor, as reported in my supervised practice essay.

Conclusion

In this essay, I have provided a reflective account concerning how I have developed personally and professionally as a Counselling Psychologist. This has included how I chose the Counselling Psychology profession and the doctorate in particular. Furthermore, my experience as a client of personal therapy and participant of P.D. groups, and how this enhanced my development as a Counselling Psychologist, was included.

Additionally, the essay contained a reflective account of my professional development. This encompassed the variety of professional contexts I have worked in with some

examples of several issues relating to the change process I have experienced, such as a restriction on the number of permitted therapy sessions.

Moreover, I have demonstrated in this essay how I have attempted to develop the Counselling Psychology profession, providing an example concerning the substance abuse charity service. In addition, a reflective account of how I have integrated theory and research, and made use of supervision in my practice as part of my development as a Counselling Psychologist, was included. Finally, in this essay I have described my personal philosophy and provided a CPD plan, which included further training in CBT and becoming a qualified supervisor in the future.

References

British Psychological Society (2011). *Becoming a Counselling Psychologist*.

Retrieved from <http://www.bps.org.uk>

DeYoung, P.A. (2003). *Relational Psychotherapy: A primer*. Routledge.

Fairfax, H. (2008). 'CBT or Not CBT', is that really the question? Re-considering the evidence base – the contribution of process research. *Counselling Psychology Review*, 23, 27-37.

Foa, E.B., Hembree, E.A. and Rothbaum, B.O. (2007). *Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experiences, Therapist Guide*. Oxford University Press.

Frost, C. (2012). Humanism vs. the Medical Model – can Pluralism bridge the divide for counselling psychologists? A trainee's perspective. *Counselling Psychology Review*, 27, 53-61.

Gilbert, M. (2003). 'A humanistic integrative approach to psychotherapy' in Whitton, E., *Humanistic Approach to Psychotherapy* (pp.138-144). Whurr Publishers Ltd.

Hammersley, D. (2010). 'The Interface between Psychopharmacological and Psychotherapeutic Approaches' in Woolfe, R., Strawbridge, S., Douglas, B. & Dryden, W. (eds.), *Handbook of Counselling Psychology* (3rd ed.) (pp.630-652). Sage Publications Ltd.

Hawkins, P. & Shohet, R. (1989). *Supervision in the Helping Professions*. Open University Press.

Hayes, S.C., Strosahl, K.D. & Wilson, K.G. (1999). *Acceptance and Commitment Therapy: An Experiential Approach to Behaviour Change*. The Guilford Press.

Health Professionals Council (2011). *Your guide to our standards for continuing professional development, with revisions*. Retrieved from <http://www.hpc-uk.org>

Lewis, Y. (2008). Counselling Psychology training: Implications for 'Self'. *Counselling Psychology Review*, 23, 63-69

National Institute for Health and Clinical Excellence (2009). *NICE Guidance: Depression: The treatment and management of depression in adults*. Retrieved from <http://guidance.nice.org.uk/CG90>

McKimm, J. (2009). *British Journal of Hospital Medicine*, 70, 348-351.

Papadomarkaki, E. & Lewis, Y. (2008). Counselling Psychologists' experience of work stress. *Counselling Psychology Review*, 23, 39-51

Perls, F., Hefferline, R., & Goodman, P. (1951) *Gestalt Therapy: Excitement and growth in the human personality*. The Julian Press Inc.

Rogers, Carl. (1961). *On Becoming a Person: A Therapist's View of Psychotherapy*. London: Constable

Roth, A.D. & Pilling, S. (2007). *The competences required to deliver effective cognitive and behavioural therapy with depression and with anxiety disorders*. Department of Health. Retrieved from <http://www.dh.gov.uk>.

Rowan, J. & Jacobs, M. (2002). *The therapist's use of self*. Open University Press.

Salkovskis, P.M. (1985). Obsessive-Compulsive Problems: a cognitive-behavioural analysis. *Behaviour, Research and Therapy*, 25, 571-583

Segal, Z.V., Williams, J.M.G. & Teasdale, J.D. (2002). *Mindfulness-Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse*. The Guilford Press.

Simms, J. (2008). Mandatory personal therapy during Counselling Psychology training: A trainee's reflection. *Counselling Psychology Review*, 27, 70-78.

Shorrock, M. (2011). The philosophical challenges within counselling psychology: Can Egan's Model help? *Counselling Psychology Review*, 26, 63-74

Whitton, E. (2003). *Humanistic Approach to Psychotherapy*. Whurr Publishers Ltd.

MY PRACTICE AS A COUNSELLING PSYCHOLOGIST IN TRAINING

Introduction

This essay will provide information regarding my practice as a Counselling Psychologist in training thus far. Supporting evidence will be provided in the appendices to substantiate a number of the points made in the essay.

Included in this essay will be a brief description of the placements I have worked in, such as a Primary Care Mental Health (PCMH) service and a Secondary Care Mental Health (SCMH) service within the NHS. Additionally, it will include my current placements within an NHS Improving Access to Psychological Therapies (IAPT) service and CRI, a national substance abuse recovery charity.

Furthermore, the clients I have worked with will be outlined. This will be followed by a description of the theoretical models, skills and techniques I have integrated into my practice on my placements. An evaluation of the similarities and differences in working with a variety of client problems, focusing on those within the substance abuse setting due to limitations of space, will also be included.

Additionally, some of the professional practice challenges I have experienced, trying to adhere to the requirements of the aforementioned services in addition to attempting to meet the needs of my clients, will be described. Moreover, I will illustrate how I have made use of, and contributed to, supervision within the placements. A brief summary will conclude the essay.

An overview of the placements

In the PCMH service during my first year, I worked within a team consisting of a psychiatrist and three community psychiatric nurses (CPN's). The service is offered to local GP surgeries that do not have in-house counselling, and to people between 18 and 65. The service, which was loosely modelled on the IAPT approach, was in its infancy, having only been established a few weeks before I started there. Clients were permitted between six to eight counselling sessions. I saw 25 clients at this placement, for issues including low mood, low self-esteem, anxiety, relationship problems, grief, infertility issues and financial stress. A number of client summaries are provided (Appendix 1).

In my second year, I worked within the same NHS trust for their established SCMH service. There are two psychiatrists, several CPN's, a Counselling Psychologist and a Clinical Psychologist in the team. The service provides longer-term therapy to people between 18 and 65 with mental health issues. Initially, there was no limit to the number of therapy sessions. The manager implemented a 25 session limit during my placement. I saw 12 clients during this placement with problems regarding sexual identity, grief, low self-esteem, health anxiety, depression, OCD and social phobia. Summaries of some of the clients are provided (Appendix 2).

At CRI, the team consists of a project supervisor, a volunteer co-ordinator, two project workers, a peer mentor and other volunteer counsellors. Only one counsellor is on site at any one time, due to space issues. The service reports to the National Treatment Agency for Substance Abuse (NTA) and the Strategic Partnership for Alcohol and Drugs (SPAD).

Referrals are principally from the NHS Community Drug and Alcohol Team (CDAT) and local GP's. Counselling is one of the services clients can select. They are usually permitted a maximum of 12 sessions. I have seen five clients on this placement, three of which are still current. The focus of the work is relapse prevention, in addition to helping clients with other issues, including anxiety and low mood. A number of client summaries are provided (Appendix 3a).

In regards to the IAPT service I am currently working in, the service offers a stepped-care approach to people between 18 and 65, suffering from depression and/or anxiety. The team consists of several Psychological Well-being Practitioners (Step Two) and High Intensity Therapists (Step Three). At Step Three, clients are offered a choice (guided by the assessor) of counselling or CBT, at triage. CBT clients are permitted on average 12 to 15 sessions and counselling clients nine sessions. During my brief time in the role, my caseload has consisted of four CBT clients diagnosed with panic disorder, health anxiety, body dysmorphia (with compulsive skin picking) and depression. Some client summaries are provided (Appendix 3b).

The integration of theoretical models and the use of skills and techniques in my practice

First Year Placement

At the PCMH, I carried out an initial assessment with my clients, using the assessment documents specified by the service. My preferred therapeutic approach as a Counselling Psychologist in training, and the one I had most experience in prior to the course, is the humanistic approach (Rowan, 1998), particularly person-centred therapy (Rogers, 1961)

and Gestalt therapy (Perls, Hefferline & Goodman, 1951). Furthermore, as I was encouraged to offer clients only six sessions, I chose to use this approach with my initial clients as I knew from past experience that I was able to establish a good therapeutic relationship rapidly using it (e.g. Appendix 1.1). My supervisor, a Counselling Psychologist, supported my decision.

I subsequently began to use Cognitive Behaviour Therapy (CBT) (Westbrook, Kinnerley & Kirk, 2007) as part of my learning and development. I used CBT with clients who, during our initial assessment session, met the suitability for short-term CBT criteria (Safran & Segal, 1990a) and whose particular needs seemed to be more appropriately met by this approach (e.g. Appendix 1.2). Furthermore, I also employed an integrative approach with a client who presented with anxiety (Appendix 1.3). The interventions I used included Greenberger and Padesky's (1991) thought records and role play (Curwen, Palmer & Ruddell, 2000), for example.

Second Year Placement

In contrast, at my second year placement other members of the SCMh team provided clients with an assessment at five-weeks following referral. Therefore, I carried out a brief informal assessment in our first therapy session, verifying the presenting issue(s) and therapy goals. I did this as clients had often been on the waiting list for several months during which time their needs had sometimes changed.

Prior to my first supervision session, I was allocated my first client, who presented with interpersonal problems and sexual identity issues. She explicitly requested that I not use

CBT due to a previous unsatisfactory experience of the approach. Hence, I used the humanistic approach (Appendix 2.1). I did this with the support of the team's Counselling Psychologist, who was the care co-ordinator of my clients due to my new supervisor's high workload.

In my first supervision session with my new supervisor, the team's Clinical Psychologist and manager of the SCMH, he informed me that our values would clash due to our differing philosophical positions. He stated CBT was the preferred therapeutic approach in the NHS and stipulated that I use this approach with all my clients. Hence, I used generic CBT (e.g. Beck, 1995) with subsequent clients. Additionally, I used specific CBT models when appropriate, such as Mindfulness-Based Cognitive Therapy (Segal, Williams & Teasdale, 2002) to help a client prevent depression relapse (Appendix 2.2), including the body scan meditation intervention (Appendix 4). I also employed the Salkovskis (1985) model with a client who presented with OCD (Appendix 2.3).

Third Year Placements

At the IAPT placement, I have carried out an assessment with each client using the IAPT documents. Furthermore, I have formulated using the models specified by the IAPT service (Appendix 5) where possible, including Clark's (1986) panic model (Appendix 6) with my client diagnosed with panic disorder. In regards to body dysmorphic disorder, IAPT have no specified model. Therefore, I have been using guidelines provided by Veale (2001) to inform the therapy, including the treatment plan (Appendix 7) and worksheets from Willson, Veale, and Clarke (2009) (e.g. Appendix 8) with the approval of my supervisor.

At CRI, the project workers implement the formal assessments with clients. Hence, I did a brief informal assessment with my initial clients in our first session, focusing on their history and therapeutic goals. However, I realised this method resulted in a lack of important information which I needed to inform the therapy, such as the client's high risk situations. Hence, I devised my own assessment document, adapted from Beck, Wright, Newman and Liese (1993) (Appendix 9).

At the service induction, my manager informed me there are no restrictions regarding therapeutic approaches. Therefore, with my initial two clients I used the CBT for substance abuse approach (Beck et al., 1993), in accordance with the National Treatment Agency guidelines (Department of Health, England, and the devolved administrations, 2007). Additionally, as it has been used with this client group, I have been using solution-focused therapy (Berg & Reuss, 1998) as an alternative with a client who is severely dyslexic (Appendix 3a.3) and a client who has been referred as part of a child protection plan (Appendix 3a.4).

Practice experience with a variety of client problems within a substance abuse service

Although all the clients at CRI have the common presenting issue of substance abuse, they also present with additional problems and I have observed some general trends. My clients have generally reported memory problems due to their long-term substance abuse, which has appeared more pronounced in the older clients, in addition to having chaotic lives, lacking in routine.

Furthermore, like a number of the clients I have seen in the NHS settings, the majority of clients I have worked with at CRI have also presented with low self-esteem and/or low self-confidence. Nevertheless, clients within this service in contrast frequently report that although they have achieved one of their main goals (i.e. being abstinent), which in theory should enhance their self-esteem, they actually report a decrease in self-esteem, as previously the substances masked this issue (e.g. Appendix 3a.3). Similarly, I have noticed a general theme of shame in these clients for their past substance abuse and related activities, which paradoxically only appears to become an issue for them when they stop abusing substances.

Additionally, I have observed that even though all my clients were abstinent at the start of counselling, they have differed in regards to their commitment and motivation to change. Moreover, it has become apparent that clients who have been highly motivated to change and remain abstinent have taken action and changed their substance related environments. They have moved and started a new life, away from their substance abuse related friends and/or connections (e.g. Appendix 3a.3). This seems to reflect the stages of change theory (Prochaska, DiClemente & Norcross, 1992). Hence, I have learnt that when working with this client group in particular, social and environmental factors need to be considered. This includes assisting clients to identify high risk factors which could trigger a relapse, and helping them to address these issues wherever possible.

Professional practice issues within the NHS and other professional contexts***First Year***

Initially, having previously worked in private practice without restrictions, I found it challenging in the PCMH service being restricted to offering clients a maximum of eight sessions. There were several clients who seemed to need more than eight sessions of therapy. Consequently, even though these clients had been referred to the PCMH at triage, I took the cases to supervision to investigate secondary care referral possibilities. In some cases, secondary care was deemed more appropriate (e.g. Appendix 1.4) and I subsequently processed the referrals.

At this placement, my first experience of working in the NHS, I observed another issue, which is the implementation of organisational change. My line manager, a CPN, along with the team's other two CPN's, reported the new counselling service had been 'forced upon them'. They had to implement it in addition to managing their normal duties. Furthermore, they had no counselling training and felt unprepared to deliver counselling. They were finding it difficult to work with clients who needed more than just someone to talk to. Thus, they expressed a sense of relief when I joined them, reporting they would refer such clients to me henceforth. Additionally, they would sometimes ask my advice regarding client work. Consequently, I felt a highly valued member of the team.

Second Year

The challenges I experienced in the SCMH regarding managing the needs of the clients' and the needs of the service were even more difficult to deal with as a Counselling Psychology trainee. My second client was a female in her 40's who presented with work-

related stress, anxiety and low mood. She had received two years of therapy from the team's former Clinical Psychologist, who had then informed the GP they could refer their patient to the service at anytime.

In our first session, we discussed what the client required from therapy over the coming months. Nevertheless, I was subsequently informed by my supervisor that GP's are now only permitted to re-refer within six months of discharge. Hence, the client should not have been automatically added to the waiting list. My supervisor then stipulated I could only provide the client with a further five therapy sessions, due to her previous two years of therapy and referral for the same issues.

I addressed these changes with the client in our following session. She was understandably angry and also distressed. Acting in her best interests (HPC, 2008), I took this to supervision again, feeding back to my supervisor the distress the situation was causing my client. Nonetheless, his decision remained unchanged. He advised me to provide my client with the details of a local counselling charity who could offer her long-term therapy, to which I did. Consequently, my therapeutic relationship with the client ruptured and she terminated therapy.

At the time, I felt angry and disillusioned with the service as a result. However, I have since reflected on the situation. I am now able to perceive the difficult position my supervisor was in, having to juggle both his role as a supervisor and manager of the SCMH responsible for implementing service policy. Furthermore, my supervisor highlighted the evidence in the client's file, which reported she had not managed to overcome her issues,

despite the previous two-years of CBT. Therefore, I agree with his point that further CBT for these same issues would probably not have helped her to achieve what she wanted from therapy. Hence, a referral to the charity that offers a variety of long-term therapeutic approaches was in her best interest it seemed.

Nevertheless, I perceive the manner in which her case was handled (having the five week assessment post re-referral, waiting 18 weeks for therapy and only then being informed of the changes) was detrimental to her well-being and not in accordance with her best interest. Therefore, I tentatively requested that my supervisor investigate how, if possible, this type of situation could be prevented in future. As I was still adjusting to the challenges of this placement, particularly working with clients with more enduring problems and being restricted to using CBT, I did not feel able to do more than this.

Third Year

In contrast, an advantage of the particular IAPT service I work in is that clients, at Step Three care, are provided with a choice between counselling and CBT, as previously mentioned. This is aligned with my professional and ethical values as a Counselling Psychologist in training, particularly regarding client autonomy (HPC, 2010; 1a.1, BPS, 2005; 1.2). Nonetheless, the system is not without its problems.

My second client was referred for anxiety regarding her physical health issues. Under the guidance of the triage assessor, she opted for CBT. This service does not have a specified health anxiety model. Therefore, I have been attempting to use a model adapted from Warwick and Salkovskis (1990) and interventions including the health anxiety thought

record (www.getselfhelp.co.uk), as recommended by my supervisor. However, the client appears more affect focused than cognitively minded. Additionally, the majority of the client's issue concerns actual physical health problems, rather than hypochondriasis. Hence, we have both been struggling in the sessions.

Furthermore, I have recently discovered that, according to the recommendations specified in the IAPT counselling checklist (Appendix 10), the client should be receiving counselling instead. I have raised this with my supervisor, who informed me I have an advantage as a trainee Counselling Psychologist. Unlike the other HI Therapists, who are only trained in CBT, I can continue to deliver therapy to my client even if we re-contract and switch to counselling. I will be addressing this option with my client.

In regards to CRI, I am benefiting from the differences of working within a smaller, tertiary sector organisation such as being able to take responsibility as a leading practitioner and implement a policy change. A supporting letter is provided (Appendix 11). At the start of my placement, there was no limit regarding the number of missed or excused sessions clients were permitted, as long as they informed the office. My first client (Appendix 3a.1), seemed only to be contemplating change (Prochaska et al., 1992) and did not appear to be engaged, cancelling several sessions in succession. This led me to reflect on this aspect of CRI policy.

This aspect of the policy appeared on the surface to be in the best interests of the clients. However, I perceived it as actually counter to this, given the frequency of poor compliance and the chaotic lives of this particular client group (Fisherman, 2002). Additionally, this

seemed counter-productive in regards to managing the high demand for the counselling service and the limited counsellor availability. Therefore, I proposed that a limit of two cancelled/missed counselling sessions be implemented at this CRI branch, and any further cancelled/missed sessions subsequently deducted from their 12 sessions.

Nevertheless, I have also experienced another conflict between client need and service need in this placement. One client, for example, presented with long-term drug abuse and other issues (Appendix 3a.2). He had chosen to attend CRI's group support sessions in addition to the counselling, as part of his recovery. The client and I appeared to have a good therapeutic relationship and he seemed fully engaged with therapy. After three sessions, the client's project worker informed me he had relapsed. He did not attend (DNA) our next session.

However, the client did attend the next scheduled session, expressing his desire to continue therapy and he attended the subsequent session. The following week, I was informed the project worker had had to discharge him from the service, as he had DNA'd two group sessions and had not been contactable. This did not seem to be acting in the client's best interests, particularly given how vulnerable he was and the fact that he had only DNA'd one counselling session.

I expressed my concerns to the project supervisor who informed me they had no choice but to implement the service policy. She added that the client could re-refer himself to the service in the future. Hence, although I was relieved to know the client could re-refer himself, I was concerned we had not been able to have a closure session. Therefore, I

implemented a strategy I learnt from my first year supervisor, and wrote the client a closure letter (Appendix 12).

The use of supervision

First year

At the PCMH placement, I found it incredibly helpful to have a Counselling Psychologist as my supervisor, as our values were so aligned. Furthermore, the psychologist employed the Hawkins and Shohet (1989) supervision model, which enabled me to explore a main issue I experienced at this placement, which was adjusting to brief time-limited therapy. Additionally, it enabled me to explore my pattern of feeling overly responsible for client change. This, in addition to personal therapy, helped me to understand the pattern and how to change it.

Furthermore, I was inexperienced regarding dealing with more vulnerable clients and having to manage risk, particularly as my most recent clients prior to the course had been coaching clients. Hence, I learnt how to manage risk therapeutically and in regards to service protocols. I perceive this provided a firm foundation for my second year placement and beyond.

Second year

I requested to join the SCMH service as I wanted to gain a depth of practice experience, delivering longer-term therapy to clients presenting with enduring problems. Moreover, I also wanted to improve my knowledge and skills regarding CBT from the team's Clinical

Psychologist, who teaches the approach. I learnt, for example, to use the Cognitive Therapy Scale (Young & Beck, 1980), assessing myself following each client session and then discussing it in supervision and continuously learning from it.

In addition, my supervisor taught me some of the CBT models for specific disorders and how to apply them, such as the Salkovskis (1985) OCD model, mentioned previously (Appendix 13). However, having such a focus on theory, skills and therapeutic techniques, meant that our supervision sessions lacked the opportunity to discuss the relational aspects of the therapy.

Furthermore, I found it more challenging having a supervisor who was also the service manager as the supervision naturally encompassed his agenda both as a supervisor and as the SCMH manager. Thus, at times it seemed he prioritised the needs of the service above the needs of my clients, as discussed previously. Several months into the placement for example, I began working with another client who was emphatic that I use an alternative approach to CBT. He had received CBT therapy in the past (from our service and others) which had only relieved his symptoms temporarily. Additionally, he expressed his disappointment having waited 18 weeks, to be allocated to a trainee. Again, acting in the best interest of my client, I took this to supervision. Nonetheless, my supervisor continued to insist I use CBT.

However, personally and professionally I found I could no longer tolerate the situation. Hence, I found the courage to speak openly to my supervisor regarding our clash in values and particularly in regards to the ethical and professional codes I was struggling to adhere

to as a Counselling Psychology trainee, having to impose CBT on my clients etc. Thankfully, he was very understanding and we were able to find a mutually acceptable solution.

Consequently, for the remainder of the placement I was permitted to use humanistic approaches with clients with whom it was in their best interest to do so. This included, for example, those who had previously had CBT and not benefited from it. The team's Counselling Psychologist provided supervision for these clients, which meant I was able to address transference and countertransference issues as they arose. Furthermore, the Clinical Psychologist continued to provide me with supervision for the clients for whom CBT was in their best interests.

Third year

At CRI, I was allocated three clients in my first week but they do not provide in-house clinical supervision. Hence, I experienced a steep learning curve, rapidly trying to teach myself how to work with clients in a substance abuse setting. Consequently, I drew on my previous clinical experience and what I had learned from my previous supervisors, particularly regarding evidence-based practice. Thus, I used CBT for substance abuse (Beck, et al., 1993) as previously mentioned, and generic solution-focused therapy (O'Connell, 2005) until I found a supervisor, who is experienced in the substance abuse field.

I had been finding O'Connell's (2005) solution-focused therapeutic approach limiting in regards to working with substance abuse. Hence, having found a supervisor experienced in

this field, I discussed this problem with her. Consequently, she introduced me to a solution-focused approach specifically for substance abuse (Berg & Reuss, 1998), which I have begun to use with my clients. I have found their substance user's recovery checklist and worksheet (Appendix 14) particularly very useful.

At IAPT, I have weekly in-house supervision which has been particularly useful in regards to having to implement specific models of CBT for specific disorders and devise treatment plans, as previously mentioned. My supervisor has been providing me with recommended reading to assist this process (such as Leahy & Holland, 2000). In addition, my supervisor reported that as a service, they have little experience working with Body Dysmorphia. Hence, I have carried out my own research, as mentioned previously, which I have then shared in supervision. However, coming from a principally humanistic background, I perceive I would benefit from further training in CBT, and I will be pursuing this as part of my CPD in the future.

Although I recognise the importance of having weekly supervision whilst in training, I also perceive it is possible to become too dependent on the supervisor for solutions. Therefore, something I have learnt from having only monthly supervision for the CRI placement, is that it is highly beneficial for me to spend time reflecting on my practice dilemmas and to think about the answers first and then discuss them with my supervisor. I perceive this has been an invaluable experience in my third year, helping to prepare me for the transition from a trainee to a qualified Counselling Psychologist.

Conclusion

In this essay, I have provided information regarding my practice as a Counselling Psychologist in training thus far. This has included an overview of my placements within the NHS, in a primary care service, a secondary care service and an IAPT service, in addition to a national substance abuse recovery service. This has demonstrated not only a breadth but also a depth of practice experience. Additionally, I have described how I have integrated theoretical models, along with some of the skills and techniques I have used, in my practice as a Counselling Psychology trainee.

Furthermore, this essay has included an evaluation of the similarities and differences in working with a variety of client problems, focusing particularly on those I have observed working at CRI. I have also demonstrated my awareness and ability to manage the changing professional contexts and subsequent issues that have arisen, in addition to demonstrating an understanding of the context for professional practice in the NHS. This has included demonstrating that I have taken responsibility as a practitioner of Counselling Psychology in training and implemented changes, where I have perceived it possible, as previously mentioned.

Finally, in this essay I have provided some examples of how I have contributed to supervision and how I have made use of it to further develop my practice thus far. Supervision has proven to be at times a very challenging experience, as described, but nonetheless an invaluable one. I wish to make further use of my experience as a supervisee in future by continuing professional development and supervising others once I am qualified.

References

Beck, J. S. (1995). *Cognitive Therapy: Basics and Beyond*. The Guilford Press

Beck, Wright, Newman & Liese (1993). *Cognitive Therapy of Substance Abuse*. The Guilford Press.

Berg, I., K. & Reuss, N., H. (1998). *Solutions Step by Step: A Substance Abuse Treatment Manual*. W.W. Norton & Company Inc.

The British Psychological Society (2005). *Guidelines for Professional Practice in Counselling Psychology*. Retrieved from <http://www.bps.org.uk>

Clark, D. M. (1986). A cognitive approach to panic. *Behaviour Research and Therapy*, 24, 461-470

Curwen, B., Palmer, S. & Ruddell, P. (2000). *Brief Cognitive Behaviour Therapy*. Sage Publications Ltd.

Department of Health (England) and the devolved administrations (2007). *Drug misuse and dependence: UK guidelines on clinical management*. London: Department of Health (England). The Scottish Government, Welsh Assembly Government & Northern Ireland Executive. Retrieved from <http://www.nta.nhs.uk>

Fisherman, M. (2002). Treatment of HIV and Addiction: Preserving Therapeutic Optimism. *Advanced Studies in Medicine*, 2, 189-194

Greenberger, D. & Padesky, C. A. (1995). *Mind over mood: Change how you feel by changing the way you think*. The Guilford Press.

Hawkins, P. & Shohet, R. (1989). *Supervision in the Helping Professions*. Open University Press.

Health Professionals Council (2008). *Standards of Conduct, Performance and Ethics, updated 1st July 2008*. Retrieved from <http://www.hpc-uk.org>

Health Professionals Council (2010). *Standards of Proficiency – Practitioner Psychologists, updated 1st October 2010*. Retrieved from <http://www.hpc-uk.org>

Leahy, R.L. & Holland, S.J. (2000). *Treatment Plans and Interventions for Depression and Anxiety Disorders*. The Guilford Press.

Mackewn, J. (1997). *Developing Gestalt Counselling*. Sage Publications Ltd.

National Institute for Health and Clinical Excellence (2005). *NICE Guidance: Obsessive Compulsive Disorder: Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder*. Retrieved from <http://guidance.nice.org.uk/CG931>

O'Connell, B. (2005). *Solution-Focused Therapy (2nd ed.)*. Sage Publications Ltd.

Perls, F., Hefferline, R., & Goodman, P. (1951) *Gestalt Therapy: Excitement and growth in the human personality*. The Julian Press Inc.

Prochaska, J.O., DiClemente, C.C. & Norcross, J.C. (1992). In Search of How People Change: Applications to Addictive Behaviours. *American Psychologist*, 47, 1102-1114.

Rogers, Carl. (1961). *On Becoming a Person: A Therapist's View of Psychotherapy*. London: Constable

Rowan, J. (1998). *The Reality Game: A guide to humanistic counselling and psychotherapy (2nd ed.)*. Routledge.

Safran, J.D. & Segal, Z.M. (1990a). *Interpersonal Process in Cognitive Therapy*. New York: Basic Books, Appendix I.

Salkovskis, P.M. (1985). Obsessive-Compulsive Problems: a cognitive-behavioural analysis. *Behaviour, Research and Therapy*, 25, 571-583

Segal, Z.V., Williams, J.M.G. & Teasdale, J.D. (2002). *Mindfulness-Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse*. The Guilford Press.

Veale, D. (2001). Cognitive-behavioural therapy for body dysmorphic disorder.

Advances in Psychiatric Treatment, 7, 125-132

Warwick, H.M.C. & Salkovskis, P.M. (1990). Hypochondriasis. *Behaviour Research and Therapy*, 28, 105-117.

Westbrook, D., Kinnerley, H. & Kirk, J. (2007). *An Introduction to Cognitive Behaviour Therapy: Skills and Applications*. Sage Publications Ltd.

Willson, R., Veale, D. & Clarke, A.(2009). *Overcoming Body Image Problems including Body Dysmorphic Disorder: A self-help guide using cognitive behavioural techniques*. Basic Books.

Young, J. & Beck, A.T. (1980). *Cognitive Therapy Scale: Rating manual*. Unpublished manuscript, University of Pennsylvania, Philadelphia, PA.

Research Dossier

**AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS
INVESTIGATION INTO MEN'S EXPERIENCE OF
PSYCHOLOGICAL CHANGE WITHOUT PSYCHOTHERAPY**

by

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Literature Review

**AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS
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What is Psychological Change?

Psychological change is the business of psychotherapy (Carey, Carey, Mullan, Murray, & Spratt, 2006). Although psychotherapy interventions have been devised to facilitate psychological change in clients, thorough research into the phenomenon of psychological change has been neglected (Greenberg, 1991, Lampropoulos, 2000, Carey et al., 2006). Attempts have been made to find a precise and accurate definition of psychological change in the literature, as it is ill-defined, with definitions being frequently neglected and when they are found, they appear unsatisfactory (Carey et al., 2006). Carey et al.'s (2006) search was unsuccessful perhaps because psychological change is 'too nebulous a phenomenon to capture with a succinct definition' (p29). An alternative explanation Carey et al. (2006) posited is that psychological change might be the same as 'any other type of change' (p31).

Nevertheless, a definition of psychological change has been provided by Gianakis and Carey (2008). The authors defined psychological change as 'a difference in the experience of psychological distress' (Gianakis & Carey, 2008; p27). However, there is a problem with restricting the definition of psychological change to a difference in psychological distress. As Linley, Joseph, Harrington and Wood (2006) indicated, in contrast to the professional practices of psychology that are more 'grounded in dysfunctional models', the practice of Counselling Psychology emphasises 'human development' (p9). Thus as practitioners,

Counselling Psychologists not only facilitate psychological change in clients wishing to overcome distress but also in those that desire personal growth.

Moreover, there is increasing interest in the area described as 'positive psychology' which emphasises 'ordinary experience, well-being and potential' (Strawbridge & Woolfe, 2010; p10). This is in contrast to the professional practices which focus on 'distress, disorder and dysfunction' (Linley et al., 2006; p6) mentioned previously. Hence, it would seem useful to investigate whether the same change processes that are involved in reducing distress are also involved in enhancing well-being and potential, for example. It is possible that Gianakis and Carey (2008) defined psychological change as 'a difference in the experience of psychological distress' as the authors are predominately from a clinical psychology background and the remit of clinical psychology concerns 'repairing weakness and damage' (Maddux, Snyder & Lopez, 2004; cited in Linley et al., 2006; p9).

The phenomenon of psychological change not only occurs with regards to overcoming distress and enhancing well-being, but also with regards to life-span development. However, psychological change across the life-span was omitted from the in-depth literature reviews on psychological change produced by Carey et al. (2006) and Gianakis & Carey (2008). This seems an important area to include especially because as Neugarten, (1979) stated 'psychological change is continuous throughout the life cycle' (p887). Furthermore, one of the most recognised changes in adulthood is that of midlife and Sugarman (2001) proposed that it is preferable to consider this particular stage in life 'as a potential psychological turning point' (p25). Sugarman (2001) also stated that the

psychological changes which occur at this time relate to 'identity, autonomy and making meaning' (p15).

The Process of Psychological Change in Psychotherapy

Following the difficulties with attempting to define psychological change documented by previous researchers (e.g. Carey et al., 2006; Gianakis & Carey, 2008), this researcher will also now focus instead on the experience of change and how change occurs, beginning with the experience of change within a psychotherapeutic context.

Psychological change is perceived to be facilitated by various means by those who deliver psychotherapy, and their perception is dependent on their theoretical orientation. The person-centred approach for example, posits that the six core conditions are 'essential for psychotherapeutic change' and if they are provided over a period of time, this is sufficient to facilitate change in therapy (Rogers, 1957; p99). Other humanistic approaches use interventions that assist clients in raising awareness of their thoughts and feelings in the present moment, encouraging them to take responsibility for themselves and to accept all parts of themselves. This gives them the freedom to choose to change and overcome their psychological distress (du Plock, 2009).

With regards to the psychodynamic approach, the past is of significant importance in order for psychological change to be facilitated. This is because the psychodynamic approach proposes that problematic behaviour is a result of 'unconscious processes rooted in traumatic early experiences' (Rizq, 2010). Therefore, the client's unconscious has to be

made conscious for psychological change to be brought about using psychodynamic therapy (Jacobs, 2004).

According to Cognitive Behavioural Therapy (CBT), it is negative or dysfunctional thinking which leads to emotional problems and unhelpful behaviour (Curwen, Palmer, & Ruddell, 2000). This approach asserts that by assisting the client to alter their thoughts, using specific cognitive or behavioural interventions, it is possible to help them alleviate their emotional suffering (Curwen, et al., 2000). Additionally, CBT maintains that thoughts determine feelings (add ref?). In contrast, the Freudian viewpoint is that feelings drive thoughts and there is evidence that supports both perspectives (Seligman, 2002).

An alternative perspective regarding psychological issues is provided by neuroscience, which proposes that clients' psychological problems are a result of 'inadequate growth and integration within and between neural networks' (Cozolino, 2002; p44). According to a neuroscientific perspective, positive psychological change within a psychotherapeutic context is brought about by 'emotional attunement, affect-regulation and the co-construction of narratives' (Cozolino, 2002; p45).

The psychology literature is replete with research to support the efficacy of psychotherapeutic interventions in facilitating psychological change, despite the limited knowledge regarding the psychological change phenomenon. Additionally, it has been suggested that differing therapies are similarly effective, frequently referred to as the 'Dodo Bird Verdict' (Budd & Hughes, 2009). A possible explanation for the Dodo Bird Verdict is that common change processes exist. Hence, there has recently been a demand for

empirically supported principles of change as an alternative to empirically supported therapies (Rosen & Davison, 2003; p300).

By altering the focus to empirically supported principles of change rather than empirically supported therapies, Rosen and Davison (2003) asserted that this 'will return our attention to what psychology is about' (p308). They posited that a clinical advantage of focusing on empirically supported principles of change is that 'decision rules become clearer' (p307). Rosen and Davison (2003) also proposed that trainee psychologists should then be taught the fundamental principles of change in addition to 'the range of their applications' (p306). Furthermore, Tyron (2005) stated that 'knowledge of a change mechanism can help resolve differential predictions made by behavioural, cognitive, and affective models of therapeutic change' (p86).

Models of Change

Attempts have subsequently been made to progress the formulation of a general change model (e.g. Carey et al., 2006; Gianakis & Carey, 2008). The stages of change model (e.g. Prochaska & Norcross, 2001), for example, asserts that behaviour change occurs in a series of discreet stages with individuals 'progressing linearly from precontemplation to contemplation, then from preparation to action and finally into maintenance' (Prochaska, DiClemente & Norcross, 1992; p1103). The stages of change model has been widely investigated and is generally acknowledged as a model that explains the process of change (Carey et al., 2006).

Nevertheless, there are criticisms of the stages of change model including that the assumptions it makes are not supported by empirical research. One such assumption concerns the assertion that common stages of change exist 'across a range of problem behaviours' (Littell & Girvin, 2002; p249). Additionally, it has been found that individuals also change following events in life or from being coerced by others 'without much reflection or prior intent to change' (Littell & Girvin, 2002; p250). The stages of change model has also been found to be inadequate as a general model of change as it is deemed to be a model of external behaviour rather than one regarding internal organisation (Carey et al., 2006).

Stiles et al.'s (1990) assimilation model is another model of change. This is an integrative model of change in a psychotherapeutic context (Stiles et al., 1990). With this model, change involves the process of assimilation along a continuum. The process of assimilation described by this model involves a schema 'taking it in', including integrating the experience, explaining it and then incorporating it 'into a system of associations' (Stiles et al., 1990; p412). The process of change proposed by this model has also been described as involving the individual 'moving from negative affect to acceptance and mastery, along with becoming clearer about the nature of the problem before insight is reached' (Gianakis & Carey, 2008; p29).

Although a common mechanism of change is 'the assimilation of problematic experiences' (Stiles et al., 1990; p411) there is a disadvantage with this model. The assimilation model is a model of change within a psychotherapeutic context and this limits its' use in regards to elucidating generic change processes (Gianakis & Carey, 2008). A particular problem with

regards to this is that when research into psychological change is executed within a psychotherapeutic context, the process of therapy is conflated with the process of change (Carey et al., 2006; Gianakis & Carey, 2008).

An alternative model of change has been proposed by Bohart and Tallman (1999). Their model focuses on the client as an 'active-self-healer' and the authors report on change with and without psychotherapeutic assistance (Bohart & Tallman, 1999). According to the 'active-self-healer' model, a person's ability to cope with and overcome problems includes change processes such as 'acceptance'; 'attention shift'; 'discussing with others'; 'doing something different'; 'adopting a metacognitive perspective', 'reframing' (Bohart & Tallman, 1999; p84) and so forth. An advantage of the active self-healer model is that it can be applied to naturally-occurring psychological change (Gianakis & Carey, 2008).

Perceptual Control Theory (PCT), developed by Powers (2005), is a 'self-regulatory framework based on control system engineering' (Higginson, Mansell, & Wood, 2011; p250) which presents an integrated theoretical explanation of human behaviour. Higginson et al. (2011) have described PCT as 'a universal theory of human function and dysfunction' (p257). PCT also provides an explanation of behaviour not from the position of an external observer, but rather 'from the inside perspective of the controlling organism.' (Forsell, 2005; p7). With regards to psychological problems, according to PCT these are perceived to be 'disruptions in control processes' (Carey, 2011; p244). Thus PCT asserts that the reorganising of 'conflicting higher order control processes' are central to psychological change (Higginson et al., 2011; p258). Hence, the significant element in the process of

therapy from the perspective of PCT is to maintain 'the conflict in awareness until reorganisation generates a satisfactory solution' (Carey, 2011; p246).

Higginson and Mansell (2008) posited that it is possible to apply PCT to 'both normal psychological functioning and across a range of psychological disorders' (p250). Additionally, Gianakis and Carey (2008) considered the concept of reorganisation in PCT may be applicable to the psychological change phenomenon. Therefore, Higginson and Mansell (2008) hypothesised that PCT could offer a suitable explanation of the psychological change mechanism. Additionally, PCT is perceived as a model which 'provides a mechanism of how change occurs' (Gianakis & Carey, 2008; p32). Another advantage of PCT is that rather than being a conceptual model of human functioning, it is a functional one 'with its principles being tested using computer simulations' (Carey et al., 2006; Carey et al., 2007; Gianakis & Carey, 2008).

PCT is still in its infancy and its real relevance has yet to be determined (Gianakis and Carey, 2008). The knowledge base regarding PCT and psychological change continues to increase, but recent investigations have explored PCT principally within a psychotherapeutic context (e.g. Carey, 2008; Mansell & Carey, 2009; Carey, 2011; Higginson et al., 2011). Hence, the aforementioned conclusions drawn by Gianakis and Carey (2008) regarding PCT are still pertinent.

Research into Psychological Change in Psychotherapy

It has been suggested that differing therapies are similarly effective, frequently referred to as the 'Dodo Bird Verdict' (Budd & Hughes, 2009), as previously stated. It has also been

asserted that the Dodo Bird Verdict might be due to a methodological issue relating to the use of randomised controlled trials (Budd & Hughes, 2009). These research trials make the assumption of a 'direct and linear cause-effect' relationship between psychotherapy intervention and patient outcome in clinical trials (Greenberg, 1999; cited in Carey et al., 2006; p33). It has been reported that linear models are erroneous and deceptive because alterations to cognitions, mood and behaviours occur simultaneously, rather than in succession (Tyron, 2005). Hence, an alternative approach to quantitative methodologies to investigate the processes of psychological change has been called for (Elliott, 1989; Greenberg, 1994; Carey et al., 2006). Gordon (2000) highlighted the need of going further than the outcomes of therapy and employing a research approach which is more interpretive and utilises detailed interviews (cited in Carey et al., 2006; p33) for example.

Additionally, it has been found that researching psychological change within a psychotherapeutic context is problematic as the change process and the psychotherapy process are conflated (Carey et al., 2006; Gianakis & Carey, 2008), as mentioned previously. This has significant ramifications for researchers because in contrast to psychotherapy, which is a communication involving a minimum of two people in specified roles, change is a personal experience which takes place, 'within the neural organisation of an individual' (Tyron, 2005; cited in Carey et al., 2006; p34). Therefore, in order to improve the understanding of psychological change, researchers need to be transparent with regards to when they are researching the process of psychological change and when they are investigating other phenomena (Carey et al., 2006).

A further problem with regards to the research on change within a psychotherapeutic context is the overlooked role of the patient (Greenberg, 1991; Carey et al., 2006; Gianakis & Carey, 2008). Greenberg (1991) is of the opinion that the importance of the client as the 'site of change' should be recognised (p10), for example. Additionally, Bohart and Tallman (1999) perceive that the client is not only the site of change but also the change generator. Hence, there is a need for researchers to put their 'investigatory emphasis on the client rather than the therapist' (Greenberg, 1999; p10).

It has also been suggested that in order to investigate and develop a greater understanding of psychological change from an individual's perspective, the use of qualitative methodologies should be used as they are deemed more suitable for 'comprehending people's construction and interpretation of the change experience' (Gianakis & Carey, 2008; p33). The qualitative research that has been carried out into psychological change has begun to provide some illuminating insights into the change phenomenon. Carey et al. (2007) for example, interviewed 27 psychotherapy clients at the end of treatment. The researchers discovered that the change process for their participants seemed to include not only an 'identifiable and memorable moment' but also a process of gradual change and furthermore, it appeared that the process of change 'was often experienced as both' (Carey et al., 2007; p182). Nevertheless, the Carey et al. (2007) investigation researched psychological change within a psychotherapeutic context, which incurs the disadvantage of the therapy process and the change process being conflated.

The Experience of Change without Psychotherapy

Carey et al. (2006) provided an in depth review of the literature on psychological change within psychotherapy. There is growing evidence though for the occurrence of individual change without professional psychotherapeutic assistance. Empirical support for this has been documented in studies concerning overcoming trauma (Tedeschi, Park & Calhoun, 1998), depression (Kelly, Roberts & Bottanari, 2007), post-traumatic growth (Linley & Joseph, 2004) and social phobia (Vriends, Becker, Meyer, Williams, Lutz & Margraf, 2007) for example.

Additionally, research into couples and particularly, why they divorce, has demonstrated that couples can experience psychological change without psychotherapy. One study which investigated this area is the Californian Divorce Mediation Project (Gigy & Kelly, 1992). This study found that almost 80% of all the men and women in the study cited the experience of 'growing apart' from one's partner as a main cause of divorce. Kabbat-Zinn (1999) added to this with his perspective on divorce which he states can occur if the people in the relationship are not able to 'adjust to the changes associated with living together' (p246). In addition to this adjustment needing to include allowing for one's own growth and change, it must also allow for one's partner's change and growth (Kabbat-Zinn, 1999).

Hence, in order to advance the psychological change knowledge base further, Gianakis and Carey (2008) suggested qualitative methodology needed to be carried out into naturally-occurring change. Researching psychological change without the assistance of psychotherapy will clearly differentiate the change process from the process of psychotherapy (Gianakis & Carey, 2008). Higginson and Mansell (2008) carried out one

such study, focusing on the process of change in general rather than within a psychotherapeutic context. Higginson and Mansell (2008) interviewed six individuals who had overcome a number of problems, with or without the assistance of psychotherapeutic interventions, and the researchers also found that both a sudden and a gradual process of change was reported by participants.

Whilst the Higginson and Mansell (2008) study investigated psychological change with or without the assistance of psychotherapy, three of their participants had experienced psychotherapy in the past. In contrast, Gianakis and Carey (2011) also investigated naturally-occurring psychological change but only included participants who had not received psychotherapy to help them overcome their problem. The authors also found that the change process involved both a sudden and gradual component (Gianakis & Carey, 2011). Nonetheless, Gianakis and Carey's (2011) study investigated seven female participants' experience of psychological change without psychotherapy, due to an absence of male participants. Consequently, the author's highlighted this gap in the research and suggested men's experience of naturally occurring psychological change be investigated.

The Psychology of Men

Men have been the subject of developmental change research in America, particularly with regards to psychological adaptation during the life cycle (Vaillant, 1977). However, in the United Kingdom, the psychology of men seems to continue to be a subject that is principally ignored, which is curious considering men account for approximately fifty percent of the population (White, 2009). With regards to biological differences, males start life being emotionally more expressive than females (Levant, 1995). Furthermore, the

socialisation process of males differs from that of females (Wexler, 2009). Consequently, males then learn to 'tune out, suppress and channel their emotions' (Levant, 1995; p262), as a result of the different socialisation process. In addition, research has demonstrated that males are less likely than females to seek help throughout the lifespan and this difference begins as young as three years old (Benenson & Koulazarian, 2008). Research has also demonstrated that there is a link between the mental health of men and the masculine gender role socialisation process (Addis & Cochane, 2005).

In spite of the aforementioned male socialisation process, recently there has been an increase in the number of men in Britain revealing their psychological and emotional problems in the media, including discussing the factors contributing to their crises (Samaritans, 2012). Furthermore, in most countries, including the UK, more men than women commit suicide (Hawton, 2000). Therefore, it is becoming more acknowledged, that the psychological functioning of men is worthy of 'attention in its own right' (Kingerlee, 2012; p84). Additionally, Good and Brooks (2005) stated it is crucial that men are 'recognised as a special culture and that diversity training include attention to the area of men and masculinity' (p8).

The need for Male-Sensitive Therapy

Gender competence of clinicians has been found to be directly related to psychotherapy outcome (Owen, Wong, & Rodolfa, 2009). Thus, Counselling Psychologists need to consider gender when dealing with male clients for therapy to be as effective as it can be for them, because as McCarthy and Holliday (2004) posited, gender culture needs to be incorporated by therapists, so that men can be better served when they do attend therapy. Similarly, Wester (2008) recommended that in order for Counselling Psychologists to work

competently in regards to multiculturalism, they must 'consider the extant literature on masculinity worthy of attention' (p295). This not only applies to individual therapy but also to couples therapy, because as Johnson and Lebow (2000) stated, therapy with couples can only be effective and unbiased if it includes 'an understanding of the role of gender and the part it plays in the issues of concern' (p30).

Good and Robertson (2010) reported that males generally perceive help-seeking when in distress as unacceptable, as it conflicts with masculine gender socialisation described previously. However, recently it has been reported that men are 'finding their way to therapy and are frequently choosing female therapists' (Johnson, 2005; p291). The problem is that when they do attend therapy, the therapeutic interaction in counselling is not conducive to masculine norms (Mahalik, Good, & Englar-Carlson, 2003). Psychotherapy is perceived by some to be overly dependent on female styles of intervention and hence there has been a call for the development of novel therapeutic interventions that are more aligned with "masculine" modes (Heesacker & Prichard, 1992). Hence, therapy needs to be delivered in a manner that is sensitive to males and their masculinity (Kiselica & Englar-Carlson, 2010).

This male-sensitivity includes being able to recognise shame, deal with resistance and manage transference and countertransference (Johnson, 2005) for example. Other factors to consider in order to successfully work with male clients include being aware that men are 'most receptive to practical, problem-solving interventions' (Wexler, 2009; p90). In addition, Wisch, Mahalik, Hayes and Nutt (1995) reported that males may be deterred from seeking help, particularly those that conform to more traditional masculinity norms,

because they may perceive therapy focuses on discussing emotions. It has therefore been argued that these male clients might be more encouraged to obtain help if they knew other forms of therapy were available that are more aligned with their 'less openly emotional style' such as cognitive-behavioural therapy (Wisch et al., 1995; p86). Similarly, Mahalik (2005) proposed that the emphasis of Cognitive Therapy on 'cognitions and its problem-solving approach may be more congruent with the actions skills of traditionally socialised men' (p218).

Research investigating the change experience from the point of view of the person within which the change has occurred using qualitative methodologies, is important to improve our knowledge of the psychological change process (Greenberg, 1991; Carey et al., 2006; Higginson & Mansell, 2008; Gianakis & Carey, 2008; Gianakis & Carey, 2011). Investigating naturally-occurring change is particularly important in order to delineate the psychotherapy process from the change process (e.g. Gianakis & Carey, 2008; Higginson & Mansell, 2008). However, psychological change also occurs without the assistance of psychotherapy, as previously mentioned. This applies not only to women but also to men.

Nevertheless, the process of psychological change, particularly without the assistance of psychotherapy, continues to be an under-researched area. Although Higginson and Mansell (2008) and Gianakis and Carey (2011) have contributed to this area of research, the former study only included one male participant and the later did not include any male participants, as reported previously. Hence, this researcher chose to attempt to fill the gap identified in the literature by Gianakis & Carey (2011) and investigate men's experience of naturally-occurring psychological change using the qualitative methodology of IPA, as detailed in the

following research report. Additionally, incorporating the findings of further research into psychological change from a male perspective into therapy could help the therapy to be delivered in a more male-sensitive manner. Furthermore, this should also enhance psychological therapies in general for those who have not thus far been able to experience benefit from therapy (Gianakis & Carey, 2008).

Research Report

ABSTRACT

The psychotherapy literature is replete with research to support the efficacy of psychotherapeutic interventions in bringing about psychological change in clients. However, relatively little is known about psychological change itself. This has been exacerbated because the therapy process is conflated with the change process when it has been investigated within a therapeutic context (Carey, Carey, Mullan, Murray, & Spratt, 2006). Whilst some qualitative research has been carried out into psychological change without the assistance of psychotherapy (Gianakis & Carey, 2011; Higginson & Mansell, 2008), men have been under-represented. Therefore, the objective of this study was to further enhance the understanding of generic change processes and in particular, elucidate men's experience of naturally-occurring psychological change.

Ten males participated in face-to-face, semi-structured interviews for this research. Their results were analysed using the qualitative method of interpretative phenomenological analysis (IPA) (Smith, Jarman, & Osborn, 1999). The findings that emerged from the analysis clustered around five main themes: coping with the problem, turning points, addressing the problem, appraising the experience positively, and time. Of particular significance was that becoming motivated to address the problem was preceded by insight. Thinking and action-orientated problem-solving were identified as central to the change process.

Incorporating the findings from naturally-occurring change research into psychotherapy will enhance it (Lampropoulos & Spengler (2005). It is also important to assimilate men's experiences into the therapy process (Mahalik, Good, & Englar-Carlson, 2003). Wider

dissemination of these findings could improve preventative measures for men who do not attend therapy too. Further research into naturally-occurring psychological change is required to extend these findings and improve their generalisability.

INTRODUCTION

The purpose of psychotherapy is to assist clients to experience positive change (Taylor, 2007). Nevertheless, surprisingly little is known about the phenomenon of psychological change itself. The author of the current study concurs with Gianakis and Carey (2008) that understanding the phenomenon of psychological change and how it happens would seem to be of use, or even a necessity, prior to developing treatments that assist clients to experience positive psychological change. Even though numerous psychological therapies have been developed, thorough research into what psychological change is and how it occurs has been neglected (Greenberg, 1991; Lampropoulos, 2000; Shapiro, 1995; Carey et al., 2006; Gianakis & Carey, 2008).

In spite of the limited knowledge of the psychological change phenomenon, there is a proliferation of empirical evidence supporting the efficacy of psychotherapies in facilitating psychological change. Furthermore, different therapies have been found to be equally efficacious and this has been termed the 'Dodo Bird Verdict' (Budd & Hughes, 2009). Several explanations have been suggested for the findings of the Dodo Bird Verdict including that it is due randomised controlled trials being the methodology used for the research (Budd & Hughes, 2009). The existence of common change processes is an alternative account for this phenomenon (Rosen & Davison, 2003). Hence, rather than empirically supported therapies, there has been a call for a focus on empirically supported principles of change, which will then 'return our attention to what psychology is about' (Rosen & Davison, 2003; p308).

Subsequently, there have been attempts to formulate a general model of change (eg. Carey et al., 2006; Gianakis & Carey, 2008). A number of models of change have been analysed as a result. The stages of change model (e.g. Prochaska & Norcross, 2001) is generally acknowledged to explain the manner in which change transpires. However, it has been found to be inadequate as a general model of change because it is a model of external behaviour, rather than a model of internal organisation (Carey et al., 2006). Additionally, evidence does not support the experience of change as necessarily being a 'step-by-step, systemic' process (Gianakis & Carey, 2008; p30).

The assimilation model is an integrative model of change in a psychotherapeutic context (Stiles et al., 1990; p411) which has also been examined. Change according to this model encompasses the process of assimilation along a continuum, and the assimilation of problematic experiences is a common change mechanism (Stiles et al., 1990). Nevertheless, the assimilation model is deemed to be limited in its usefulness with regards to illuminating general mechanisms of change due to it being a model of change only within a psychotherapeutic context (Gianakis & Carey, 2008).

An analysis of Bohart and Tallman's (1999) 'active-self-healer' model, which involves change with and without psychotherapy, has also been carried out (Gianakis & Carey, 2008). The change processes that Bohart and Tallman reported for example, include 'attention shift'; 'looking for other paths'; 'exposure' and 'adopting a metacognitive perspective' (Bohart & Tallman, 1999; p84). Although there is an advantage with the self-healer model compared to the assimilation model in that it can also be applied to naturally-

occurring psychological change, it is lacking with regards to an explanation of how the proposed change processes occur (Gianakis & Carey, 2008).

The attempt to formulate a generic model of change has also included exploring Perceptual Control Theory (PCT) developed by Powers (2005). This is a framework which is based on control system engineering (Higginson, Mansell, & Wood, 2011). PCT offers a 'functional and transdiagnostic approach to the consideration of mechanisms of change' (Carey, 2011; p237). Hence, an advantage of PCT is that it can be applied both across a variety of psychological problems and to 'normal psychological functioning ' (Higginson & Mansell, 2008; p250). A key concept within PCT is that of reorganisation and it has been considered that this aspect of PCT might be applicable to the process of psychological change (Gianakis & Carey, 2008).

Although the PCT knowledge base with regards to psychological change continues to grow (eg. Carey, 2008; Mansell & Carey, 2009; Carey, 2011; Higginson et al., 2011), the majority of the research has involved investigating psychological change within a psychotherapeutic context and this is problematic. This is because when psychological change is researched within the context of psychotherapy, the process of therapy is conflated with the process of change (Carey et al., 2006; Gianakis & Carey, 2008). Psychotherapy involves at least two individuals who have specific roles (Tyron, 2005). In contrast, psychological change occurs within the client, who is the 'site of change' (Greenberg, 1991; p10).

Furthermore, there is empirical evidence to support that both within and outside psychotherapy sessions clients principally change by themselves (e.g. Bohart & Tallman, 1999; Lambert, 1992; Prochaska & DiClemente, 1992; Lampropoulos & Spengler, 2005). Thus, as Prochaska (1995) stated, 'without self-change processes, therapists would be helpless' (p101). Particular examples of empirical research supporting psychological change without the assistance of psychotherapy include studies regarding recovery from trauma (Tedeschi, Park, & Calhoun, 1998), depression (Kelly, Roberts, & Bottanari, 2007), post-traumatic growth (Linley & Joseph, 2004), and social phobia (Vriends, Becker, Meyer, Williams, Lutz, & Margraf, 2007) for example.

Additionally, to develop a greater comprehension of psychological change processes from the perspective of the person who experiences the change, the use of qualitative methodologies has been recommended (Greenberg, 1991; Carey et al., 2006; Gianakis & Carey, 2008; Higginson & Mansell; 2008). A number of these studies have been executed which have encompassed change in a generic sense, rather than within a psychotherapeutic context. Higginson and Mansell (2008) and Gianakis and Carey (2011) investigated naturally-occurring change and found the change experience involves both a gradual component and sudden moments. Themes relating to identity or self-concept were also discovered (Higginson & Mansell, 2008; Gianakis & Carey, 2011). In addition, the theme of identity was reported by Miller (2004) in his longitudinal study concerning quantum change. Heatherton and Nichols (1994) in their narrative investigation into successful versus failed attempts at life change, and Keski-Rahkonen and Tozzi (2005) in their internet-based study regarding recovery from an eating disorder also reported themes of identity, or self-concept.

A further theme discovered by Heatherton and Nichols (1994), Banyard and Williams (2007), and Gianakis and Carey (2011) were relationships with others being central to the change experience. This has also been observed in psychological change studies within a psychotherapy context (Carey, Carey, Stalker, Mullan, Murray & Spratt, 2007; Clarke, Rees, & Hardy, 2004). Equally, a theme identified in the accounts of naturally-occurring psychological change by participants includes a thinking process (Gianakis & Carey, 2011). This theme also featured in the studies into change within a psychotherapy context (Carey et al., 2007; Clarke et al., 2004).

A period of some distress culminating in an intolerable limit being reached has been documented in a number of ways, as being of important in the change experience too. This has been described variously as a 'threshold' (Gianakis & Carey, 2011), 'quantum change' (Miller, 2004), and a 'crystallisation of discontent' (Heatherton & Nichols, 1994). Bohart and Tallman (1999) stated that numerous therapists perceive 'psychotherapy is a learning process' (p.vii) and increased knowledge about the self or about life was reported by the majority of individuals in the Gianakis and Carey (2011) study. Similarly, a high percentage of the successful change accounts documented by Heatherton and Nichols (1994) identified learning from the experience as part of their change process, particularly relating to increased knowledge and understanding about the self. Banyard and Williams (2007) also identified 'turning points and lessons learned' as important in the recovery experience of the women in their study regarding childhood abuse (p285).

The aforementioned studies have provided some useful insights into individuals' experiences of change in a variety of contexts. Even so, some disadvantages with these studies have been documented by Gianakis and Carey (2008) including the conflation of the psychotherapy process and the change process in the studies by Carey et al. (2007) and Clark et al. (2004), in addition to the investigation of only one particular problem area (e.g. Banyard & Williams, 2007; Kelly et al., 2007; Vriends et al., 2007; Keski-Rahkonen & Tozzi, 2005; Clark et al., 2004).

In order to further advance the psychological change knowledgebase, it has been suggested that qualitative research regarding naturally-occurring change, defined as 'overcoming a problem without the assistance of psychotherapy', be investigated (Gianakis & Carey, 2008). Although Higginson and Mansell (2008) investigated naturally-occurring psychological change, three of their six participants had received psychotherapeutic assistance regarding their issues. An advantage of the Gianakis and Carey (2011) investigation into the experience of psychological change without psychotherapy was that none of their seven participants had received psychotherapy. Gianakis and Carey (2011) identified the following themes in their investigation: connection, identity, threshold, thinking process, gradual process and sudden moments of change, as previously mentioned. A desire for change theme was also reported. Nevertheless, their study did not include any male participants and hence, the researchers suggested men's experience of psychological change without psychotherapy is investigated (Gianakis & Carey, 2011).

Surprisingly, given the numbers of men in the country, the psychology of men seems to be a subject that is generally ignored in the United Kingdom (White, 2009). This is in spite of

the rise in the number of men disclosing their psychological and emotional problems in the media recently (Samaritans, 2012). Additionally, a greater number of men than women commit suicide (Hawton, 2000). Hence, it is perceived that the psychological functioning of men is worthy of separate attention (Kingerlee, 2012). Furthermore, help-seeking conflicts with masculine gender socialisation (Good and Robertson, 2010). Thus, a development of new more "masculine" styles of therapeutic interventions have been called for due to some perceiving psychotherapy to be too reliant on female modes of intervention (Heesacker & Prichard, 1992). Therefore, therapists must incorporate gender culture into therapy, so that men can be better served when they do attend (McCarthy and Holliday, 2004)

Aims and rationale of the present study

In accordance with Gianakis and Carey (2008), psychological change in the current study is defined as 'a difference in the experience of psychological distress' (p27) and more specifically, change in a positive direction. The aim of this study was to explore men's experience of psychological change without the assistance of psychotherapy. This investigation is important because psychological change, the purpose of psychotherapy, is under-researched and furthermore, men appear to be under-represented in this area. Additionally, it was deemed important to attempt to fill the gap in the literature highlighted by Gianakis and Carey (2011), by replicating their study but from the perspective of men to discover whether the prominence of particular features of the change experience reported in the previous studies emerge.

According to Mahalik et al. (2003), the experience of men needs to be assimilated into the therapy process in order to enhance it. Furthermore, this study is important because as Lampropoulos and Spengler (2005) reported, investigating naturally-occurring psychological change, in addition to self-help, and integrating findings from these areas into psychotherapy will improve it. Finally, in addition to the possibility of ameliorating the provision of psychotherapy, it was hoped that preventative measures can be improved by disseminating results of research into naturally occurring change to the general public (Lampropoulos & Spengler, 2005), which, given the increasing reports of men's psychological distress and suicide rates previously described, seemed to be urgently required.

METHOD***Participants***

A snowball sampling method was used to recruit participants from within Wolverhampton University initially. The researcher displayed recruitment posters (Appendix 1) throughout Wolverhampton University. A recruitment e-mail (Appendix 2) was also sent to the university staff and students, inviting male volunteers who had overcome a problem without the assistance of counselling or psychotherapy, to participate in the study. The target sample size for the study was 12 participants. It was the intention of the researcher to carry out six face-to-face interviews and implement an in-depth analysis on said data, and request the remaining six individuals to provide written narratives, with a group analysis being carried out on this data. Nevertheless, the response rate was incredibly low. Following supervision consultation, the snowball sampling method was extended to outside the university and all the individuals who volunteered for the study, and met the inclusion criteria, participated in a face-to-face interview.

Subsequently, ten participants were recruited, of which three were from Wolverhampton University. The remaining seven participants were located in various geographical locations throughout England. Each participant was allocated a participant number by the researcher, according to the order they were recruited in, and this number will be used to refer to the participants throughout the research report. Of the ten participants, whose ages ranged from 23 to 55, eight were Caucasian and two were of other ethnic origins. The men all reported they had successfully overcome their problems without any professional psychotherapeutic assistance. Table 1 provides participant's demographic information,

including their age, profession/student status, demonstrating the range of issues the men had resolved, the interview length and their associated participant number.

Table 1: Participant characteristics and interview lengths

Participant number	Age	Profession	Problem participant volunteered to discuss	Interview length in minutes
1	43	Student and part-time worker	Alcohol Addiction	35
2	29	Student	Loss of Passport and driving licence	25
3	28	Student and part-time worker	Relationship break-up	40
4	23	Student	Relationship break-up	60
5	41	Computer Programme Manager	Bereavement	45
6	28	Graphic designer	Relationship problems	60
7	55	Marketing and New Business Manager	Redundancy	60
8	32	Personal Trainer	Relationship break-up	60
9	46	CBT Well-being Practitioner	A family dilemma	60
10	27	Software Developer	Relationship with parents	45

Materials

The materials that were used for this study included a consent form (Appendix 3), an information sheet (Appendix 4), and a de-brief sheet (Appendix 5). In order to replicate the Gianakis and Carey (2011) study, the researcher employed the same semi-structured interview schedule used by Gianakis & Carey (2011) (Appendix 6), which was originally devised by Higginson and Mansell (2008). To record the interviews, the researcher used an Olympus PearlCorder S701 Microcassette™ recorder and Olympus XB60 Microcassette™

tapes. The Microcassette™ tapes and completed consent forms have been stored in accordance with the Data Protection Act 1998.

Procedure

Once the researcher received an email from an interested volunteer, the researcher then sent an email to the potential participant which included an outline of the research, in addition to a request for the volunteer to ensure they met the specified inclusion criteria. The inclusion criteria for the study was that a participant had to be male, over 18 years of age, and needed to have overcome a problem at least six months previously without the assistance of counselling or psychotherapy. After the researcher had confirmed the participant met the inclusion criteria and verified they still wished to take part in the study, the researcher arranged a telephone conversation with the participant to organise the interview date, time and location. During this telephone call, the researcher repeated the purpose of the research and interview. The researcher also asked the participant to give a brief outline of the problem they had overcome and would be willing to discuss in the interview. Additionally, the researcher verified once more that the participant met the inclusion criteria, and clarified whether they were still happy to proceed with the interview.

Semi-structured qualitative interviews were conducted to explore the participants' experience of psychological change without psychotherapy. Oliffe and Mróz (2005) recommended that prior to interviewing male participants, researchers provide them with a number of questions from the interview in advance, to assist the introspection process and help assuage any fear the men might have regarding difficulties in responding to the interview questions. Therefore, one week before each interview, the researcher sent an

email (Appendix 7) to each participant with information regarding some of the questions they would be asked in the interview. There were two exceptions to this, participants two and three, as they were ad-hoc volunteers recruited whilst the researcher was waiting for other participants who did not attend, and the interviews were held the same day these participants volunteered.

Each participant was informed about all aspects of the interview process, the materials to be used and how their information would be stored, as per British Psychological Society (BPS, 2006) guidelines prior to commencing the interview. Additionally, each individual was given the detailed information sheet regarding the study and reminded that they could withdraw from the study at any time up until the point of analysis. Each participant was subsequently given the consent form. Once they had read the consent form, informed the researcher they had understood the information and what was required, notified the researcher that they were still happy to proceed and signed the form as confirmation of this, the interview began.

The three University students were interviewed in the departmental interview rooms. Four of the other interviews were carried out in private offices at the participants' places of employment. One interview took place in a Buddhist Centre meeting room and another interview was carried out in a complementary health clinic practice room. The final interview took place in the participants' home. Following the first two short interviews, the researcher took Oliffe and Mróz's (2005) recommendations a step further and provided the participants with the complete interview schedule at the start of each interview, providing

the participants with a few minutes to read through the schedule, with the aim of facilitating optimal length and depth of the interviews.

Every participant was fully de-briefed at the end of their interview. This included answering any questions that might have arisen during the interview, providing them with the de-brief sheet and asking them if they were still happy to be included in the study. Several of the participants had become a little tearful at times during their interview. Hence, the researcher re-iterated the information specified in the de-brief sheet regarding what to do if they felt they needed to or would like to discuss further any of the issues covered in the interview. The participants were also informed that they could receive a summary of the study, if they wished to, by contacting the researcher via email by the date specified on the de-brief sheet. The interviews varied from between 25 minutes to 60 minutes, with seven of the interviews lasting for 45 minutes or more (see Table 1). The researcher subsequently transcribed the recordings of the interviews and line numbers were added to the transcripts. Copies of the interview transcripts are provided on CD in the confidential attachment.

Researcher

IPA demands reflexivity from its researchers, including overtly communicating their own perceptions, which illuminates the analysis (Willig, 2001). The researcher is a final year trainee Counselling Psychologist with no previous experience of qualitative research. This investigation was informed by the researcher's own experience in successfully overcoming Myalgic Encephalomyelitis (M.E) ten years ago, which included a brief period of psychotherapeutic assistance and a lengthy period of self-help. Hence, the researcher is in concurrence with Gianakis and Carey (2011) and Bohart and Tallman (1999) that

individuals change themselves. Furthermore, the strength of the researcher's belief that individuals are their own change agents is such that she has authored a popular self-help book to assist others in enhancing their self-esteem and relationships (Buchan, 2008).

Ethics

The researcher applied for ethical approval for this study using the Res20A form (Appendix 8). The University's Ethics Committee granted the researcher approval to proceed with the investigation, following a number of amendments. A record of this is provided (Appendix 9). Hence, this research was carried out in accordance with the British Psychological Society's code of conduct, ethical principles and guidelines (BPS, 2009) which were adhered to throughout.

Quality and Validity

With regards to quality and validity, a rigorous paper-trail has been maintained by the researcher. This paper-trail includes two A5 research diaries which were used throughout the research process. The researcher made extensive use of these research diaries to assist in the bracketing process (Smith, Flowers, & Larkin, 2009) during the investigation, but particularly following the interviews and during the process of analysis. This paper-trail also consists of the materials used to carry out the investigation, the information recorded and the transcripts subsequently produced. Full details of the analysis process have been maintained too. However, only the main points of the analysis process are included in this research report, due to limitations of space.

Supervision was provided to the researcher from within the university by a Chartered Counselling Psychologist, which involved face-to-face meetings in addition to telephone and e-mail communication. Professor Carey, a doctor of Clinical Psychology and an experienced researcher in psychological change, provided external consultation throughout the investigation too. At various stages of the analysis process the data set, and the subsequent notes documented at each stage, were subjected to a verification process by the researchers' supervisors for quality and validity purposes. Minor recommendations were made on how to improve the analysis and these were then implemented by the researcher.

Methodological Rationale

It has been suggested, as mentioned previously, that qualitative research methods may be more useful in helping to elucidate individual's experience of the change process than quantitative methods (Carey et al., 2006). Hence, a qualitative method was chosen for this study, and in particular, the research data were analysed using the IPA method. IPA is phenomenological in its origins and also stems from symbolic interactionism, which posits that people make sense of their lives and ascribe meaning to events by devising personal accounts that they comprehend rather than being 'passive perceivers of an objective reality' (Brocki & Wearden, 2006; p88). IPA was chosen with the purpose of gaining an understanding of the meaning that an individual makes of their personal, subjective experience (Biggerstaff & Thompson, 2008) and thus increase the understanding of the psychological change process.

IPA was chosen above Discourse Analysis (DA) because it places more importance on cognition than DA, such that by employing the process of analysis (of transcripts for

example), it hopes to elucidate something about the process of thinking. It does this whilst acknowledging that it is not possible to have direct access to someone's thoughts, rather it is only possible to obtain an interpretation of them (Smith et al., 1999).

Additionally, IPA is concerned with the 'nature or essence of phenomena' (Willig, 2008; p73) such as that regarding psychological change. Further support for the appropriateness of using IPA to research psychological change is provided by Smith and Osborn (2004) who reported that IPA is especially appropriate when the subject being researched 'is novel or under-researched....and where one is concerned to understand something about process and change' (p231). Hence, this was consistent with the aim of the present study to investigate the under-researched area of psychological change, and men's experience of this in particular. IPA can also facilitate 'deeper understanding than traditional psychological methods' (Reid, Flowers & Larkin, 2005; p20) due to its use of in-depth interviews. Finally, IPA was first used in Health Psychology. However, it is being increasingly employed in other areas including Counselling Psychology (Smith et al., 2009) such as in research with naturally-occurring psychological change (Gianakis & Carey, 2011; Higginson & Mansell, 2008).

Data Analysis Process

Each transcript was subjected to an in-depth individual analysis, with the researcher only moving to the next transcript following completion of the previous one. During the early stages of the analysis, the researcher followed the IPA process described by Gee (2011), based on Smith et al.'s (2009) guidelines. The analysis process included the following stages: reading the transcript and highlighting first impressions on the text; re-reading the

transcript and making initial notes and descriptive comments; re-reading the transcript and documenting linguistic comments; and finally, re-reading the transcript and recording conceptual/psychological comments.

With regards to the process of identifying emergent themes, Gee (2011) reported she carried this part of the analysis process out after having completed all the aforementioned stages. The researcher of the current study made several attempts to adhere to Gee's (2011) order of analysis but found it made the task of identifying emergent themes very difficult and hence, a change was implemented with regards to the stages. The first stage was replicated, as previously described, but on the following re-reading of the transcript, the researcher chose to then identify tentative emergent themes. The remainder of the stages were then repeated, as described previously. Tables of the tentative emergent themes identified for each participant, with the relevant text extracts, are included in the confidential attachment and an abridged example (for Participant 4) is included in this research report (Appendix 10).

The researcher adhered to the recommendations by Smith et al. (2009) regarding working with larger samples for the group analysis stage. Therefore, the researcher refrained from identify individual super-ordinate and sub-themes for each participant, and instead shifted to identifying the main emergent themes for the group as a whole. This involved a creative thinking process, re-reading of and checking against the transcripts, with notes and diagrams recorded in the research diary. A preliminary table of super-ordinate themes, with sub-themes, for the group was subsequently produced (Appendix 11). In addition, a complete set of relevant text extracts from the transcripts was compiled for the super-

ordinate/sub-themes included in the preliminary table, to ensure these themes were appropriately and sufficiently evidenced in the data set. This information is available in the research diary and was verified by the researcher's principal supervisor, with the preliminary table of themes identified being verified by both supervisors.

During the process of writing up the analysis, the researcher's ideas developed further and consequently, some of the themes were collapsed, and a final master table of super-ordinate and sub-themes across cases was produced (see Table 2). This master table was also verified by both supervisors. The set of relevant text extracts from the transcripts compiled for the preliminary super-ordinate/sub-themes table was subsequently amended to verify that these updated themes were appropriately and sufficiently evidenced in the data set too. The final super-ordinate/sub-themes tables with relevant text extracts are provided in the confidential attachment.

ANALYSIS

Data from the interviews were analysed using IPA, as previously described. This section provides a description and analysis of the five main themes which emerged during the IPA process. These super-ordinate themes were 'coping with the problem', 'turning points', 'addressing the problem', 'appraising the experience positively' and 'time'. Sub-themes within the super-ordinate themes also emerged and these are described within the super-ordinate theme headings.

Table 2: Super-ordinate and sub-themes of men's experience of psychological change without psychotherapy

Super-ordinate themes	Sub-themes
<i>Coping with the problem</i>	Issues of control Being supported by others Distracting thoughts from the problem
<i>Turning points</i>	Threshold Becoming motivated to address the problem
<i>Addressing the problem</i>	Thinking Taking action
<i>Appraising the experience positively</i>	Learning from the experience Past self vs new enhanced self
<i>Time</i>	Change as a gradual process Sudden moments of change

Coping with the problem

This super-ordinate theme reflects the participants' experience of the problem (or problems) and what helped them to deal with it, as it was occurring. The subthemes of 'issues of

control', 'being supported by others' and 'distracting thoughts about the problem' were identified.

Issues of control

The majority of participants identified issues of control which were triggered by change being forced upon them by others (Pts. 2,3,4,5,7) and others trying to control them (Pt. 10). Additionally, one participant (Pt. 6) experienced a sense of a loss of control being in a new relationship. The emotional response of the participants to these issues of control varied from shock (Pts. 5,7) and anger (Pt. 2) to depression, with one individual (Pt. 8) even feeling suicidal at one point.

Furthermore, half of the participants reported a sense of powerlessness about their problem, with some participants expressing they felt helpless to address the problem initially, as the following extracts demonstrate:

'It..it...it made me ..it.. it disempowered me. It made me feel powerless yeah, I..I couldn't do anything, you know' (Pt. 2, L458-460)

'I wasn't looking at it, I wasn't trying to deal with it because I couldn't yet [...] erm so I was just letting it happen to me.[..]' (Pt. 4, L1641-1644)

'Then it f.. it was because I was financially dependent on them at the time, it was..it was one big..I kind of, well we'll put up with this just because we have no other choice at the moment [.....]' (Pt. 10, L996-999)

In contrast, one participant employed cognitive strategies to maintain a sense of control as he was experiencing the problem, which seemed to enable him to simultaneously cope with the problem and also address it, as he explains:

'And also er be...being a...man and being [..] someone who's trained in cognitive behavioural therapy, you know, I try to [..] keep my emotions managed [..] to make the situation more effective' (Pt. 9, L289-296)

Additionally, another individual only experienced issues of control as part of his threshold experience. This could be because prior to the threshold experience it seems he had not admitted to himself that he had a problem with alcohol:

'When I gave up, I don't think that I admitted I had a problem. I don't think I'd admitted to myself I'd got a problem' (Pt. 1, L555-556)

Distracting thoughts from the problem

In response to being asked what they did to deal with the problem at the time, most participants attempted to distract their focus of attention away from the problem, and thus avoid experiencing the associated undesirable thoughts and emotions. The participants used various distraction techniques which included substance abuse (Pt. 2), spending time with

others (Pt. 4,5), and computer-related activities (Pt.8, 10). Additionally, keeping busy was identified as a distraction technique as these extracts illustrate:

'it's..it's like, once the car is clean[..] Y..you can't just clean it every day and [..]..so all those sort of things that I did [..] really just to take my mind off...' (Pt. 7, L521-527)

'so I know that if I'm busy, then whatever the problem is, you know, I would still have plenty of time to think about it [..]. So to keep busy was important' (Pt. 9, L709-713).

It seems that coping with the problem was such a struggle for one individual that in addition to distracting his thoughts from the problem in various ways, he also attempted to avoid the reality of it altogether as he explains:

'[.....] but dealing with it at the time like I say it was just... er a lot of almost denial that it happened and just [...] just make it all go away, don't don't talk about it' (Pt. 5, L523-527)

Similarly, another participant also attempted to avoid the reality of his situation initially:

'Erm but still there is something inside me saying 'maybe if I do this' 'maybe if I do this' then something will happen then I'll get to be with her in the end anyway [..] and that was the process in..in the denial one [...]' (Pt. 3, L337-342)

Being supported by others

Nearly all the participants identified that they were assisted, to various degrees, in coping with the problem by receiving support from others. Some participants experienced support from the presence of friends, as illustrated by the following extracts:

'thinking of them [...] makes me feel emotional but only in..a very strong feeling of gratitude (pause) not that they did or needed to do a huge amount but then they were always there' (Pt. 9, L690-694)

'[.....] I have some good friends as well, so they were always around. It's good to spend time with them.' (Pt. 4, L730-732)

Other participants received support from a partner, or another person, who provided reassurance and positive encouragement, as these extracts demonstrate:

'she used to give us a lot of comfort, she would tell us, you know, everything would be alright and you know, you just have to handle it and stuff' (Pt.2, L257-259)

'erm (pause) I mean.. it helped to have kind of 'Y' there just to say just 'what's the worse that can happen, just kind of calm down' [...] erm and yeah and 'think it through' (Pt. 10, L485-487)

Furthermore, for several individuals talking to others about the problem was an important aspect of coping, even if this strategy was not effective in helping them overcome their problem, as illustrated here:-

'I had friends as well I mean I talked to my friends as well a lot. I talked obsessively with it but that didn't....at the time I thought was helping, but in my, my opinion is it didn't help me.' (Pt. 8, L679-681)

It is possible that talking was not helpful as in this case it appears to be a form of 'emotional venting' and thus an avoidance-orientated coping strategy (Lee, Su, & Yoshida, 2005).

Additionally, some participants identified knowing others had experienced a similar problem as being supportive:

'Erm and I think knowing that she had problems in the past relationship where she used to bottle a lot of things up [...] erm it made me feel, you know I that I could talk about them without actually having to be embarrassed or you know shy about it' (Pt. 6, L786-790)

Rather than receiving support from others, one individual coped with his problem by being supportive of others, particularly his mother, in his attempt to distract himself from the reality of his father's death as he explains:

'Because it's er (pause) the first couple of years it was .. spending time with me Mum, taking my mind away from it' (Pt. 5, L749-751)

Paradoxically, several of the participants who identified being supported by others as important in their coping also identified self-reliance and stoicism as elements of their change experience, which could be related to masculine socialisation and their masculine identity:

'I'm...I'm..I'm the sort of person who.. who..who wouldn't talk to anybody about anything [...] try and solve my own problems, you know.' (Pt. 2, L731-735)

'erm and (pause) yeah it..I just..I had to rely on myself [...] for everything then and it just.. that stress, I suppose' (Pt. 4, L436-438)

Turning Points

The majority of the participants described the occurrence of a shift (*or shifts*) as part of their experience. Hence, the super-ordinate theme 'turning points' was identified, in addition to the sub-themes of 'threshold' and 'becoming motivated to address the problem'.

Threshold

Five of the participants appeared to experience a type of threshold as part of their change experience. In general, the thresholds described by interviewees seemed to encompass a gradual build up over time of some emotional discomfort, followed by a psychological and

emotional (and in some cases physical) limit being reached, or even exceeded, as illustrated by the following extracts:

'I'm always, always looking for that praise erm and I get frustrated that I don't get it from home so I'd be, you know, I'd really have a go at her and it was, it was just getting too much you know [.....]' (Pt. 6, L977-979).

'At that point it become .. it was very much a point where I said 'OK look I need to I..I. I just need to break away from kind of communications and all of this stress just for a period of time just because it's becoming far too much [..]' (Pt. 10, L81-84)

Nevertheless, the threshold experienced by one of the individual's differed. This participant did not perceive he had an alcohol problem prior to the threshold experience, as previously mentioned, and therefore he did not experience a gradual build up over time of any discomfort. However, his threshold experience did involve extreme physical discomfort, issues of control and strong undesirable emotion (fear), albeit briefly, as he explains:

'[...] I couldn't get my breath [..] and everything was going dark and I couldn't breathe and I was choking and then I couldn't see, and then I woke up again [...]' (Pt. 1, L339-342)

Furthermore, it appears that although there was an absence of a gradual build up of discomfort over time, physical limits were exceeded as part of his threshold experience:

'corpuscles [...] had like burst in my face through the strain erm and I couldn't see very well. The bright lights really affected me. .. had to keep my eyes shut or wear sun glasses for four days after' (Pt. 1, L347-351)

Additionally, some participants' experienced strong undesirable emotions including fear, frustration, and anger as part of their threshold experience, and this was closely associated with becoming motivated to address the problem (*addressed further in the next sub-theme*). In contrast, for one of the individuals, extreme fatigue was associated with his threshold experience, as the following extract illustrates:

'The exhaustion was just..there was..there was too much going on in my head and there was too much going on you know, I'd have to be there then there then there then there then there.' (Pt. 4, L397-399)

However, for another participant threshold was important in his change experience for different reasons, such that he was motivated to try and avoid reaching a threshold, as he explains:

'It's just what...what does "John" (referring to himself) do? [...] to a.. fill his time, coz I've always had a very low boredom threshold so [...] it would just drive me round the bend being at home' (Pt. 7, 431-436)

Becoming motivated to address the problem

Many of the participants experienced their turning point as becoming motivated to address the problem. Following on from the previous sub-theme, some participants (Pts. 1,3,6,10) experienced both a threshold and becoming motivated, as mentioned previously, although some interviewees (Pts. 5,7,8) became motivated to address the problem without experiencing a threshold.

However, all the participants who experienced becoming motivated to address the problem reported experiencing insights associated with this theme and importantly, these insights, or shifts in perspective preceded becoming motivated, as illustrated by the following extracts:

'I just realised that if I didn't stop [...]...I was going to die... [...]' (Pt. 1, L575-577)

'Erm and then there was the period before I made the decision to do that but it..it did take a while to kind of open my eyes to that' (Pt. 10, L1125-1127)

In addition, for some individuals the insights they experienced were facilitated by other people, as this extract demonstrates:

'never want to be like that, but I think with her pointing it out to me, because she does point it out to me, I start to think 'oh yeah, I'm like that' erm and it..it lead to, I so..sort of sat with her and said 'how can I get over it?' [.....]' (Pt. 6, L89-92)

Moreover, some participants (Pts. 1,3,6,10) appeared to identify undesirable emotions in connection with becoming motivated to varying degrees of magnitude, (with the stronger the emotion, the more motivated they seemed to be) which might explain the absence of a motivation theme in the fatigued participant (Pt. 4). This may suggest therefore, that their desire to address the problem could have been triggered by these emotions:

'erm feeling [...] very heated, very energetic, [...] very aggressive [...] not towards someone but just, that's the way you use it..you've just gotta go full on' (Pt. 3, L419-426)

In contrast, one participant seemed to be motivated not only by intrinsic factors, as mentioned previously, but also by extrinsic factors which the following extract illustrates:

'So I..I could have just left the bank and just been down and depressed and miserable but [...] then you don't want to take that into a new job [...] it's...it's a new thing. You want to impress your employer and all that [...]' (LPt. 7, 1050-1055)

Following on from the above, some individuals were motivated by others to address the problem:

'Erm and that my Mum started to say 'You need to go out, you need to...' so she was pushing me away and it was .. then starting work and meeting new friends and all and all of that helped [.....]' (Pt. 5, L601-604)

Furthermore, unlike the afore mentioned participants, one individual who experienced questionable resolution of his problem revealed in the interview that he was aware of the reasons for the relationship break-up from the beginning and yet he appeared to become highly motivated to find a more acceptable rationale:

'[...] The reason she gave me didn't make sense for me personally I thought, so I was reaching out to other people to try and find a solution and the same thing kept coming back.' (Pt. 8, L436-438).

Addressing the Problem

All the participants transitioned from coping with, or avoiding the problem, to addressing the problem and attempting to solve the problem in a variety of ways. Thus, 'addressing the problem' was identified as a super-ordinate theme, with the sub-themes of 'thinking' and 'taking action'.

Thinking

All the interviewees reported engaging in the process of thinking as an important aspect of their change experience as this participant explains:

'Erm I think it's just ... (pause) it's just almost taking yourself out of the situation and trying to look back into the situation'] (Pt.5, L617-619)

It also appeared that some of the individuals who engaged in the thinking process also seemed to experience a greater sense of control, as demonstrated in the following extracts:

'[.....] that was..that was sort of part of [...] the recovery, started bringing back to myself' (Pt.3, L279-282)

'[...] so, that was when I started thinking about these things more and trying to fit them into the context of sort of what my life was gonna be like in the future really..start getting used to things' (Pt.4, L517-525)

Furthermore, the participants employed a number of different thinking strategies as part of the change process. Over half the participants thought the problem through, or processed it, and this extract is an illustration of this:

'Ok this is.. maybe they'd mentioned in the message they were going ... er to attempt to come round and do something or and I just kind of (pause) thought through it and thought what's the worse that can happen?' (Pt. 10, L268-271)

Additionally, more than half the interviewees found putting the problem into perspective helped them to cope with and overcome their problem as the following extract reveals:

'I mean..I.. my sort of prevailing thoughts were 'it's not the end of the world. There are more..[.] 'there are people worse off than you'' (Pt. 4, L306-309)

Similarly, employing a positive focus of attention was identified as an important cognitive strategy in their change experience for some:-

'[.....] I knew at the end I..I would get my passport and everything would be alright you know [..]. I guess that er light at the end of the tunnel gave me hope and kept me going [.....]' (Pt. 2, L247-252)

'[.....] you can become...what we learnt as an emotional hoover [..] 'hi "John". how are you today?'. 'Oh my cat's died and it's raining..we went on holiday, I didn't feel well...[.]' and it sort of permeates to the whole office and everyone is down and miserable, or you can be positive' (Pt. 7, L1507-1514)

Even the individual who experienced questionable resolution, as mentioned previously, used positive thinking in his attempts to overcome the problem:

'[.....] I just decided that I would use it. I would try to use it ultimately as a positive experience' (Pt. 8, L842-845).

In contrast, another individual's cognitive strategy involved generating an explanation. This appeared to give his experience meaning which helped him to overcome his issue to a certain extent, as the following extract illustrates:

'hit the low points to realise what the high points are and (pause) that is my that is my mechanism now for dealing with a whole lot things and even looking back at (pause) my my Father's death it's still... I think it happened for a reason' (Pt. 5, L840-845)

Nevertheless, several participants struggled to overcome the problem on their own. Consequently, they received assistance from their partners to challenge their thinking as demonstrated by the following extract:-

'then look what she's wrote and thought well hold on a minute, when I look back at what I wrote, yeah she's right, she's right. I am doing that [...] or I don't need to be like that you know [.....]' (Pt.6, L1026-1030)

Furthermore, one individual who had kept his problem a secret, and finding the process of self-change incredibly difficult, actively sought help from an on-line support site on one occasion, which challenged his thinking:

'So er the..the..the person replied, just gave a very short advice saying 'think about what you may have done' er and that's, that's when I started thinking well, yeah it was really me who instigated it' (Pt. 3, L487-490)

For some participants, thinking was also employed to maintain the change they were able to implement in the long-term as illustrated below:

'[...] And how every time I thought of having a drink ..i just thought of those days coming down the stairs, that day coming down the stairs..' (Pt.1, L474-476)

'[...] now it's like I I sort of coach myself in my head [...]. I definitely, definitely think I, you know, I will stop and I will do what I was doing in the book, I'm now doing in my head [...]. (Pt. 6, L1491-1495)

Although thinking was an important aspect of addressing the problem for the participants which helped them to resolve their psychological distress, many individuals still expressed contradictory beliefs, or unresolved undesirable emotions, relating to the problem as the following quote demonstrates:

'So erm (pause) I kept getting told that you..you can't, you can't live your Father's life but ... still I feel to a degree I do' (Pt. 5. L361-363)

A possible explanation for these continuing contradictory beliefs or unresolved emotions is provided by Greenberg (2012), who states that 'much of the processing involved in the generation of emotional experience occurs independently of and prior to conscious thought' (p.697). Hence, it seems as though the participants who attempted self-help on purely a cognitive level at the exclusion of emotional processing, could have limited their level of resolution.

Taking action

All the interviewees identified taking action as important to their change experience, with some being more pro-active than others. The majority of participants implemented practical action steps to overcome their problems such as communicating with the relevant authorities to obtain a new passport (Pt.2), socialising and attempting to date again (Pt. 4), applying for a new job (Pt.7), and negotiating the use of a meeting room to enable the family to discuss their dilemma (Pt. 9).

Some participants implemented action steps that were not only practical, but also therapeutic. One individual, for example, appeared to devise his own behaviour therapy strategy to help him to overcome his alcohol addiction:

'[.....] I used to buy boat loads and boat loads and boat loa.. I'm talking loads and loads of [...] cheap lemonade which is basically carbonated water with a bit of citrus powder put in [...] do you know what I mean. I used to use it every time I wanted a drink [.....]. (Pt. 1, L769-776).

Similarly, another individual devised a strategy to proactively address his issues. He used journaling and sought help from his girlfriend to resolve his problems using this tool, as the following extract illustrates:

'[.....] 'If I got a diary and wrote things down that you could possibly read, would that help? Would you be more willing to er have a read of it and then you

could think of some answers and you could possibly write back?' [.....]
(Pt. 6, L857-860).

Although the above participant found the cognitive processes of reading and analysing his diary entries important in helping him resolve his issues, it seems the diary was additionally an emotional processing tool for him:

'I used to write things and say 'Look, I don't want you to reply to this, I just need, to just waffle' [..]. You can read it if you want, erm but I will just feel better for writing' (Pt. 6, L989-992)

With regards to his change experience, another individual also expressed the importance of sharing his problem with another person, in confidence, and seeking their help as he explains:

'I had to do it [..] because it was part of person, part of the condition that was still consuming me at that time [..] erm but once I'd spoken out, it felt a bit easier [....]'
(Pt. 3, L512-517)

In contrast to the participant who frequently received regular assistance from his girlfriend to overcome his problem over a period, the above individual (Pt. 3) communicated with his helper and received advice to challenge his thinking only once, as previously mentioned.

Another participant, who struggled to accept his relationship break-up at the time, also experienced a need to share his problem with others and sought their help:

'[.....] I mean I was trying to reach out, I was talking to people who knew her where I met her at the job [.....]' (Pt. 8, L406-407).

Communicating with others was an important element of addressing the problem for another participant too, as his problem was a group-related issue involving his family, as the following quote demonstrates:

'I think the..I think the th..the single biggest thing that allowed us to make a decision about my Dad being told about my Mum's dying, was this meeting' (Pt. 9, L926-928).

In addition to the aforementioned action, the process of making a decision was also important in addressing the problem for this individual, as he explains:

'But it..for me the decision wasn't made necessarily in that room [..]. It had been a process that had been going on for weeks coz we knew it was coming' (Pt. 9, L110-114).

Another interviewee implemented an iterative change process. Initially he took action to regain control by reducing contact with his parents to a minimum. He assessed this strategy over a period of time. He subsequently amended his strategy, following an insight

facilitated by his girlfriend, and seemed to implement a more solution-focused approach, as this extract demonstrates:

'we kind of talked about... well... we didn't so much focus on what the problems had been but it was more about 'OK, how are we gonna go forward erm' (Pt. 10, L790-792)

Appraising the experience positively

All the participants, with the exception of one individual (Pt. 5), perceived that on reflection, the problem experience was ultimately a positive one. Hence, 'appraising the experience positively' was identified as a super-ordinate theme, with sub-themes of 'learning from the experience' and 'past self vs new enhanced self'.

Learning from the experience

The majority of the interviewees perceived the experience as beneficial in that they generally learnt something from it, as the following extracts illustrate:

'I see it as a lesson, a lesson in life er (pause) just a very, very good lesson' (Pt. 3, L740-741)

'I hadn't figured any of that out until I'd experienced all of this' (Pt. 10, L1086-1087)

Some of the participants appeared to continue to apply the lessons they learnt from their experience, thus enabling them to benefit from it in the present and future as demonstrated by these extracts:

'[.....] I would always fly off the handle, where now it's like I I sort of coach myself in my head' (Pt. 6, L1490-1491)

'More richer in experience [...] so when you see other people's family dynamics and grief and about problem solving [...], there's something for you to sort of draw on' (Pt. 9, L1388-1393)

Furthermore, another individual gained insight about himself as a consequence of the change experience as he explains:

'[.....] so I've sort of realised how much I do rely on other people [...] in some ways and I've also realised that I have to rely on myself more for sort of emotional support and that sort of thing, sort of realising that that was underdeveloped in me' (Pt. 4, L1728-1731)

Several participants perceived that although their experiences were difficult or uncomfortable at the time, they were also necessary. One individual for example, perceived that exceeding his threshold was necessary with regard to him successfully overcoming his addiction to alcohol. However, although he initially attributed the experience to the amount of alcohol he had consumed, as he reflected in the interview he seemed to reject this

hypothesis in favour of a more spiritually determined one as the following extract illustrates:

'[.....] if there is a higher power out there [...] then it's erm (pause)..I. I..thank them for that because [...] the..the...although it was a cruel thing to put me through, the design of it was..it..it achieved it's goal [...] which was to get me to stop drinking' (Pt. 1, L940-947)

This seems to reflect the struggle of several participants to understand their own change processes during the experience. In addition, it is possible that generating this explanation may enable the aforementioned participant (Pt. 1) to accept the reality of his experience more easily. Furthermore, it is posited that individuals may be able to obtain positive feelings of control from the belief that a benevolent other is in control, particularly those who do not engage in strategies of self-control (Shapiro, Schwartz & Astin, 1996).

Following on from the above, another individual appeared to use a cognitive strategy to try and reach a place of acceptance about his experience, by re-framing it too, as demonstrated below:

'[.....] I mean to just put a positive spin on it erm the thing is one of the things I learnt, one of things I learnt from the er er the girl that I was seeing was that there is a very positive spin on it was that erm I realised that most people are just completely stupid about things [.....]' (Pt. 8, L938-943)

Nevertheless, learning from the experience was not identified as part of the change experience for several participants (Pt. 5, Pt.7). It is possible that for one individual (Pt. 5), learning did occur as a result of the problem experience, but this was simply not revealed in the interview. This could be because he attributes his change to life-span development principally, as the following extract illustrates:

'[.....] a..a at the time I think there was still a very young mind but a..a.. young mind that worked in the same way and looking for answers [..] and there were no answers and as you get older you you sometime you get get to the point where you accept well there is no answer for that [.....]' (Pt. 5, L965-971).

Alternatively, it might be because he experienced a bereavement shortly prior to the interview, which seemed to re-trigger the same emotions he experienced when his father died. Hence, he may have concluded he had not learnt from the experience, particularly regarding how to manage his emotions.

With regards to the other participant (Pt. 7), it seems that rather than learn from this experience, he applied lessons he had previously learnt throughout his professional and personal life to help him overcome his problem. He attended courses provided by the company to prepare him for the transition to retirement too. Learning as a sub-theme may have also been absent from his interview because of the fact he was able to minimise the

situational change by maintaining continuity in regards to his extra-curricular activities and his subsequent new job:

'erm my job here is Marketing and New Business manager which involves doing the same networking events I did in the bank [...] and more [...] so I've still got the same peer group of business colleagues and friends [...] so that's..that's carried on' (L848-855).

Past self vs new enhanced self

The positive perception of the experience also included a positive change to their identity for the majority of interviewees. More than half of the participants indicated that overcoming the problem had made them stronger and made them more self-reliant, thus providing them with an improved sense of agency as demonstrated by the following extract:

'It's..it's just (pause) it's just another you know, another hardening process. It's something that makes me even..even more hard and more.. I think more more resilient to..to future problems' (L554-557).

Five of the ten participants reported that they perceived they had become more mature as a consequence of their experience, as illustrated in the extracts below:

'but yeah, whereas at the time I thought I was maybe a bit silly the way I was thinking about things and [...] sort of...I feel like I've matured as a result erm [...]'
(Pt. 4, L1674-1677)

'er and I feel...I feel also... perhaps I grew a little bit in being one of the youngest in the family coz erm in your sibling and parental relationships, you're still a child to your parents [...] and I'm still the younger brother, you know [...] with older sisters and I suppose that was er me being more of a, you know, a bit more 'adulty''
(Pt. 9, L1304-1312).

However, several individuals experienced an increase in maturity as they were experiencing the problem too:

'Erm which I think in itself, just writing down, the having the book idea, I think that was a big, big step for me. I think that was a mature thing to do [...]' (Pt. 6, L1363-1365).

Similarly, another participant felt he increased in maturity as he was experiencing the problem, once he had obtained employment and was living independently. Consequently, his self-confidence increased and he became motivated to implement the first of his change iterations as he explains:

'The first stage was really kind of OK we're now, financial.. I'm now comfortable and have more confidence t..to kind of take care of myself and take care of [...] me

and 'Y', erm and that's when I said ok right, let's deal with this [.....]' (Pt. 10, L1036-1041).

Several other participants experienced an increase in self-confidence as a consequence of overcoming their problem as the following extract demonstrates:

'and I'm also more confident as well when I go out knowing that I can enjoy myself without having to have a drink' (Pt. 1, L839-840)

This participant appeared to experience the greatest personal transformation and had the strongest negative evaluation regarding his past self compared to his present self too:

'You've got a drunk blithering idiot here and somebody's who's going to university to get a degree here' (L859-860).

In contrast, another individual identified elements of an enhanced self but this appeared to be a minor theme for him. The qualities he identified were very different to those previously mentioned by the other participants. Instead, he reported the following:

'and actually being positive, it was probably the best thing that could ever have happened to me [...] erm everyone I speak to says I look less stressed, I seem to be happier and more relaxed' (Pt. 7, L1307-1311)

This difference could be attributed to the fact that he maintained as much continuity as possible during and after the experience, and perhaps because of his age or life experience, as mentioned previously. Alternatively, it could be a reflection of his tendency in the interview to avoid discussing his intrapsychic experiences, preferring to focus on situational or external factors instead.

Similarly, although another individual reported during the interview:-

'[...] I feel inside myself a better person from it in different ways' (Pt. 8, L1386)

his words prior to the above comment are more revealing and perhaps provide greater evidence to suggest that he perceives the problem has had a detrimental impact on his identity, as the following demonstrates:

'Yeah, I'm more, I'm more morose now. I'm more, I'm more negative I'm I'm actually not as nice a person as I used to be and that's a horrible thing to say but it's changed me in a way that I never would have thought I would be changed' (Pt. 8, L1357-1360).

Again, the previously mentioned positive appraisal might be another example of this participant's attempts to employ a cognitive strategy to try and reach a place of acceptance about his experience. Alternatively, perhaps the latter appraisal is a reflection of his unresolved grief or depression relating to the death of his sister that occurred less than six months prior to our interview, which he did not mention until the interview was occurring.

Although all the other participants identified that the experience had had a positive impact on them, albeit to varying levels, one individual (Pt. 5) seemed conflicted regarding his perception of the problem experience. Although he recognised that change had occurred, particularly causing him to mature rapidly, this is not necessarily perceived positively, rather it particularly impacted him negatively in regards to his emotion-regulation, as the following extract demonstrates:

'And probably made me erm (pause) more emotionally unstable should I say erm (pause) [...]' (Pt. 5, L1084-1085)

Nevertheless, he also seemed to identify an enhanced self, although it is unclear whether this was attributed to overcoming the problem or general life-span development, as previously mentioned:

'Erm because now I believe that I've got more skills to deal with that [...] than I had the time' (Pt. 5, L1055-1058)

Akin to participant eight, participant five had also experienced a recent bereavement which was not disclosed prior to the interview. He reported in the interview that the experience re-triggered the emotions he experienced relating to his father's death. Hence, it is possible that the conflict in appraisal of the experience could be influenced by the grief he was experiencing at the time of the interview.

Time

Time was a significant feature of the change experience for all ten participants and therefore 'time' was identified as a super-ordinate theme. Additionally, two sub-themes were identified, 'change as a gradual process' and 'sudden moments of change'.

Change as a gradual process

All the interviewees described experiencing a gradual process of change, to varying degrees. It seems, for example, that it took the majority of participants a significant amount of time to overcome their problem, as illustrated by the following extract:

'And it's like, I feel I got over that myself, and it was OK it was over year and half, a two year period [...] of..of writing in that book [...] erm, so it was definitely a long term thing of getting over it' (Pt. 6, L1226-1231)

One individual experienced some change a number of years following his father's death which enabled him to experience a degree of resolution, as previously explained. It appeared the belief that 'everything's happened for a reason', which enabled him to experience further resolution, was formulated over a much greater period of time though:

'Erm not until, not for a long time after the event, a long long time after the event. Probably erm that happened twenty-five years ago and it probably took fifteen years plus ..[...] before erm I'd gone through various stages in my life to realise that actually that you know that's happened because of that and starting trying to connect to things [.....]' (Pt. 5, L941-949)

Some participants expressed their gradual change in terms of a number of distinct sequential steps, which seemed to be associated with increasing degrees of responsibility and self-awareness, as the following extract demonstrates:

'and er (pause) it took me a while to get over that period after the denial and after the..and after the er taking care of myself then (pause) the third step was to start thinking of 'what were the mistakes that I made?' (Pt. 3, L262-265).

These sequential steps were an important part of the change process for another individual, as they enabled him to assess the initial change he implemented over time and regain a sense of control. It was only when he concluded he was ready, and in addition to prompting by his partner, that he implemented the second change iteration, as he explains:

'Erm (pause) I was very nervous about it ...f..feeling that it would just back to the old ways quite easily [...] which is why it was kind of better to have it as kind of a step process' (Pt. 10, L607-611)

Time was also perceived by participant eight as important to his change experience:

'Even with time basically, it happens as it happens as the flow of life within the realms of your existence and no matter how you try to force your recovery as a patient.as a self psychotherapist patient, or however I can describe it [...] self therapy, no matter how much you try to for force it by a thousand mile an hour fall

to try and resolve something you can never do that. It's nature that resolves the solution [...]' (Pt. 8, L1595-1602).

However, this seems to reflect a sense of powerlessness. Hence, although it could be an example of natural resolution of a problem over time, a deeper interpretation is that he is intellectualising and thus it is perhaps more a reflection of his questionable resolution, as revealed in the interview.

Experiencing a gradual process of change was also demonstrated with regards to the participants' experiences of becoming motivated following an insight and the amount of time differed between participants. A number of interviewees appeared to experience a brief time lapse between experiencing an insight and becoming motivated to address the problem, as this extract illustrates:

'[.....]. We are where we are. Banks not gonna change it's mind [...] so the only thing is to move on' (Pt. 7, L1529-1531)

Alternatively, a greater period of time lapsed between insight and becoming motivated for others, as the following quotes demonstrate:

'Er, but from the..from the realisation it's probably six months to a year before it had actually, that's it it's time to move on' (Pt. 5, L743-747)

'I think it took... it..er..it took a wh.. a kind of a while or a number of kind of years to at that start of university t..to realise what this is why I'm feeling..this is what's..what's going on here, this is why things are stressful, this is why I'm anxious when we're going home because of the control and the time constraints [..]'
(Pt. 10, 1115-1120).

Sudden moments of change

In addition to experiencing a gradual process of change over time, a number of interviewees also described sudden moments of change which were important to their change experience.

A number of participants described sudden and important decisions that they made during the change process as illustrated by these extracts:

'So I thought this (smoking marijuana) is not a good idea, stop... I stopped doing that' (Pt. 2, L125-126)

'I think at the time I decided to stop there was a realisation that it couldn't continue'
(Pt. 1, L531-532)

'And that's made a big difference. The moment we decided to move into our own place I felt my whol..you know, my life was more mature.' (Pt. 6, 1416-1419)

Some individuals also appeared to experience almost instantaneous amelioration of the problem:

'You know, as so...as soon as I got my passport, I felt, you know, I felt you know, I...I..I felt empowered. I felt I could do something now' (Pt. 2, L428-430)

'and I remember the feeling I had after watching that and [...] I just felt ok with the whole thing.' (Pt. 4, L883-886)

'yes, I think that erm..I suppose as soon as I started working here [...] I pretty much got over it...pretty much completely [.....]' (Pt. 7, L1219-1221)

In contrast, several participants seemed to describe both a gradual process of change and sudden moments of change. Participant one for example, when asked about the speed of the change, he described it as 'instantaneous'. However, a closer analysis revealed that although he was describing the decision to stop drinking as instantaneous, this was actually preceded by the threshold experience which lasted a number of hours, and this was subsequently followed by several days of processing the threshold experience.

Additionally, another individual seemed to describe the experience of change as a sudden moment:

'And er it was erm it was good when we made the decision I feel.. I felt better about it then' (Pt. 9, L410-411)

But he also appeared to describe the decision making process as a gradual process of change:

'But it..for me the decision wasn't made necessarily in that room [..]. It had been a process that had been going on for weeks coz we knew it was coming' (Pt. 9, L110-114)

Similarly, another participant described aspects of the change process he experienced as both a gradual process and a sudden moment, as the following extract demonstrates:

'Erm So it did take...it did take a while to kind of to come to that point. [.....]' (Pt. 10, L1140-1141)

DISCUSSION

In recent years, there has been a call for research into the experience of change with individuals who have not undergone psychotherapy or counselling in order to enhance knowledge of the change process and create or improve therapies that facilitate psychological change (Gianakis & Carey, 2008). This study replicates one such previous study (Gianakis & Carey, 2011). However, the previously mentioned study, carried out in Australia, only included female participants. Similarly, Higginson and Mansell's (2008) study into psychological change involved six participants, of which only one was male. Additionally, some of the participants had experienced therapy previously. Hence, the purpose of this study was to provide an analysis of the male experience of psychological change without psychotherapy, and to consider these experiences in light of the previous research, by interviewing ten men who had no prior experience of psychotherapy and counselling, who perceived they had successfully resolved an issue. These individuals provided substantial reports regarding a variety of problems, ranging from interpersonal issues to redundancy.

The main themes that emerged following the IPA analysis were coping with the problem; turning points; addressing the problem; appraising the experience positively and time. Each of these super-ordinate themes encompassed a number of sub-themes. Initially, most participants felt powerless to address their problem and coped with this undesirable emotion by distracting their thoughts from the problem. They also received a degree of support from others which assisted their coping. The majority of the men subsequently experienced turning points, whereby they became motivated and ready to address their problem. A period of tackling the problem followed, during which time they implemented

cognitive and action-orientated problem solving strategies to resolve their issues. Overcoming the problem was experienced by the participants as a gradual process. However, some also reported sudden moments of change. Furthermore, participants' appraisal of the experience was positive such that they perceived they had learnt from the experience and that it had generally changed them for the better. The findings from this study will now be discussed in the context of the relevant literature.

Coping with the problem

Coping is deemed to be important with regard to experiencing and treating emotional and psychological problems (Lazarus & Folkman, 1984). Participants of this study identified the theme of loss of control, in addition to the themes of distracting thoughts from the problem and being supported by others in regards to their attempts at dealing with their distress.

Issues of control

Shapiro, Astin, Shapiro, Robitshek, and Shapiro (2011) state that frequently it is 'the unknown and unpredictable in life...that engender feelings of lack of control' (p.16). This was reflected in the participants' accounts of the current study and is consistent with the findings reported by Higginson and Mansell (2008). Additionally, the majority of the current study's participants responded to this loss or lack of control by feeling powerless or helpless, which is also consistent with Higginson and Mansell's (2008) findings. Furthermore, this powerlessness and initial passive response to the loss of control has been described as a 'negative yielding mode of control' by Shapiro et al. (1996). This is in contrast to what they describe as a 'positive assertive mode of control', also referred to as a

'fighting-spirit mode' (Shapiro et al., 1996; p1218) control response. However, although the later mode did not feature in participants' accounts of coping, it seemed to be encompassed within the turning point theme.

This initial inaction response as a consequence of the feelings of powerlessness and helplessness is also accounted for in the literature by the theory of learned helplessness (Seligman, 1975). Their response may also have been compounded by the fact that these feelings of helplessness and loss of power, according to Mahalik et al. (2003), might be threatening for men, due to masculine socialisation.

Distracting thoughts from the problem

The interviewees of the current study employed an avoidant coping strategy initially, that of self-distraction, as a method of experiential or emotional avoidance relating to the issue of control. This is referred to by Shapiro et al. (1996) as an aspect of the 'negative yielding mode' of control-related coping strategies mentioned previously. The theme of distracting thoughts from the problem was manifested to some degree in the theme identified by Higginson and Mansell (2008) of 'avoiding the problem to facing the problem'. It has been reported that this avoidance of experience is a 'maladaptive emotional coping strategy' (Higginson & Mansell, 2008; p323).

The process of experiential avoidance is also acknowledged by a broad range of theoretical frameworks (Hayes, Strosahl & Wilson, 1999). Hayes et al. (1999) reported that experiential avoidance 'has been implicitly or explicitly recognised in most systems of therapy' (p58). This particular form of avoidance is strongly associated with

psychopathology in general (Higginson & Mansell, 2008; p323). Moreover, there is empirical evidence which demonstrates that experiential avoidance is more frequently a male response than a female response. With regards to depression, for example, a greater number of males than females report carrying out an activity to distract themselves from thinking about their depression (Magovcevic & Addis, 2008; p118).

Furthermore, Taylor, Klein, Lewis, Gruenwald, Gurung, and Updegraff (2000) reported that males and females respond to stress differently, such that the traditional response to stress, 'flight or fight', is principally a male response to stress compared to what they describe as the female response of 'tend-and-befriend' (p411). The 'flight' response to stress referred to by Taylor et al. (2000) also seemed to be demonstrated by the participants of the current study by this thought distraction avoidance activity, which is consistent with White's (2009) investigation regarding men's reluctance to engage in counselling.

The response to stress documented in the current study could perhaps be attributed to masculine socialisation because as Levant (1996) reported, males 'learn to tune out, suppress and channel their emotions' (p262). Similarly, Iwamoto, Liao, and Liu (2010) suggested that males who subscribe to the norms of masculinity (including being self-reliant and maintaining emotional control) might deal with uncomfortable emotions by employing an avoidance activity, because this might be 'in concert with their conceptualisation of what it means to be a man' (p16).

Being supported by others

It is generally agreed that a common coping strategy reported in leading theories relating to stress, emotion, and coping is that of social support (McDonough, Sabiston, & Crocker, 2008). As Lampropoulos and Spengler (2005) state 'most people at some point in their life have experienced the helping aspects of friendship' which they say might 'lessen the need for professional help' (p49). Nevertheless, males are socialised to be stoic, independent, and physically strong (Magovcevic & Addis, 2008) which could dissuade them from benefitting from social support. However, the male interviewees of the current study did identify receiving support from others as a helpful coping resource in regards to dealing with their issue. This is consistent with White (2009) who found that men who had overcome a problem without therapy 'appeared to privately (at least) acknowledge and share their problems with others' (p.5).

Other research into change without psychotherapy also identified social support as important with regard to the change process including Heatherton and Nichols (1994) and Banyard and Williams (2007), although the latter focused solely on women's experience of recovery. This was also consistent with Carey et al.'s (2007) investigation into psychological change but within the context of psychotherapy. Similarly, Gianakis and Carey (2011) reported 'connection' as significant regarding the process of change in their study.

The participants of the study benefitted in their coping by support from others, but they did not report a motivation to change that was related to a 'connection with others' or a 'disconnection' from others, in contrast to previous studies (Gianakis & Carey, 2011;

Banyard & Williams, 2007). Similarly, participants of this investigation did not report the involvement of important others in relation to critical events that lead to change, unlike previous investigations (Gianakis & Carey, 2011; Heatherton & Nichols, 1994). These differences in support-related coping featured in the accounts of the men in the current study could also perhaps be attributed to male socialisation. It has been posited, for example, that for males, being reliant 'on the connection with an 'other' to get them through, is less of an option and actually associated with weakness and shame' (Wexler, 2009; p25).

Turning Points

The majority of participants in the current study identified the importance of a turning point in their change experience. The accounts documented by participants of the Banyard and Williams (2007) investigation also included reports of 'turning points' as being important to their change experience (p286). Furthermore, it seems that the interviewees in the current study experienced what Laub and Sampson (1993) referred to as both 'negative turning points' and 'positive turning points' (p317). The negative turning points appear to transpose in this study to the threshold experience and the positive turning points to becoming motivated to address the problem.

Threshold

The theme of 'threshold' was identified as a significant aspect of the change experience for five out of ten participants of the current study. The threshold experience involved reaching, or exceeding, a psychological or emotional limit which then initiated change. This finding is consistent with Gianakis and Carey (2011), whose study's most important contribution regarding the change process was this threshold concept. Similarly, a threshold

experience was documented by Miller (2004), who investigated quantum change, with some of his storytellers reporting that 'their pain had become so great that something had to give' (p458). Additionally, Heatherton and Nichols (1994) reported participants documented 'an increase in disturbance' which involved 'intense and enduring negative affect' prior to experiencing a transformation (p672). This period of disturbance is referred to in some instances as a 'crystallisation of discontent' (Baumeister, 1994; cited in Heatherton & Nichols, 1994; p672). This 'crystallisation of discontent' has been linked to an increasing impetus to change (Heatherton & Nichols, 1994) and the results of the current study are in accordance with this previous finding.

Nevertheless, the 'crystallisation of discontent' reportedly involves the process of a cost-benefit analysis (Heatherton & Nichols, 1994; p665) which was not identified in the current study or in the Gianakis and Carey (2011) investigation. Threshold was not identified as a theme in Carey et al.'s (2007) investigation into psychological change in a psychotherapeutic context, which involved 27 participants, of which nine were men. However, it was documented that some participants in the study reported reaching 'rock bottom', within the theme of 'motivation and readiness' (Carey et al., 2007; p182).

Gianakis and Carey's (2011) super-ordinate 'threshold' theme included the sub-theme of 'strong emotions'. Although the participants of the current study reported experiencing emotions relating to their threshold experience, to varying degrees, a 'strong emotions' sub-theme was not identified. It is possible that the difference in the depth of emotion associated with the thresholds experienced by the male participants of the current study

may be attributed to masculine socialisation and the fact that men are socialised to 'surmount their feelings' (Meth, Pasick, Gordon, Allen, Feldman, & Gordon, 1990; p63).

Becoming motivated to address the problem

Forbes (2011) stated that behaviour is principally driven by motivation. Motivation is perceived as an essential aspect of the whole process of change according to DiClemente, Schlundt, and Gemmell (2004). Motivation was identified as an important aspect of the process of change for the majority of participants in the current investigation. Participants described a period of having been coping with the problem and then experiencing a shift, or turning point, when they subsequently became motivated to address the problem.

This theme of becoming motivated to address the problem echoes Gianakis and Carey's (2011) theme of a desire for change. In addition, Heatherton and Nichol's (1994) accounts of successful change included a desire to change. Carey et al (2007) documented in their investigation into change within psychotherapy, that motivation (and readiness) is a pre-requisite for change to occur too.

Additionally, the current study's participants who became motivated to address the problem identified that their motivational shift was preceded by a new awareness, perspective shift, or insight. Higginson and Mansell (2008) also documented that the participants of their study experienced realisations or insights as part of their change process, within the theme of 'avoiding the problem giving way to facing the problem' and the authors refer to the importance of insight in relation to psychotherapeutic change (Higginson & Mansell, 2008; p24). Gianakis and Carey (2011) similarly reported that the process of change experienced

by their participants encompassed a desire for change (and a threshold), as mentioned, in addition to insight. Nevertheless, in contrast to the participants in the current study, insight followed the desire for change/threshold for the participants in the Gianakis and Carey's (2011) study.

Threshold, motivation and insight in relation to the change process

Following on from the above, previous researchers have documented both threshold and motivation in relation to the change process, such that Heatherton and Nichols (1994) reported in their study that threshold was linked to an increasing impetus to change, for example. Similarly, participants in the Gianakis and Carey (2011) investigation also reported both a desire for change and a threshold regarding their change experience. The results of the current study appeared to be in accordance with this finding, such that four of the five participants who experienced a threshold also identified becoming motivated to change in their recovery.

However, in the current investigation, only some participants experienced a threshold whereas the majority experienced becoming motivated to address the problem. In other words, in contrast to Gianakis and Carey's (2011) study, some individuals in the current study became motivated to change without experiencing a threshold first. Hence, in contrast to the participants in Gianakis and Carey's (2011) investigation, it could be suggested that for the participants in this study, becoming motivated was a greater contributor to their process of change than experiencing a threshold. This finding seems to add further support to the notion that motivation is an essential part of the change process (DiClemente et al., 2004), as mentioned previously.

Furthermore, it could be concluded that for the participants of the current study, a new awareness, or insight, appeared to be a pre-requisite of becoming motivated to change. Moreover, it seemed that for the majority of the participants of the current investigation, insight and motivation were necessary for change to occur. Consequently, there are clinical implications relating to the importance of motivation regarding the change process, particularly the finding that insight preceded becoming motivated, and these will be discussed further in the contribution and clinical implications section (see p194).

Addressing the problem

Another important aspect of the change process for the participants of this study was addressing the problem, which as Folkman and Lazarus (1998) reported, enables individuals to start to 'feel better when they turn to the problem that is causing them distress' (p473). Addressing the problem involved the cognitive process of thinking and the behavioural process of taking action.

Thinking

The cognitive process of thinking was a prominent feature of the recovery process for the participants in this study, with all ten participants demonstrating a thinking process was involved in their attempts to recover from their problem. 'A process of thinking' was also documented, even though it featured less prominently, in the accounts of the participants in Gianakis and Carey (2011). A thinking process was not identified as a theme in Higginson and Mansell's (2008) study, but it would appear that the process of thinking was involved in the theme 'avoiding the problem to facing the problem' (p318-319). Thinking did feature in

the accounts of the Higginson and Mansell's (2008) participants following recovery, regarding the super-ordinate theme 'putting the problem into perspective', and the sub-theme of 'rational perspective'. In contrast, putting the problem into perspective was reported by several of the participants of the current study as an aspect of the cognitive processing strategy that many employed to proactively resolve their problem.

A thinking process was also reported in the change experience in the studies into change within a psychotherapy context (Carey et al., 2007; Clark et al., 2004). It was deemed very important in the latter research into CBT for depression, which is unsurprising given the characteristics of CBT. Cochran and Rabinowitz (1996) have documented 'positive aspects of masculinity' which include 'the ability to think logically and solve problems' (p598). Additionally, with regards to coping mentioned previously, Courtenay (2005) reported that 'intellectual, logical and rational approaches are highly valued coping mechanisms among men' (p. 44). Furthermore, as Good and Robertson (2010) indicated, the majority of men 'are socialized to approach problems cognitively' (p311). It is perhaps for this reason that thinking featured more prominently in the men's accounts of natural change in this study in comparison to previous research into change without psychotherapy mentioned previously.

Taking action

Another prominent feature of the recovery process for all except one of the interviewees in the current study was the prolific use of behavioural strategies in their change process. Similarly, Carey et al.'s (2007) participants reported that what was important in their process of change, albeit in a psychotherapeutic context, was playing 'an active role' and using 'tools and strategies' in addition to moving further than thinking about the issue

(p183). The theme of 'taking action' seems consistent with the sub-theme documented by Clark et al. (2004) regarding 'testing things out', which included clients practicing 'active approaches to problem solution' (p77).

Taking action featured to some extent in the Heatherton and Nichols (1994) study too, in the theme 'methods of change' with a change in environment documented as the predominant method reported in the accounts of successful change. Taking action also appears to have been expressed, though to a minor extent, in the sub-theme of 'agency/action', but within the super-ordinate theme of 'desire for change' in Gianakis and Carey (2011). However, this theme did not feature in the Higginson and Mansell (2008) study, nor in the Banyard and Williams (2007) investigation into women's recovery of sexual abuse.

A possible explanation for the prominence of proactive behavioural strategies in the change process employed by the participants of the current study could be attributed to gender differences. That is, it is generally reported in the literature that males 'prefer doing over being' (Wexler, 2009; p57). It has also been reported with regards to coping mechanisms, referred to previously, that compared to women, men also undertake a greater amount of 'action-orientated, problem-solving' coping (Courtenay, 2005; p44). This is important because, as Courtenay (2005) stated, an action-orientated, problem-solving style can not only help men to cope with their problems, but it can assist men in the process of overcoming their problems too.

Appraising the experience positively

People seek to discover meaning about an event and it is this meaning regarding the situation which 'is an important key to understanding reactions to stress' (Thompson, 1981; p99). The meaning attributed to a problem can even be positive, because as Higginson and Mansell (2008) stated, 'there is personal gain to be found in suffering' (p324). Experiencing personal gain following a problem has been identified in the literature, as post-traumatic growth (Joseph & Linley, 2006) for example. The findings of this study seem consistent with this, as demonstrated in the theme concerning the participants' positive appraisals of the problem experience. Reflecting on the problem experience, the majority of the interviewees in the present investigation identified learning from it and experiencing positive changes in identity. Positive appraisal of experience was also featured in the Higginson and Mansell (2008) study, although it featured less prominently as a sub-theme of the super-ordinate theme 'putting the problem into perspective'.

Learning from the experience

Increased knowledge about the self or about life was reported by the majority of individuals in this study and identified as an important aspect of the change process. Nevertheless, learning from the experience was not identified in the investigation into naturally-occurring change by Gianakis and Carey (2011). Although learning from the experience was not identified as a theme in the Carey et al. (2007) study into psychotherapeutic change, it was documented in the study that 'a number of participants identified learning as a necessary part of the change process' (p182). Similarly, this theme was expressed to some degree in the study by Higginson and Mansell (2008) within the sub-theme of 'acceptance and positive appraisal of experience', with participants reporting 'a sense of achievement and

accomplishment' with regards to successful recovery (p322). Increased self-knowledge was also reported by Higginson and Mansell's (2008) participants. A high percentage of the successful change accounts reported by Heatherton and Nichols (1994) included learning from the experience as part of their change process too, particularly an increase in 'self-knowledge and understanding' (p668). Learning was a feature of the Banyard and Williams (2007) research, as previously mentioned.

Empirical support regarding the importance of learning from the experience as part of the change process has also recently been provided by Triplett, Tedeschi, Cann, Calhoun, and Reeve (2012) concerning their research into posttraumatic growth. Their research results suggested that by 'trying to make sense of a traumatic experience, and achieving some understanding, people may come to recognise the positive impact that wrestling with the experience has had on them' (p408). Linley and Joseph (2003) referred to reports of posttraumatic growth, which include individual's interpretation of their traumatic experience as 'a valued learning opportunity' (p135) following the event. Additionally, it has been posited that 'when people feel that they have a sense of understanding for events, they feel more control in dealing with those events' (Harvey, 2001; p844). Therefore, it seems that interpreting 'major losses as valued learning experiences' could be an aspect of or related to 'effective adaptation over time' (Harvey, 2001; p850). It could be suggested that this may apply equally with regards to the insights experienced during the problem and to the lessons gained, or new understanding gained, as a result of the experience.

Past self vs new enhanced self

Following on from the above, almost all of the participants in the current study experienced a positive change in their identity to some extent. The participant who experienced the most dramatic threshold experience (Pt. 1), also appeared to experience the greatest positive personal transformation. This seems consistent with Miller's (2004) investigation regarding quantum change, such that participants reported experiencing a 'dramatic change', with the greatest changes concerning 'their identity, their fundamental perceptions of self and reality' (Miller, p458). In comparison, the other participants in the current study seemed to experience more conservative positive changes in identity. The participant who appeared to have the most questionable resolution (Pt. 8), however, reported mostly negative changes to the self, in addition to minor positive changes, as a consequence of the experience.

This positive appraisal of identity change following adversity was also expressed in the Higginson and Mansell (2008) study in the theme 'new versus old self', with participants reporting changes in identity that were perceived positively. This theme found a degree of expression in the study by Heatherton and Nichols (1994) in the accounts of successful change which included 'a new sense of identity' (p664). This theme regarding a positive identity change was not expressed in the participant accounts in Carey et al. (2007) or in the Gianakis and Carey (2011) investigation, although 'moving towards a new identity' was identified in the latter study.

There is empirical support for positive identity change following adversity provided by the literature on posttraumatic, or adversarial, growth, as mentioned previously. Linley and Joseph (2003) for example, reported that with regards to the positive changes found in

individuals following trauma, these can include believing that they have increased wisdom or that they do more for others. It can also include perceiving they 'have a greater sense of personal resilience and strength' (Linley & Joseph, 2003; p135). These findings appear to be born out in the current investigation as more than half of the participants indicated that overcoming the problem had made them stronger and more self-reliant, as previously mentioned. It is possible that this could also be associated with masculine socialisation which expects males to be tough and independent (Good & Robertson, 2010).

It is also possible that the increased maturity, strength, and self-reliance reported by the interviewees in the current investigation might be a perceived means of increasing control, or at least the sense of control. This is related to the Minimax hypothesis which proposes that 'having control in a situation indicates one will be able to minimise maximum future danger' and thus people feel reassured that the feelings or sensations they will experience will not be intolerable (Miller, 1979; cited in Thompson, 1981; p97). This would also appear to be in accordance with the masculine gender role socialisation.

Time

According to the Prochaska and Norcross's (2001) stages of change model, the change process involves a number of specific stages over time. Only one of the ten participants in the current study described progressing through a number of distinct sequential stages as part of their change process. In contrast, the interviewees described a process of change which involved a gradual process over time and sudden moments of change. This finding is consistent with previous research by Gianakis and Carey (2011), Higginson and Mansell

(2008), Banyard and Williams (2007) and Heatherton and Nichols (1994), in addition to Carey et al.'s (2007) research in a psychotherapeutic context.

Change as a gradual process

A gradual process of change seemed to be a prominent feature of all the individuals' accounts of change in the current study. The interviewees experienced periods of trying to cope with the problem and proactively trying to resolve the problem, using the strategies mentioned previously, which supports prior empirical research (Gianakis & Carey, 2011; Higginson & Mansell, 2008; Banyard & Williams, 2007; Heatherton & Nichols, 1994; Carey et al., 2007). One participant in the current study described an iterative change process, involving monitoring the changes implemented over time and another described their change process as involving a series of specific identifiable stages, which contrasts with the aforementioned research.

Sudden moments of change

Consistent with previous research, sudden moments of change seemed to be experienced by all participants (Gianakis & Carey, 2011; Higginson & Mansell, 2008; Banyard & Williams, 2007; Heatherton & Nichols, 1994; Carey et al., 2007) too. In line with the aforementioned research, the accounts of sudden moments of change reported by half of the participants in the current study involved sudden realisations or shifts in perspectives, which was subsequently followed by a prolonged period of change. However, the findings of the current study also mirror those reported by Higginson and Mansell (2008) and Carey et al. (2007) regarding the changes in perspective or realisations, that they were reported both as sudden moments and as occurring gradually over time.

There is a phenomena in the psychotherapeutic change literature, termed 'sudden gains', which are defined as 'a large symptom improvement in one between-session interval' (Andrusyna, Luborsky, Pham, & Tang, 2006; p526). Four of the ten individuals in the current study reported significant amelioration of their distress in a sudden moment as part of their change process. These sudden moments of change may have been identified as 'sudden gains', had they occurred within the context of psychotherapy. According to Hopko, Robertson, and Carvalho (2009), who investigated 'sudden gains' in depressed cancer patients, it is suggested that these sudden gains are a reflection of what they referred to as 'self-activation' which occurs when guidance from a therapist is absent. This appears to be consistent with the Bohart and Tallman (1999) model of individuals as active self-healers. With regards to the participant with the greatest questionable resolution of his problem, the sudden moment of change he reported encompassed the decision to positively appraise the problem experience. It could be suggested that, given his questionable resolution, this may relate to needing to feel a sense of control or to meaning making, as mentioned previously.

Application of the research findings to theoretical constructs

Previous naturally-occurring change researchers have found that their studies have lent support to a number of theoretical frameworks regarding change and these are now discussed. An integrative model of change within psychotherapy, concerning a key concept of the change process, was presented by Stiles et al. (1990). This is referred to as the assimilation model as it presents the central concept of 'the assimilation of problematic

experiences' (Stiles et al., 1990; p411). Gianakis and Carey's (2011) research, which the current study replicates, lent support to the assimilation model particularly with regards to the threshold experience and sudden moments of change. Certain findings of the current study appear to lend support to several aspects of the assimilation model too.

The assimilation model proposes that at the beginning of the assimilation experience, the client organises the life they live, in addition to their thinking, in such a way to evade their problem experiences (Stiles et al., 1990; p413). This seems to be consistent with the current study's theme of 'distracting thoughts from the problem'. In comparison to Gianakis and Carey (2011), the present investigation also found support for the assimilation model with regards to the threshold experience and sudden moments of change. The current study's themes of 'becoming motivated to address the problem', which included personal insights or shifts in perspective, seem to be comparable to the assimilation model's processes of 'problem clarification' and 'personal insights/new perspective'.

According to the Stiles et al. (1990) assimilation model, the final aspect of the assimilation process of problematic experiences involves 'problem solution', including a plan and course of action, which seems compatible with the current study's theme of 'addressing the problem'. This model also posits that, as part of the assimilation process, successfully applying a schema to a novel area 'yields feelings of mastery and satisfaction' (Stiles et al., 1990; p413). This current study's findings of 'learning from the experience' and in some respects to the participants' reports of increased self-reliance and confidence as part of the theme of 'past self vs new enhanced self', appear to be consistent with this.

Another framework, but one regarding naturally-occurring change, which has received support from previous research is Bohart and Tallman's (1999) 'active self-healing model'. The aspects of the 'active-self-healing' model which has received support in the study by Gianakis and Carey (2011) on psychological change without psychotherapy are: 'a strong sense of agency', 'an engagement in social resources', 'experiencing strong emotion', and 'confronting issues'. Similarly, the current study appeared to find support for several of the 23 processes in the active self-healer model (Bohart & Tallman, 1999; p84), although in different aspects compared to Gianakis and Carey (2011) which may relate to the differences in gender of the participants.

The aspects of the Bohart and Tallman (1999) model that seemed to receive support from the current study include: 'searching for new perspectives', 'finding other paths', 'perseverance', and 'exposure' as they seem to be reflected in the current study's super-ordinate theme of 'addressing the problem', and in the sub-themes of 'thinking' and 'taking action'. Their theme of 'reframing', which includes discovering something positive in the problem, appears to be supported by the finding in the present study of 'appraising the problem positively'. The active self-healing model also posits that individuals make small changes over time (described as 'first order changes') but occasionally they may make significant 'second-order changes' particularly with regards to experiencing long periods of stress too (Bohart & Tallman, 1999; p84). In comparison to Gianakis and Carey (2011), the present study found participants described first order changes over time, with half of the participants also experiencing sudden moments of second-order change or sudden major shifts.

Powers' (2005) perceptual control theory (PCT) is another integrative theory which has received support from previous research with regards to psychological change (Carey et al., 2007; Higginson & Mansell, 2008; Gianakis & Carey, 2011). Four main areas of human functioning and behaviour are proposed by this model, namely 'control, hierarchical organisation, conflict, and reorganisation' and it is the aspect regarding 'hierarchical organisation' within the PCT model which is most relevant to the comprehension of psychological change (Higginson et al., 2011; p250). Hence, according to PCT, 'systems at levels higher than those which are in conflict need to be reorganised' for conflict resolution, and thus change, to occur (Carey, 2008; p10).

The theory of PCT indicates that it is possible to formulate the issues people experience as 'problems of control' (Carey, 2008; p7) and support seemed to be found for this in the current study such that the majority of the accounts included issues of control initially. Empirical evidence to support other aspects of PCT, such as the reorganisation concept, appeared to be provided in the current study. Participants' accounts included moving on from the issues of control to experiencing new insights, or a shift in perspective, and emotions, along with becoming motivated to change for example.

Additionally, a number of participants experienced sudden moments of change, as mentioned previously, which are also reported to be an aspect of PCT's reorganisation process (Mansell & Carey, 2009). In addition to the sudden moments that the PCT framework seems to incorporate, it appears to include a gradual process of change from conflict to successful reorganisation (Higginson & Mansell, 2008), and this gradual process was reported by the participants in the current study and other studies too, as mentioned

previously. Similarly, in comparison to Higginson and Mansell (2008), the accounts of change documented by the individuals in the current study reported a positive appraisal of the problem experience and a positive change in self-identity post recovery.

Contribution and clinical implications

In recent years there has been a request for empirically supported change principles, rather than empirically supported therapies, which put the client, the site of change, at the centre of the therapeutic process. This move appears consistent with the humanistic philosophy which underlies Counselling Psychology, and is further demonstrated by the growing interest within the field towards pluralism (McLeod & Cooper, 2011). Additionally, following an identified absence in the literature regarding naturally-occurring psychological change, to ensure the change process is not conflated with the therapy process, two studies have been carried out (Gianakis & Carey, 2011; Higginson & Mansell, 2008). Hence, by replicating Gianakis and Carey (2011), the current study has contributed to this important but under-researched area. It has also added to this relatively small area of research by assisting in the elucidation of naturally-occurring psychological change in the under-represented area of men's experience.

It could be perceived that the in-depth interviews in this study provided validation to an extent of some of the findings concerning naturally-occurring psychological change identified in the previous investigations, including themes relating to, or including, issues of control, motivation, threshold, identity, and learning, in addition to sudden moments and a gradual process of change. Furthermore, the interviews appeared to provide novel information regarding the ways in which men specifically experience naturally-occurring

psychological change. This includes the importance of experiencing insights, or a shift in perspective, prior to becoming motivated to address a problem, and thinking and taking action as central to their change process. Moreover, in contrast to previous research, relationships were not central to the change experience of these men.

The findings reported in this phenomenological investigation have also been compared to several theoretical frameworks with regards to change, namely the assimilation model, the active-self-healer model and PCT. It could be suggested that these findings have lent further support to these theoretical frameworks and thus have added to the small body of research previously carried out by the researchers working towards a generic change model. It seems increasingly likely as Prochaska, Norcross, and DiClemente (1994) posited, that 'all change is self-change' and therefore 'therapy is simply professionally coached self-change' (cited in Bohart & Tallman, 1999; p40). A clinical implication of this perspective of therapy as professionally coached self-change is that by incorporating the findings from naturally-occurring change research into psychotherapy, this will enhance the therapeutic process (Lampropoulos & Spengler, 2005). The therapeutic process can be improved further by therapists activating clients' self-healing abilities too (Bohart & Tallman, 1999).

It has been reported that males are more reluctant than females to seek help when they are experiencing distress, due to male socialisation (Wexler, 2009). Hence, it is important that when men do seek help, they are assisted by therapists who are well-informed (Good & Robertson, 2010). This is particularly important because it has been discovered that the gender competence of therapists is directly associated with psychotherapy outcome (Owen, Wong & Rodolfa, 2009). Being informed about masculinity research will improve

Counselling Psychologists' multicultural competencies (Wester, 2008) which therefore includes men's experience of naturally-occurring change. This increased understanding of the role of gender should also enhance couples therapy (Johnson & Lebow, 2000) when one or both of the couple are male.

It is essential to not only be aware of the experience of men, but also to assimilate it into the therapy process in order to enhance it (Mahalik et al., 2003). With regards to this, there has been a demand for novel more masculine modes of therapy interventions (Heesacker & Prichard, 1992). Furthermore, it has been asserted that therapy should be delivered in a more male-sensitive manner for male clients (Kiselica & Englar-Carlson, 2010). It is perceived that if men were aware of more male-sensitive styles of therapeutic intervention, it might provide greater encouragement for them to seek help when necessary (Wisch et al., 1995).

With regards to improving psychotherapy with men, and following the results of the current study, it could be suggested that it seems pertinent for Counselling Psychologists to raise awareness of their male client's problem experience and explore their coping strategies. This includes sensitively highlighting any avoidance strategies and exploring them. Additionally, motivation is reported to be essential in the change process according to DiClemente et al. (2004), and this seemed to be the case with the majority of the participants in the current study too. Thus, as Counselling Psychologists, it seems very important to try to help enhance male clients' motivation to address their problems.

Gianakis and Carey (2011) found their participants reported reaching an emotional threshold, which was followed by insight, or a sudden realisation. Hence, the researchers suggested that 'it may be counterproductive for therapists to try to move clients away from feeling pain as it may provide the impetus for naturally occurring change to occur' (p13). However, the findings of the current study did not find support for this. In contrast, motivation appeared more of a contributing factor to the change process than threshold and also, strong emotions were not identified as a sub-theme. Furthermore, insight, or a shift in perspective, appeared to be a pre-requisite of becoming motivated to address the problem for the participants in the current study. Therefore, it is suggested that it may be more appropriate for therapists working with male clients to focus less on emotional experiencing (at least during the initial stages of therapy) and more on facilitating insight, to enhance the motivation for subsequent interventions, including behavioural changes or problem-solving action.

Moreover, given the centrality of thinking in relation to the change process for these men, it seems important to engage male clients in their thinking, including thinking about their feelings, whatever the therapists' theoretical orientation. Participant 10 seemed to aptly summarise this point with the advice that was given to him by his partner: 'think it through'. Additionally, in accordance with masculine socialisation and thus to hopefully reduce, or alleviate, men's possible feelings of shame or embarrassment about seeking psychological therapy, it seems useful to emphasise Counselling Psychology's values of autonomy and client empowerment when working with male clients.

This study demonstrates the importance of behavioural strategies for these men with regards to their change processes. Thus, it seems important to encourage male clients to identify appropriate action steps to implement themselves whenever possible. This should foster a greater sense of control, which again is in accordance with the principles of Counselling Psychology. Another implication of the findings of this research is that it appears particularly useful for men to identify what they have learned from their problem experience, the process of change, in addition to identifying any positive changes in their identity. Therefore, it seems particularly pertinent to encourage reflection on these aspects in male clients as part of the therapy ending.

Limitations and future research

Although this study included 30% more participants than Gianakis and Carey (2011) and 40% more than Higginson and Mansell (2008), the participant numbers are still relatively small, in accordance with the principles of IPA (Smith et al., 2009). Hence, the previously mentioned clinical implications are tentative and further research in this area continues to be required to improve the generalisability of the results.

Furthermore, this investigation, as with the Gianakis and Carey (2011) study, reported an issue regarding the resolution of problems. This was in spite of the fact that the researcher verified all participants met the inclusion criteria prior to the interviews, with the participants reporting they had successfully resolved the issues they would be willing to discuss for the study. Several participants expressed contradictions regarding resolution such that it appeared they had resolved the problem cognitively but not necessarily emotionally. One participant, for example, reported that "I...I..I can rationalise the situation

but, I don't know, I think there's still this need for this sort of sign almost" (Pt. 4) and another stating that they "still feel bit bitter about it but I've moved on" (Pt. 7). According to PCT, this may indicate that reorganisation has yet to be successfully completed given that conflicts regarding the problem are still being experienced by these participants to varying degrees. It is also possible that this is an illustration that resolution should be perceived as a continuum rather than as categorical.

Thus, it is recommended that future research into participants' lived experience of psychological change without the assistance of psychotherapy explores this question of resolution further. Future studies in this area could include a specific question on how participants themselves would define recovery, or resolution, as per the Banyard and Williams (2007) investigation, for example. This was excluded from the current investigation as the aim of this study was to replicate the Gianakis and Carey (2011) investigation but with male participants, as they were under-represented in this area, as previously mentioned.

Additionally, as indicated by Gianakis and Carey (2011) a limitation of their study, and hence this investigation, is that the interviews pertained to retrospective accounts of psychological change. Therefore, different themes may have been identified as more important at the time the change was occurring. Consequently, it has been suggested that future research could investigate individuals who are experiencing psychological distress and are attempting to overcome it without the assistance of psychotherapy and prospectively follow them (Gianakis & Carey, 2011). Although this researcher acknowledges the benefit in possibly further illuminating the psychological change

processes in carrying out such an investigation, it does raise significant ethical questions, including the issue of similarities between research and therapy (Hart & Crawford-Wright, 1999). The participants of the current study also reported challenges in understanding how they actually managed to change and this may not be any easier for them to understand as they are experiencing the change.

Finally, this investigation has focused on men's experience of naturally-occurring psychological change, as men appear to be under-represented in this area, as previously mentioned. However, it could be suggested that the findings of the current study could also apply to other groups, particularly given the similarities between some of the themes identified in the current research which compare to previous research, such as a gradual process of change (e.g. Higginson & Mansell, 2008; Gianakis & Carey, 2011). Therefore, further research into naturally-occurring psychological change experienced by both males and females is recommended, especially as this continues to be a relatively under-researched area of psychology.

Conclusion

Following on from Gianakis and Carey (2011) and Higginson and Mansell (2008), the purpose of this IPA study was to investigate the under-researched but important area of psychological change from the perspective of the individual (the site of change) without the assistance of psychotherapy. This ensured the psychological change process was not conflated with the psychotherapy process. As men had been under-represented in previous research into this area, the current study was a replication of the Gianakis and Carey (2011) study, but with a male only sample of ten men. This phenomenological investigation revealed that the experience of the change process for males in this study included coping with the problem using avoidance strategies and by receiving some support, and subsequently experiencing turning points, with the majority becoming motivated to address the problem.

An important finding was the discovery that becoming motivated to address the problem was preceded by insights or a new perspective. Additionally, thinking and action-orientated problem solving was identified as central to the change process for these men. Consistent with other research into psychological change previously mentioned, participants of this study experienced sudden moments of change and a gradual process of change. This study has also contributed to this important area of psychology with regards to lending support to various theoretical constructs, including the assimilation model of change, the active-self-healer model and PCT, and hence it could assist those working towards a generic change model. Incorporating research on naturally-occurring change, such as the findings from

this study, into psychotherapy, and activating the self-healing abilities of clients, the therapy delivered by Counselling Psychologists can be enhanced.

Furthermore, men's experience needs to be assimilated into the process of therapy and a more 'male-sensitive' therapy developed, with the availability of such styles of therapy being made aware to men. This might encourage men to seek help when they require it, as previously reported. Given the association of gender competence in relation to psychotherapy outcome, if the findings from the current investigation, particularly the centrality of thinking and action, are assimilated into psychotherapy, it should enhance the experience of psychotherapy for the men that do attend therapy. It is also hoped that with the wider dissemination of these findings, in addition to the previous research into the area of naturally-occurring change, preventative measures can be improved and thus help those men in psychological distress who do not seek professional help.

Nevertheless, there are limitations with this study, particularly regarding the question of resolution, along with the need for further research to enhance the generalisability of the results. In summary, further research into psychological change without the assistance of psychotherapy, with regards to both males and females, continues to be required.

Critical Appraisal

CRITICAL APPRAISAL OF THE RESEARCH PROCESS***Reflections on the initial stages of the research process***

The first challenge I had was deciding on a research topic, which was a daunting task. Initially, I drew on strategies which had helped me in the past in other areas of university work, including creating a mind map of my main relevant interests. I subsequently searched the journals in the university library, in the hope of finding a research area relating to my interests, which I could contribute to. I am particularly interested in post-traumatic growth and transformation, due to my personal experience of overcoming M.E. Hence, after much searching, I was relieved, and excited, to discover the Carey and Gianakis (2008) review on psychological change, which highlighted a gap in the literature too. It felt like a major discovery. Nevertheless, I felt I had embarked on an emotional rollercoaster ride (a 'ride' which was to last throughout the research process).

Following the 'high' of my discovery, came the 'low' as anxious thoughts seeped into my consciousness, including fearing someone may have beaten me to the research since the publication of the review. I contacted Dr. Carey to clarify this. He informed me his co-author, and MSc student, was currently finalising such research (*subsequently published as Gianakis & Carey, 2011*), but I felt relieved to discover from him that research into men's experience of psychological change was still required. Another challenge then presented itself. The remaining supervisors had all been allocated, leaving me with only one internal supervisor. Consequently, I felt frustrated and unsupported. Nevertheless, I had begun to establish a good relationship with Dr. Carey. Thus, with the approval of my internal supervisor Dr. Primrose, I approached Dr. Carey to be my second supervisor and

thankfully, he agreed. I have found Dr. Carey to be a constant source of support throughout the research process. Although having a supervisor based in Australia has also had its challenges, particularly during the analysis stage.

Prior to starting the process, I had been aware of the research recruitment challenges, particularly regarding recruiting men (Olliffe & Mróz, 2005). However, I perceived men would be eager to share how they had successfully resolved a problem without the help of others, to the extent that I feared I might have more volunteers than I needed! I discussed my fears with Dr. Primrose and planned to limit the number of participants to 12. I intended to interview six people and ask the remaining six participants to provide written narratives. I intended to carry out in-depth analysis of the interviews and analyse the remaining data as a group but I struggled to recruit any participants at all. This triggered feelings of powerlessness and helplessness in me. The recruitment challenges resulted in the process of data collection taking much longer than I had estimated.

Once I had participants, I then had to overcome another difficulty in my transition from practitioner to practitioner-researcher which related to the interview process. I thought, for example, that the first two interviews were too brief and lacked depth. Feeling worried, I consulted my supervisors, but they were unconcerned. I still felt I needed to adapt my interview process though, to try and improve the facilitation of introspection. Thus, after they had signed the consent form, I gave the remaining participants the complete interview schedule to read. Although this measure seemed to aid the interview process with some participants, with others, I still experienced difficulties, which is perhaps because as

Bonhomme (2005) reported, some men are 'less able to inform the interviewer of his feelings' (p262).

Additionally, some of the participants discussed issues, and responded in ways I was not expecting. Consequently, I found myself experiencing the problem regarding the similarities of a therapy session and a research interview which Hart and Crawford-Wright (1999) highlighted. One participant, for example, revealed self-doubt in the interview, particularly with regards to attracting a new partner. As this is an area I have previously specialised in and written about (Buchan, 2008), I found it challenging to bracket-off my knowledge and refrain from stepping into the helping role. Hence, I made use of my 'internal supervisor' (Casement, 1985). I reminded myself that my role was to gather information, in order to 'meet the aims of the research study' (Hart & Crawford-Wright, 1999; p208) rather than deliver therapy.

Reflections on the analysis process

A further unexpected and major challenge I experienced was carrying out in-depth analysis on ten individual transcripts. Smith et al. (2009) reported that qualitative research involves 'a certain amount of unpredictability, chaos and mess' and they warned the researcher that sometimes during the process, 'you may feel out of your depth' (p55). This certainly reflected my experience, as I struggled to understand how to do the analysis and began to experience the 'chaos and mess' as I followed Gee's (2011) guidelines, particularly when I reached the conceptual stage and the emerging themes stage. As a novice IPA researcher, I found the amount of information I was dealing with, having so many participants and such long transcripts in most cases, overwhelming. Moreover, as I read, re-read and analysed the

transcripts I noticed I had made mistakes in the interviews at times, such as asking a question that appeared closed or leading, which was very difficult. Additionally, I noticed at times I had accepted a participant's answer in the interview, seeming to understand their meaning but during the analysis, their reply seemed more ambiguous. I wanted the opportunity to ask the participant for clarification, but unlike in a therapy session, this was not possible and I experienced this as frustrating.

In regards to the conceptual stage, I found it challenging being a trainee Counselling Psychologist, trained in several therapeutic approaches, to analyse from a general psychological perspective, particularly as it had been eight years since I completed my undergraduate degree. I discovered, with the help of my supervisors, that my early attempts at interpretation were too psychodynamic which was reflected in the psychodynamic language I had used. However, I also found in some regards that being a Counselling Psychologist trainee helped with this stage, particularly regarding being able to provide deeper interpretations beyond the surface level. Furthermore, it assisted the process with regards to understanding the importance of the language participants had used and other linguistic nuances, which I had identified at the earlier linguistic comments stage.

I struggled following the order Gee (2011) described, identifying emergent themes after the other stages too. I also struggled with the movement from micro to macro level and at the same time, ensuring I did justice to each individual's experience. Hence, another challenge I had to contend with during the analysis was considering individual differences. Although all participants met the inclusion criteria, I had concerns about how participant nine's professional role might influence my results, given that he had some training in a

therapeutic approach (CBT) for example. Thus, after verifying with my supervisors that it was still appropriate to include him in the study, I followed their advice to continually keep this in mind as I carried out the analysis and kept going back to the text, and questioned my assumptions as I did so.

Consequently, it seemed participant nine attempted to draw on his professional training to help him to cope, demonstrated by his use of 'try to keep my emotions managed' for example (L289-296). However, I also noticed he still implemented coping strategies that were common to the other participants, including distracting his thoughts from the problem by keeping busy. During the analysis, I went back to the transcript to test my assumption that he would make references to specific CBT tools or strategies in relation to how he resolved the problem given his job, but he made none. In contrast, I discovered he employed similar strategies as the other participants. Furthermore, I was particularly observant of his use of language regarding his identity and discovered that his identity as a nurse/CBT well-being practitioner helped him to cope to some extent, but it also seemed that experiencing a problem personally was quite a different experience for him than helping others with their problems (e.g. L671-674). Hence, at the end of the analysis, the change processes that seemed important to this participant seemed to be similar to that of the other participants, in spite of his professional training.

I was also very mindful during the analysis of the differences regarding participant seven, the oldest participant. He seemed to draw on his previous personal development and life experience as part of his change process, which is unsurprising given that, as Neugarten (1979) reported with regards to older patients, they have a 'large repertoire of experience'

and a 'long practice at working out solutions to problems' (p893). Again, I dealt with the difference regarding the knowledge and experience he had, by checking out my assumptions and continually referring back to the transcript. Ultimately, it appeared that in spite of these articulated or obvious differences, he seemed to experience a similar change process to the other participants too.

I have focused on the two aforementioned participants regarding the process of drawing on previous learnings or experience in life or work to resolve a problem. However, I am conscious that this process could be extended to all participants. Kolb (1984) stated that learning happens in 'all human settings, from schools to the workplace.....' and that learning 'encompasses all life stages, from childhood to adolescence, to midlife and old age. Therefore, it encompasses other, more limited adaptive concepts such as creativity, problem-solving, decision making and attitude change' (p32), which seems to reflect this point. Hence it appears learning and change goes together.

I made use of supervision, as previously mentioned, particularly during the analysis process too, not only with regards to individual differences but also in relation to verifying emergent themes, for example. I was extremely grateful for Dr. Carey's rapid responses to my emails, especially as he is based in Australia. This only proved problematic with regards to certain aspects of the analysis process, which arose principally because I carried out the process on hard copies of the transcripts, as per Smith et al.'s (2009) guidelines for novice researchers. This largely coincided with Dr. Primrose's absence from the university. I often felt alone and unsupported at that time and turned to my husband frequently for moral support, in addition to my peers and my therapist.

Following on from the above, A further issue I experienced during the analysis stage concerned my use of the research diary. Prior to the analysis, I had found the research diary purely beneficial, particularly regarding the 'bracketing-off' process, expressing my thoughts and emotions and recording general notes, following the interviews. Nevertheless, at the analysis stage I found it both helped and hindered my process. In the initial reading and re-reading stages, I found it helpful as so many thoughts and ideas were occurring to me at the time that it was useful to make a note of them so I could refer to them at a later date, and to assist in subsequent stages. It facilitated my thinking process, and as at times analysing prompted me to reflect on my own psychological change experience of overcoming M.E, it helped in the bracketing-off process too. Being a detailed and thorough person, I also perceived the value in the research diary with regards to maintaining a rigorous and detailed paper trail. However, the further I progressed with the analysis process, the more I came to resent the constant interruption to my work to record my thoughts and actions in the diary. At times, I felt it hindered my progress, particularly as I was often unsure what was relevant to record and what was unnecessary, which in turn, fuelled stress and anxiety.

Reflections on how the research process impacted my clinical practice

During the research process, I experienced the thesis as impacting my placements. It instigated thoughts regarding the possible outcomes of my study and how they might positively impact the therapeutic service I provide to male clients. I also found myself questioning whether as a female practitioner, I am as equipped as I could be to assist men to change or overcome a problem, particularly given the challenges I experienced

interviewing my participants, as mentioned. These were not questions I had previously contemplated, as I had been focusing on other areas, including increasing my skills and knowledge of therapeutic approaches, for example. Consequently, I then found myself contemplating questions such as do men prefer approaches such as CBT to more emotion-focused approaches like Gestalt therapy? This helped my research to feel more 'alive' and meaningful to me, which in turn helped me to continue with the research process, even when I experienced it as incredibly difficult.

Reflections and amendments to my previous work regarding CBT and psychological change

With regards to the work contained in other areas of the portfolio, previously submitted to the university, my understanding and perspectives concerning the particular psychotherapeutic approach of CBT had been informed by the reading I carried out at that time and my experiences on my placements, particularly in my second year. Consequently, this resulted in me representing CBT in a particular way, which may be perceived as inaccurate, or not as accurate as possible, in a number of ways. Hence, I will take the opportunity here in this reflective piece, to demonstrate the development of my thinking in relation to particular aspects of the approach such as the unconscious, the formation of schemata, the therapeutic relationship and the role of early experiences.

Samuels (2008) reported that one of the concerns regarding CBT is its 'lack of any perspective on, or consideration of, the unconscious' (piv). This perspective mirrored my own due to my placement experiences and reading about others, such as Clemens (2003), who reported knowing CBT therapists that 'do not believe in an unconscious mental life'

(p463). Nevertheless, I have come to appreciate that this is only one perspective and not representative of CBT theory. I have discovered for example, that whilst CBT might be perceived as ignoring the unconscious, this appears to apply only with regards to 'the Freudian psychoanalytic view' of the unconscious (Neenan, 2012; p70). This point is demonstrated by Beck (1976) who stated that, 'the complex psychoanalytic concept of the unconscious, a postulated mental organisation that is not only remote from conscious experience but consists of ideas and wishes antagonistic to conscious cognition, is drastically modified' (p318). Although Beck is referring to cognitive therapy here, this also applies to CBT because behaviour therapy and cognitive therapy merged into CBT (Rachman, 1996).

Furthermore, in relation to clinical practice, after working with Negative Automatic Thoughts (NAT's), a therapist will move on to 'uncovering the deeper beliefs that predispose individuals to experience their problems' (Neenan, 2012; p67) if there is clinical justification for doing so. These deeper beliefs will commonly be out of the client's conscious awareness initially. Hence, using an exercise such as the downward arrow technique for example, the therapist 'peels back the layers by continuing to ask for the meaning of the patient's thoughts' (Beck, 1995; p166) and in doing so, will make the thoughts that were out of conscious awareness conscious. Thus, as Mansell (2008) indicated, CBT 'acknowledges that unconscious processing clearly exists' (p19).

Additionally, I had previously concurred with Monaghan and Moorey (1999) that CBT therapists 'would provide a behavioural explanation for the formation of schemata' (P41). Nevertheless, this perspective now seems limited to those therapists who do not accept the

concept of the unconscious, rather than being representative of CBT in general. This is because with regards to core beliefs, or schemas, Beck (1995) stated that they 'develop in childhood as the child interacts with significant others and encounters a series of situations' (p166). Furthermore, Moorey (2012) reported that 'CBT has needed to construct a more sophisticated theory of how beliefs develop in response to childhood adversity, and how they influence relationships in the present' in order to adapt to working with disorders that are more complex (p54). According to Holmes (2010), what CBT therapy terms 'maladaptiveness of depressive thinking' seems to be in accordance with 'psychoanalytic defence analysis in which patterns of self-protection appropriate to childhood persist into adult life to the subject's disadvantage' (p20) too.

With regards to the therapeutic relationship in CBT, elsewhere in the portfolio I had previously made a reference to Clemens (2003) who reported that 'the therapist generally has a supportive value' (p463). On reflection, this may appear to misrepresent the therapeutic relationship in CBT because although the relationship may include understanding and support from the therapist (Gordon, 2000), the therapist provides more than this. It could be suggested that it is more accurate to describe it as a collaborative relationship because in CBT, the therapist attempts to 'engage the patient in a therapeutic alliance of collaboration', such that 'the therapist and patient form a "team"' according to Beck, Rush, Shaw and Emery (1979; p54). Moreover, as Mansell and Taylor (2012) stated, even with third-wave CBT (e.g. ACT) 'the development of a collaborative therapeutic relationship remains central' (P9).

There are also misrepresentations of CBT regarding the role of early experiences. Beck (1976) reported that cognitive therapy does not attempt 'to recover remote infantile memories or make speculative reconstructions of the patient's childhood experiences and early family relationships' (p321). Additionally, it has been stated that the approach focuses mainly on 'clients' present problems and how these problems are being maintained rather than how they were acquired or developed' (Neenan, 2012; p66). Consequently, there is a perception that CBT has little interest in engaging with people's backgrounds, but this is untrue according to Gilbert (2009). Veale (2008), for example, pointed out that this therapy 'ignores neither the history nor the context of how a problem developed. A developmental formulation takes into account known factors that have led to the current problems' (p3). In addition, although CBT may initially be present-focused, the therapy can include an exploring of the past in a number of cases. According to Beck (1995), for example, this may occur when 'the patient expresses a strong predilection to do so; when work directed toward current problems produces little or nochange; or when the therapist judges that it is important to understand how and when important dysfunctional ideas originated and how these ideas affect the patient today' (p7). Furthermore, Ehlers and Clark's (2000) CBT model of PTSD considers the past as it 'takes into account several background factors that are likely to influence' and this includes 'previous experience of trauma' (p332).

Thus, I have begun to appreciate that the view I previously held of CBT was heavily influenced by the views of others who were not necessarily representative of most CBT therapists, and who perhaps hold a more traditional perspective. There are, it seems, many more perspectives and methods of working within the approach. This is highlighted by Moorey (2012) who pointed out that not only are there CBT therapists 'who practise short-

term therapy, only focus on maintenance processes and eschew core beliefs' but there are also others 'who focus entirely on early maladaptive schemas and see patients twice a week for three years' (p58). Additionally, as Monaghan and Moorey (1999) reported, 'trainees can be tyrannised by technique, a persecution that is encouraged by some of the more cook-book descriptions of CBT' (p42) and I think this perhaps reflects my past experience with the approach. But, as they explained 'real cognitive therapy is much more alive and dynamic than this stereotype' (Monaghan & Moorey, 1999; P42) and I look forward to increasing my knowledge and skills regarding CBT as part of my planned CPD, as previously indicated in this portfolio, to experience this first-hand for myself.

REFERENCES

Andrusyna, T.P., Luborsky, L., Pham, T. & Tang, T.Z. (2006). The Mechanisms of Sudden Gains in Supportive-Expressive Therapy for Depression. *Psychotherapy Research, 16*, 526-536.

Banyard, V.L., & Williams, L. M. (2007). Women's voices on recovery: A multi-method study of the complexity of recovery from child sexual abuse. *Child Abuse & Neglect, 31*, 275-290.

Baumeister, R.F. (1994). 'The crystallization of discontent in the process of major life change' in Heatherton, T. & Weinberger, J. (Eds.), *Can personality change?* (pp. 281-297). Washington, DC: American Psychological Association.

Beck, A. T. (1976). *Cognitive Therapy and the Emotional Disorders*. Penguin Books.

Beck, J. S. (1995). *Cognitive Therapy: Basics and Beyond*. The Guilford Press.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive Therapy of Depression*. Guilford Press.

Benenson, J.F. & Koulkazarian, M. (2008). Sex differences in help-seeking in early childhood. *British Journal of Developmental Psychology, 26*, 163-169.

Biggerstaff, D. & Thompson, A., R. (2008). Interpretative Phenomenological Analysis (IPA): A Qualitative Methodology of Choice in Healthcare Research. *Qualitative Research in Psychology*, 5, 214-224.

Bohart, A.C. & Tallman, K. (1999). *How Clients Make Therapy Work: The Process of Active Self-Healing*. American Psychological Association.

Bonhomme, J.J.E. (2005). Editorial comment: men interviewing men about illness and health. *The Journal of Men's Health & Gender*, 2, 257-260

The British Psychological Society (2009). *Code of Ethics and Conduct: Guidance published by the Ethics Committee of the British Psychological Society*. Retrieved from <http://www.bps.org.uk>

The British Psychological Society (2006). *Professional Practice Guidelines for Counselling Psychologists*. Retrieved from <http://www.bps.org.uk>

Brocki, J.M. & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health*, 21, 87-108.

Buchan, C.A. (2008). *22 Boyfriends to Happiness: My Story and the Seven Secrets on How to Find True Love*. Trinita Press.

Budd, R. & Hughes, I. (2009). The Dodo Bird Verdict – Controversial, Inevitable and Important: A Commentary on 30 Years of Meta-Analyses. *Clinical Psychology and Psychotherapy*, 16, 510-522.

Carey, T.A. (2011). Exposure and reorganization: The what and how of effective psychotherapy. *Clinical Psychology Review*, 31, 236-248.

Carey, T.A. (2008). Conflict, as the Achilles heel of perceptual control, offers a unifying approach to the formulation of psychological problems. *Counselling Psychology Review*, 23, 5-16.

Carey, T.A., Carey, M., Stalker, K., Mullan, R. J., Murray, L. K. & Spratt, M., B. (2007). Psychological change from the inside looking out: A qualitative investigation. *Counselling and Psychotherapy Research*, 7, 3, 178-187

Carey, T.A., Carey, M., Mullan, R. J., Murray, L. K. & Spratt, M., B. (2006). Psychological change: What changes and how does it occur? A critical review. *Counselling Psychology Review*, 21, 4, 28-38

Casement, P. (1985). *On Learning From the Patient*. Tavistock Publications Ltd.

Clarke, H., Rees, A. & Hardy, G. (2004). The big idea: Clients' perspectives of change processes in cognitive therapy. *Psychology and Psychotherapy Research*, 77, 67-89.

Clemens, N.A. (2003). Psychotherapy: Insight, Consciousness, Learning and Change. *Journal of Psychiatric Practice*, 9, 462-464.

Cochran, S.V. & Rabinowitz, F.E. (1996). Men, loss and psychotherapy. *Psychotherapy*, 33, 593-600.

Courtenay, W. H. (2005). 'Counseling Men in Medical Settings: The Six-Point HEALTH Plan' in Good, G., E., & Brooks, G., R. (eds.), *The New Handbook of Psychotherapy and Counseling with Men: A Comprehensive Guide to Settings, Problems, and Treatment Approaches* (Revised and Abridged from the Previous Edition) (pp.29.-53). Jossey-Bass. A Wiley Imprint.

Coyle, A. & Olsen, C. (2005). Research in therapeutic practice settings: ethical considerations in Tribe, R. & Morrissey, J. (Eds.) *Handbook of Professional and Ethical Practice for Psychologists, Counsellors and Psychotherapists* (pp.249-262). Brunner-Routledge.

Cozolino, L. J. (2002). *The neuroscience of psychotherapy: Building and rebuilding the human brain*. W.W. Norton & Company, Inc.

Curwen, B., Palmer, S. & Ruddell, P. (2000). *Brief Cognitive Behaviour Therapy*. Sage Publications Ltd.

Data Protection Act 1998. (1998) London: Stationery Office.

DiClemente, C.C., Schlundt, D. & Gemmell, L. (2004). Readiness and Stages of Change in Addiction Treatment. *The American Journal on Addictions, 13*, 103-119.

Du Plock, S. (2009). 'Humanistic Approaches' in Woolfe, R., Strawbridge, S., Douglas, B. & Dryden, W. (eds.), *Handbook of Counselling Psychology* (3rd ed.) (pp.130-150). Sage Publications Ltd.

Ehlers, A. & Clark, D. M. (2000). 'A cognitive model of posttraumatic stress disorder', *Behaviour Research and Therapy, 38*, 319-345.

Elliott, R. (1989). Comprehensive process analysis: Understanding the change process in significant therapy events, in Packer, M.J. & Addison, R. B. (eds.), *Entering the circle: Hermeneutic investigation in psychology* (pp. 165-184). New York: SUNY.

Emmanual, E. J., Wendler, D. & Grady, C. (2000). What makes clinical research ethical? *Journal of the American Medical Association, 283*, 2701-2711

Folkman, S. & Lazarus, R.S. (1998). Coping as a Mediator of Emotion. *Journal of Personality and Social Psychology, 54*, 466-475.

Forbes, D. L. (2011). Toward a Unified Model of Human Motivation. *Review of General Psychology, 15*, 85-98.

Forsell, D. (2005). *People as Living Things: The Story in Perceptual Control Theory: Science & Applications, A Book of Readings*. Living Control Systems Publishing.

Gee, P. (2011). 'Approach and Sensibility': A personal reflection on analysis and writing using Interpretative Phenomenological Analysis. *Qualitative Methods in Psychology Bulletin*, 11, 8-22

Gianakis, M. & Carey, T. A. (2011). An interview study investigating experiences of psychological change without psychotherapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 84, 442-457.

Gianakis, M. & Carey, T. A. (2008). A review of the experience and explanation of psychological change. *Counselling Psychology Review*, 23, 27-38.

Gigy, L. & Kelly, J. B. (1992). Reasons for divorce: Perspectives of divorcing men and women. *Journal of Divorce and Remarriage*, 18, 169-187.

Gilbert, P. (2009). Moving beyond cognitive behaviour therapy. *The Psychologist*, 22, 400-403.

Gillon, E. (2007). *Person-Centred Counselling Psychology: An Introduction*. Sage Publications Ltd.

Good, G., E. & Brooks, G. R. (2005). *The New Handbook of Psychotherapy and Counseling with Men: A Comprehensive Guide to Settings, Problems, and Treatment Approaches*. John Wiley & Sons, Inc.

Good, G., E. & Robertson, J., M. (2010). To accept a pilot? Addressing men's ambivalence and altering their expectancies about therapy. *Psychotherapy Theory, Research, Practice, Training, 3*, 306-315.

Gordon, N.S. (2000, March). Researching psychotherapy, the importance of the client's view: A methodological challenge. *The Qualitative Report* [online serial], 493/40. Available at: <http://www.nova.edu.ssss/QR/WR4-1/gordon.html>

Greenberg, L., S. (2012). Emotions, the Great Captains of Our Lives: Their Role in the Process of Change in Psychotherapy. *American Psychologist, 67*, 697-707

Greenberg, L. S. (1999). Ideal psychotherapy research: A study of significant change processes. *Journal of Clinical Psychology, 55*, 1467-1480.

Greenberg, L.S. (1994). The investigation of change: It's measurement and exploration in Russell, R.L. (ed.), *Reassessing psychotherapy research* (pp.114-143). New York: The Guilford Press.

Greenberg, L., S. (1991). Research in the process of change. *Psychotherapy Research, 1*, 3-16.

- Hart, N. & Crawford-Wright, A. (1999). Research as therapy, therapy as research: Ethical dilemmas in new-paradigm research. *British Journal of Guidance & Counselling, Vol. 27, 2*, 205-214
- Harvey, J.H (2001). The Psychology of Loss as a Lens to a Positive Psychology. *The American Behavioral Scientist, 44*, 838-853.
- Hawton, K. (2000). Sex and Suicide: Gender differences in suicidal behaviour. *British Journal of psychiatry, 177*, 484-485
- Hayes, S. C., Strosahl, K. D. & Wilson, K. G. (1999). *Acceptance and Commitment Therapy: An Experiential Approach to Behavior Change*. The Guilford Press.
- Heatherton, T. F. & Nichols, P. A. (1994). Personal Accounts of Successful Versus Failed Attempts at Life Change. *Personality and Social Psychology Bulletin, 20*, 664-675.
- Heesacker, M., & Prichard, S. (1992). In a different voice, revisited: Men, women, and emotion. *Journal of Mental Health Counseling, 14*, 274-290.
- Higginson, S., Mansell W., & Wood, A., M. (2011). An integrative mechanistic account of psychological distress, therapeutic change and recovery: The Perceptual Control Theory approach. *Clinical Psychology Review, 31*, 249-259.

Higginson, S. & Mansell, W. (2008). What is the mechanism of psychological change? A qualitative analysis of six individuals who experienced personal change and recovery. *Psychology and Psychotherapy: Theory, Research and Practice*, 81, 309-328.

Holmes, J. (2010). Psychoanalysis and CBT: Confluence of Theory, Watershed in Practice? in Loewenthal, D., & House, R. (eds.) in *Critically Engaging CBT* (pp. 18-32). Open University Press.

Hopko, D. R., Robertson, S.M.C. & Carvalho, J.P. (2009). Sudden Gains in Depressed Cancer Patients Treated With Behavioral Activation Therapy. *Behavior Therapy*.

Iwamoto, D.K., Liao, L. & Liu, W.M. (2010). Masculine Norms, Avoidant Coping, Asian Values, and Depression Among Asian American Men. *Psychology of Men & Masculinity*, 11, 15-24.

Jacobs, M. (2004). *Psychodynamic Counselling in Action* (3rd ed.). Sage Publications Ltd.

Johnson, N., G. (2005). Women Helping Men: Strengths of and Barriers to Women Therapists Working with Men Clients in Good, G., E. & Brooks, G. R. (eds.) *The New Handbook of Psychotherapy and Counseling with Men: A Comprehensive Guide to Settings, Problems, and Treatment Approaches* (pp.291-307). John Wiley & Sons, Inc.

Johnson, S., & Lebow, J. (2000). The "Coming of Age" of couple therapy: A decade review. *Journal of Marital and Family Therapy*, 26, 23-38.

Joseph, S. & Linley, A. P. (2006). Growth following adversity: Theoretical perspectives and implications for clinical practice. *Clinical Psychology Review, 26*, 1041-1053.

Kabat-Zinn, J. (1999). *Full catastrophe living: How to cope with stress, pain and illness using mindfulness meditation*. Piatkus Books.

Kelly, M.A.R., Roberts, J.E. & Bottanari, K.A. (2007). Non-treatment-related sudden gains in depression: The role of self-evaluation. *Behaviour, Research and Therapy, 45*, 737-747.

Kesi-Rahkonen, A., & Tozzi, F. (2005). The process of recovery in eating disorder sufferers' own words: An internet-based study. *International Journal of Eating Disorders, 37*, 580-586.

Kingerlee, R. (2012). Conceptualising men: A transdiagnostic model of male distress. *Psychology and Psychotherapy: Theory, Research and Practice, 85*, 83-99.

Kiselica, M.S. & Englar-Carlson, M. (2010). Identifying, affirming and building upon male strengths: the positive psychology/positive masculinity model of psychotherapy with boys and men. *Psychotherapy, Theory, Research, Practice, Training, 47*, 276-287.

Kolb, D. A. (1984). *Experiential Learning: Experience as the source of learning and development*. Prentice-Hall, Inc.

Lambert, M. (1992). Psychotherapy outcome research: Implications for integrative and eclectic therapists in Norcross, J.C. & Goldfried, M. R. (Eds.) *Handbook of Psychotherapy Integration* (pp.94-129). New York: Basic.

Lampropoulos, G. K. (2000). Definitional and research issues in the common factors approach to psychotherapy integration: Misconceptions, clarifications, and proposals. *Journal of Psychotherapy Integration, 10*, 436-455.

Lampropoulos, G. K., & Spengler, P.M. (2005). Helping and change without traditional therapy: Commonalities and opportunities. *Counselling Psychology Quarterly, 18*, 47-59.

Laub, J. H. & Sampson, R.J. (1993). Turning points in the life course: why change matters to the study of crime. *Criminology, 31*, 301-325.

Lazarus, R. S. & Folkman, S. (1984). *Stress, Appraisal and Coping*. Springer Publishing Company Inc.

Lee, R.M., Su, J. & Yoshida, E. (2005). Coping With Intergenerational Family Conflict Among Asian American College Students. *Journal of Counseling Psychology, 52*, 389-399.

Levant, R.F. (1996). The New Psychology of Men. *Professional Psychology: Research and Practice, 27*, 259-265.

- Levant, R.F. (1995). Toward the reconstruction of masculinity in Levant, R. F. & Pollack, W. S. (Eds.) 'A new psychology of men' (pp. 229-251). New York: Basic Books.
- Linley, A., P., Joseph, S., Harrington, S., & Wood, A.M. (2006). Positive Psychology: Past, present, and (possible) future. *The Journal of Positive Psychology, 1*, 3-16.
- Linley, A.P. & Joseph, S. (2004). Positive change following trauma and adversity: A review. *Journal of Traumatic Stress, 17*, 11-21.
- Linley, A.P. & Joseph, S. (2003). Trauma and personal growth. *The Psychologist, 16*, 135.
- Littell, J. H., & Girvin, H. (2002). Stages of Change: A Critique. *Behavior Modification, 26*, 223-273.
- McCarthy, J., & Holliday, E.L. (2004). Help-Seeking and Counseling Within a Traditional Male Gender Role: An Examination from a Multicultural Perspective. *Journal of Counseling & Development, 82*, 25-30.
- McDonough, M.H., Sabiston, C.M. & Crocker, P.R.E. (2008). An Interpretative Phenomenological Examination of Psychosocial Changes among Breast Cancer Survivors in their First Season of Dragon Boating. *Journal of Applied Sport Psychology, 20*, 425-440.
- McKimm, J. & Swanwick, T. (2009). Assessing learning needs. *British Journal of Hospital Medicine, 70*, 348-351.

McLeod, J. & Cooper, M. (2011). A protocol for systematic case study research in pluralistic counselling and psychotherapy. *Counselling Psychology Review*, 26, 47-58.

Maddux, J.E., Snyder, C. R. & Lopez, S. J. (2004). 'Toward a positive clinical psychology: Deconstructing the illness ideology and constructing an ideology of human strengths and potential', in Linley, P.A. & Joseph, S. (eds.), *Positive psychology in practice* (pp. 320-334). Hoboken, NJ: Wiley.

Magovcevic, M. & Addis, M.E. (2008). The Masculine Depression Scale: Development and Psychometric Evaluation. *Psychology of Men & Masculinity*, 9, 117-132.

Mahalik, J. R. (2005). Cognitive Therapy for Men in Good, G., E. & Brooks, G. R. (eds.) *The New Handbook of Psychotherapy and Counseling with Men: A Comprehensive Guide to Settings, Problems, and Treatment Approaches* (pp.217-233). John Wiley & Sons, Inc.

Mahalik, J.R., Good, G.E. & Englar-Carlson, M. (2003). Masculinity Scripts, Presenting Concerns and Help Seeking: Implications for Practice and Training. *Professional Psychology: Research and Practice*, 34, 123-131.

Mansell, W. (2008). 'What is CBT *really*, and how can we enhance the impact of effective psychotherapies such as CBT?' in House, R., & Loewenthal, D. (eds.), *Against and For CBT: Towards a constructive dialogue?* (pp.19-32). PCCS Books Ltd.

Mansell, W. & Carey, T. A. (2009). A century of psychology and psychotherapy: Is an understanding of 'control' the missing link between theory, research and practice? *Psychology and Psychotherapy: Theory, Research and Practice*, 82, 337-353.

Mansell, W. & Taylor, J. L. (2012). What Is CBT and What Isn't CBT? in Dryden, W., & Branch, R. (eds.), *The CBT Handbook* (pp.5-24). Sage Publications Ltd.

Meth, R. L., Pasick, R. S., Gordon, B., Allen, J., Feldman, L. B. & Gordon, S. (1990). *Men in Therapy: The Challenge of Change*. Guilford Press.

Miller, W. R. (2004). The Phenomenon of Quantum Change. *Journal of Clinical Psychology*, 60, 453-460.

Miller, S. M. (1979). Controllability and human stress: Method, evidence and theory. *Behaviour, Research and Therapy*, 17, 287-304.

Moorey, S. (2012). CBT: Past, Present and Future in Dryden, W., & Branch, R. (eds.), *The CBT Handbook* (pp.45-64). Sage Publications Ltd.

Neenan, M. (2012). Common Myths and Misconceptions about CBT in Dryden, W., & Branch, R. (eds.), *The CBT Handbook* (pp.65-80). Sage Publications Ltd.

Neugartn, B. L. (1979). Time, Age, and the Life Cycle. *The American Journal of Psychiatry*, 136, 7, 887-894.

Oliffe, J. L. & Mróz, L. (2005). Men interviewing men about health and illness: ten lessons learned. *The Journal of Men's Health & Gender, 2*, 257-260

Owen, J., Wong, J.Y. & Rodolfa, E. (2009). Empirical Search for Psychotherapists' Gender Competence in Psychotherapy. *Psychotherapy Theory, Research, Practice, Training, 46*, 448-458

Powers, W.T. (2005). *Behaviour: The control of perception (2nd ed.)*. New Canann, CT: Benchmark.

Prochaska, J., O. (1995). Common Problems: Common solutions. *Clinical Psychology: Science and Practice, 2*, 101-105.

Prochaska, J. O. & DiClemente, C. C. (1992). The transtheoretical approach in Norcross, J.C. & Goldfried, M. R. (Eds.) *Handbook of Psychotherapy Integration* (pp.300-334). New York: Basic.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In Search of How People Change: Applications to Addictive Behaviors. *American Psychologist, 47*, 1102-1114

Prochaska, J. O., & Norcross, J.C. (2001). Stages of change. *Psychotherapy, 38*, 443-448.

Prochaska, J. O., Norcross, J.C. & DiClemente, C. C. (1994). *Changing for good*. New York: Morrow.

Rachman, S (1996). 'The Evolution of Cognitive Behaviour Therapy' in Clark, D. M. & Fairburn, C. G. (Eds.) *Science and Practice of Cognitive Behaviour Therapy* (pp1-26). Oxford University Press.

Rawson, D. (2006). Planning, conducting and writing up research in Bor, R. & Watts, M. (eds.) *The Trainee Handbook (2nd Ed.): A Guide for Counselling and Psychotherapy Trainees* (pp.249-283). Sage Publications Ltd.

Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience. *The Psychologist*, 18, 20-23.

Rizq, R. (2010). 'Psychodynamic Approaches' in Woolfe, R., Strawbridge, S., Douglas, B. & Dryden, W. (eds.), *Handbook of Counselling Psychology* (3rd ed.) (pp.85-104). Sage Publications Ltd.

Rogers, C. R. (1957). The Necessary and Sufficient Conditions of Therapeutic Personality Change. *Journal of Consulting Psychology*, 21, 95-103.

Rosen, G. M., & Davison, G., C. (2003). Psychology Should List Empirically Supported Principles of Change (ESP's) and Not Credential Trademarked Therapies or Other Treatment Packages. *Behaviour modification*, 27, 300-312.

Samaritans (2012). *Men and depression*. Retrieved from www.samaritans.org/news/media-men-and-depression

Samuels, A. (2008). Foreword in House, R., & Loewenthal, D. (eds.), *Against and For CBT: Towards a constructive dialogue?* (pp. iii-iv). PCCS Books Ltd.

Seligman, M. E. P. (2002). *Authentic Happiness: Using the new positive psychology to realise your potential for deep fulfilment*. Nicholas Brealey Publishing, London.

Seligman, M. E. P. (1975). *Helplessness: On depression, development and death*. San Francisco, CA: W.H. Freeman.

Shapiro, J., Astin, J., Shapiro, S.L., Robitshek, D. & Shapiro, D.H. (2011). Coping With Loss of Control in the Practice of Medicine. *Families, Systems & Health*, 29, 15-28.

Shapiro, D.H., Schwartz, C.E. & Astin, J.A. (1996). Controlling Ourselves, Controlling our World: Psychology's Role in Understanding Positive and Negative Consequences of Seeking and Gaining Control. *American Psychologist*, 12, 1213-1230.

Shapiro, D. A. (1995). Finding out how psychotherapies help people change. *Psychotherapy Research* 5, 1-21.

Smith, J., A., Flowers, P. & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. Sage Publications Ltd.

Smith, J. A., Jarman, M. & Osborn, M. (1999). Doing interpretative phenomenological analysis. In M. Murray & K. Chamberlain (Eds.) *Qualitative Health Psychology: Theories and Methods* (pp.218-241). London: Sage.

Smith, J., A., & Osborn, M. (2004). Interpretative Phenomenological Analysis in Breakwell, G., M., *Doing Social Psychology Research* (ed.) (pp.229-254). BPS and Blackwell Publishing Ltd.

Stiles, W.B., Elliott, R., Llewelyn, S.P., Firth-Cozens, J.A., Margison, F.R., Shapiro, D.A. & Hardy, G. (1990). Assimilation of problematic experiences by clients in psychotherapy. *Psychotherapy*, 27, 411-420.

Strawbridge, S. & Woolfe, R. (2010). 'Counselling Psychology: Origins, Developments and Challenges' in Woolfe, R., Strawbridge, S., Douglas, B. & Dryden, W. (eds.), *Handbook of Counselling Psychology* (3rd ed.) (pp. 3-22). Sage Publications Ltd.

Sugarman, L. (2001). *Life-span Development: Frameworks, Accounts and Strategies* (2nd ed). Psychology Press Ltd: Taylor & Francis Group.

Taylor, M. A. (2007). What constitutes change? *Counselling Psychology Review*, 22, 13-20

Taylor, S.E., Klein, L.C., Lewis, B.P., Gruenewald, T.L., Gurung, R.A.R. & Updegraff, J.A. (2000). Biobehavioral Responses to Stress in Females: Tend-and-Befriend, Not Flight-or-Fight. *Psychological Review*, *107*, 411-429.

Tedeschi, R. G., Park, C. L & Calhoun, L.G. (Eds.) (1998). *Post-traumatic growth: Positive changes in the aftermath of crisis*. Mahwah, NJ: Erlbaum.

Thompson, S. C. (1981). Will It Hurt Less If I Can Control It? A Complex Answer to a Simple Question. *Psychological Bulletin*, *90*, 89-101.

Triplett, K.N., Tedeschi, R.G., Cann, A., Calhoun, L. G. & Reeve, C.L. (2012). Posttraumatic Growth, Meaning in Life and Life Satisfaction in Response to Trauma. *Psychological Trauma: Theory, Research, Practice and Policy*, *4*, 400-410.

Tyron, W. W. (2005). Possible mechanisms for why desensitization and exposure therapy work. *Clinical Psychology Review*, *25*, 67-95.

Vaillant, G. (1977). *Adaptation to Life*. Boston, Little, Brown and Co.

Veale, D. (2008). 'Psychotherapy in dissent', *Therapy Today*, February, 4-7

Vriends, N., Becker, E. S., Meyer, A., Williams, L.S., Lutz, R. & Margraf, J. (2007). Recovery from social phobia in the community and its predictors: Data from a longitudinal epidemiological study. *Journal of Anxiety Disorders*, *21*, 320-337.

Wester, S., R. (2008). Male Gender Role Conflict and Multiculturalism: Implications for Counseling Psychology. *The Counseling Psychologist*, 36, 294-324.

Wexler, D.B. (2009). *Men in Therapy: New Approaches for Effective Treatment*. W.W. Norton & Company, Inc.

White, A. (2009). Big boys really don't cry: Considering men's reluctance to engage in counselling. *Counselling Psychology Review*, 24, 2-8.

Willig, C. (2001). *Introducing Qualitative Research in Psychology: Adventures in Theory and Method*, Buckingham: Open University Press.

Wisch, A.E., Mahalik, J.R., Hayes, J.A. & Nutt, E.A. (1995). The impact of gender role conflict and counselling technique on psychological help seeking in men. *Sex Roles*, 33, 77-89

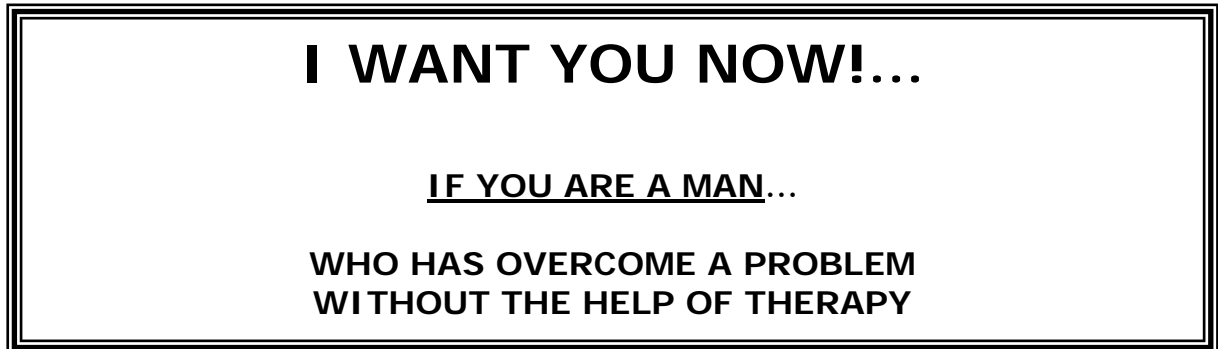
Yin, R. (1989). *Case Study Research: Design & Methods (2nd edn)*. Beverly Hills: Sage.

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Appendix 1: Recruitment Poster



- 1. Have you successfully resolved a problem which caused you some distress without the help of counselling/therapy?**

(Some examples of problems: Relationship break-up, divorce, bereavement, financial hardship, burnout, job loss, illness, alcohol/drug addiction etc.)

- 2. Did you resolve the problem at least six months ago?**

- 3. Would you be happy to take part in a confidential interview about your experience in January?**

If the answer is **YES** and you are interested in taking part in my study about men's experience of overcoming a problem without the help of therapy, to find out how you can volunteer then...

Email me NOW at Catherine.Buchan@wlv.ac.uk

**IF THIS APPLIES TO SOMEONE YOU KNOW, PLEASE
PASS THIS INFO ON TO THEM**

Thank you for your time and interest

Researcher:

Catherine Buchan

Practitioner Doctorate in Counselling Psychology student (2nd year)

University of Wolverhampton

Research Supervisor:

Dr. Yvette Primrose, y.primrose@wlv.ac.uk

University of Wolverhampton

Date: December 2010

Appendix 2: Recruitment E-mail

Recruitment email

Subject: Looking at Men's experience of overcoming a problem without the help of therapy

I am a postgraduate student on the Practitioner Doctorate in Counselling Psychology at Wolverhampton University. I am writing to find out if you would be interested in taking part in my study of men's experience of overcoming a problem without the assistance of psychotherapy, or if you know someone who might be.

The inclusion criteria for the study is:-

1. Men
2. Have resolved a problem (at least six months ago) which caused you some psychological distress
3. Are not undergoing (*nor have in the past*), psychotherapy or counselling
4. Would be happy to take part in a face-to-face interview or provide written answers to questions (*an information sheet and some interview questions will be provided in advance*)

If the above applies to you and you are interested in taking part in my study, please email me at Catherine.Buchan@wlv.ac.uk by _____ (date to be inserted).

When you email me, please provide the following:-

- Your contact telephone number
- The most convenient day and time to call you (morning, afternoon or evening)

NB: If the above does not apply to you, but you know someone who it does apply to, I would be very grateful if you would forward this email on to them.

Thank you for your time and assistance.

Kind regards
Catherine Buchan
Researcher
Practitioner Doctorate in Counselling Psychology student
University of Wolverhampton

Research Supervisor:
Dr. Yvette Primrose, y.primrose@wlv.ac.uk
University of Wolverhampton

Appendix 3: Consent Form

Consent Form

Looking at Men's Experience of Overcoming a Problem without the help of psychotherapy

Researcher: Catherine Buchan, University of Wolverhampton
Catherine.Buchan@wlv.ac.uk

Supervisor: Dr. Yvette Primrose, University of Wolverhampton
y.primrose@wlv.ac.uk

This study will be looking at men's experience of overcoming a problem in their life without the help of counselling or therapy. Some research has been carried out into people's experience of overcoming a problem in their life without the help of therapy, but men are underrepresented in the research.

It is hoped the information resulting from this study will increase our understanding about the experience of overcoming a problem, particularly from the male perspective. It is hoped that this will assist therapists to become better at helping men who seek therapy or counselling to overcome their problems.

I understand that I am voluntarily participating in this study and to a face-to-face interview.

I understand that I have the right to refuse to answer any questions during interview that I do not feel comfortable in answering.

I understand that I have the right to withdraw from the study at any point up until the time when the analysis is written up.

I understand that all the information subsequently published by the researcher as a result of the study is anonymous and strictly confidential.

I understand that anonymous quotes are to be used and published in the study.

I confirm that I am in possession of all the information I need.

I confirm that I am happy to participate in this study.

Signed: _____

Date: _____

Appendix 4: Information Sheet

Information Sheet

Looking at Men's Experience of Overcoming a Problem without the help of psychotherapy

Researcher: Catherine Buchan, University of Wolverhampton
Catherine.Buchan@wlv.ac.uk

Supervisor: Dr. Yvette Primrose, University of Wolverhampton
y.primrose@wlv.ac.uk

I am researching men's experience of overcoming a problem in their life without the help of counselling or therapy.

Some research has been carried out into people's experience of overcoming a problem in their life without the help of therapy, but men are underrepresented in the research.

It is hoped the information resulting from this study will increase our understanding about the experience of overcoming a problem, particularly from the male perspective. It is hoped that this will assist therapists to become better at helping men who seek therapy or counselling to overcome their problems.

During the interview, you will be asked to provide information about the problem that you overcame, how it affected you at the time, what you did to overcome it, and what you think about it looking back now.

You have the right to refuse to answer any questions that you do not feel comfortable about answering during the interview.

All the information that I collect during this study and the information about it which will then be published as a result, is kept anonymous and strictly confidential.

You have the right to withdraw from the study at any point up until the time when the analysis is written up.

You will be able to receive a summary of the finished study in the future, if you wish to by emailing me. Information on how to do this will be provided after the interview.

NB: Please retain this information sheet for future reference

Appendix 5: De-brief Sheet

De-brief Sheet

Looking at Men's Experience of Overcoming a Problem without the help of therapy

Researcher: Catherine Buchan, University of Wolverhampton
Catherine.Buchan@wlv.ac.uk

Supervisor: Dr. Yvette Primrose, University of Wolverhampton
y.primrose@wlv.ac.uk

Thank you for participating in this study about men's experience of overcoming a problem in their life without the help of counselling or therapy.

All the information you have provided will be kept strictly confidential, in accordance with the British Psychological Society's (2006; 2007) code of ethical research practice.

It is hoped the information resulting from this study will increase our understanding about the experience of overcoming a problem, particularly from the male perspective. It is hoped that this will assist therapists to become better at helping men who seek therapy or counselling to overcome their problems.

If you are interested in receiving a summary of the study, please e-mail me at Catherine.Buchan@wlv.ac.uk by **the end of April 2012**. The summary is expected to be ready in May 2012.

If you think or feel participating in this study has raised issues which you would like to discuss further please contact the following: -

Samaritans

www.samaritans.org
Tel: 08457 909090

Alternatively, you could contact your GP and ask to be referred to a counsellor.

Thank you for your time and participation. It is much appreciated.

NB: Please retain this de-brief sheet for future reference

Appendix 6: Semi-Structured Interview Schedule

Interview Schedule

Target Questions for Participant Experiences of Psychological Change

1. Let us start by telling me a bit about yourself and the course that you're studying (if a student) and/or the job that you do (if working). (*This introductory question is to help put the participant at ease and settle into the interview process*).
2. You have volunteered to discuss a problem that you have successfully overcome without the assistance of psychotherapy. Please could you explain in as much detail as you can what the problem was?
3. To what extent did the problem affect your life at the time?
4. To what extent did the problem affect you personally at the time?
5. What sort of things did you do to help you to deal with the problem?
6. Which ones did you notice actually helped you?
7. What do you think happened that enabled you to overcome this problem? (*related to self, others or situation?*)
8. How would you describe the speed of the change that you experienced? (*Prompts: was overcoming the problem slow and incremental or more 'one day the problem was gone'?*)
9. What, if anything, do you think it was that stopped you from overcoming the problem before that time?
10. Looking back, how do you think or feel now about the problem?
11. How do you view your problem now compared to how you viewed it at the time you were experiencing the problem?
12. How do you view yourself now compared to how you viewed yourself at the time you were experiencing your problem?
13. We now have an opportunity for you to say anything else which you would like to say add regarding your experience of a overcoming a problem.....

Originally adapted from Higginson, S. & Mansell, W. (2008) and utilised in Gianakis, M. & Carey, T. A. (2011).

Appendix 7: Information E-mail sent to participants prior to the interview

Pre-Interview Information E-mail

Thank you for volunteering for my study into men's experience of overcoming a problem in their life without the help of therapy or counselling.

Please check you meet the following criteria to ensure you are eligible to participate: -

- 1) You have successfully overcome a problem which caused you some distress
- 2) You resolved the problem at least six months ago
- 3) You resolved the problem without the help of therapy or counselling (includes NLP, Hypnotherapy etc)

The interview takes approximately one hour. The more information you are able to provide about your experience during the interview, the better. During the interview the items you will be asked to discuss will include what your problem was that you successfully overcame, how it affected you and what you did to overcome it for example.

I look forward to meeting you.

Many thanks.

Kind regards
Catherine Buchan
Researcher
Practitioner Doctorate in Counselling Psychology Student

Research Supervisor:
Dr. Yvette Primrose, y.primrose@wlv.ac.uk
University of Wolverhampton

Appendix 8: University of Wolverhampton RES 20a Form



**RES 20A
(October 2003)**

**School of Applied Sciences
Behavioural Sciences Ethics Committee:
submission of project for approval**

To be completed by SEC:
Date Received:
Project No:

- **This form must be word processed – no handwritten forms can be considered**
- **ALL sections of this form must be completed**
- **No project may commence without authorisation from the Divisional and School Ethics Committees**

CATEGORY A PROJECTS:

There is no significant interference with participants’ physical or psychological wellbeing. In detail:

- The research procedure is not likely to be stressful or distressing.
- The research materials are not of a sensitive, discriminatory or otherwise inappropriate nature.
- The participants are not members of a vulnerable group, such as those with a recognised clinical or psychological or similar condition.
- The research design is sufficiently well-grounded so that the participant’s time is not wasted.

Projects involving access to confidential records may be considered Category A provided that the investigator’s access to these is part of his/her normal professional duties.

Category A projects will be approved by the Behavioural Sciences Ethics Committee and monitored by the School Ethics Committee. The School Ethics Committee will not normally examine individual Category A projects but receives a record of projects that have been approved at subcommittee level.

Title of Project:	An Interpretative Phenomenological Analysis Investigation into Men’s Experience of Psychological Change without Psychotherapy
Name of Supervisor: (for all student projects)	Dr. Yvette Lewis
Name of Investigator(s):	Catherine Buchan
Level of Research: (Module code, MPhil/PhD, Staff)	Practitioner Doctorate in Counselling Psychology
Qualifications/Expertise of the investigator relevant to the submission:	BSc (Hons) Psychology & Counselling

<p>Participants: Please indicate the population and number of participants, the nature of the participant group and how they will be recruited.</p>	<p>The population for the study will consist of men between the ages of 21 and 39, who have resolved a problem at least six months previously which caused them some psychological distress. They must not be undergoing, or have undergone in the past, psychotherapy or counselling. The number of participants is expected to be 12, with six individuals participating in face-to-face interviews and the remaining participants to provide written narrative answers. In order to recruit the participants, a poster (see appendix 3) will be displayed on the noticeboards in Wolverhampton University. This will inform the staff and students about the subject of the study and invite them to participate if appropriate, or pass the information on to men they know who might be interested in participating.</p>
--	---

Please attach the following and tick the box* provided to confirm that each has been included:

**in the case of undergraduate projects, this should be done by supervisors to confirm that each part is properly constituted*

Rationale for and expected outcomes of the study	√
Details of method: materials, design and procedure	√
Information sheet* and informed consent form for participants <i>*to include appropriate safeguards for confidentiality and anonymity</i>	√
Details of how information will be held and disposed of	√
Details of if/how results will be fed back to participants	√
Letters requesting, or granting, consent from any collaborating institutions	n/a
Letters requesting, or granting, consent from head teacher or parents or equivalent, if participants are under the age of 16	n/a
<p>Is ethical approval required from any external body? NO (delete as appropriate) If yes, which committee?</p> <p><i>NB. Where another ethics committee is involved, the research cannot be carried out until approval has been granted by both the School committee and the external committee.</i></p>	

Signed: _____ Date: 15.9.2010
 (Investigator)

Signed: _____ Date: 15.9.2010
 (Supervisor)

Except in the case of staff research, all correspondence will be conducted through the supervisor.

FOR USE BY THE SCHOOL ETHICS COMMITTEE

Subcommittee _____ Date: _____
 Approval Granted: _____

 (Chair of Behav Sci Ethics
 Committee)
 School Approval _____
 Granted: _____ Date _____

 (Chair of School Ethics
 Committee)

Appendix 9: E-mail received from the University of Wolverhampton's Ethics Committee

3. RES20A (Prac Doc) "An Interpretative Phenomenological Analysis Investigation into Men's Experience of Psychological Change without Psychotherapy"
Investigator: Catherine Buchan

Supervisor: Dr Y Lewis

1. How will the six participants be chosen?
2. Information Sheet – "IPA" may be too technical for participants. Do they really need this information? There is a generally high level of psycho-jargon, which should be reduced. A more user-friendly title on communications to participants would also be better.
3. The purpose of the participant code (to maintain confidentiality) is unclear.
4. An indication of time-frame is required for the receipt of an abstract of the completed study.
5. The consent form does not cover all essential details. Two separate information sheet and consent forms should be used, one for face-to-face interviews and another for written interviews, as the processes differ. Consent is also required for anonymous quotes to be used in the study.
6. Where will the interviews take place?
7. Is the upper age limit justified?

SUPERVISOR TO MONITOR

Appendix 10: Table of emergent themes with text extracts for Participant 4 (abridged version)

Participant 4

Emergent Theme and Notes	Transcript Extracts	Line Number(s)
<i>Dealing with the unexpected</i>	and yeah it was just a sort of sea change [...] a a bad moment really (slight laugh)	108-110
	erm..yeah I..I just didn't [...] expect it at..at all really [...] I just thought 'oh well maybe it's a rough patch and we'll get through it' [...]	366-371
	it was just..it was just completely unexpected and [...] so it's like oh..what's (pause) you know what, coz that was such a big part of my life and	649-652
<i>Strong emotions?</i>	[.....] I mean the problems with the girlfriend were, they..they were upsetting. They were very upsetting er, yeah, that made me feel quite lonely at points [...] that really added to the stress	212-217
	[..] Yeah, just, just abandoned really and yeah, annoyed at her	433-434
	it was just six weeks of constant turmoil [.....]	1321
<i>Experiencing/ Reaching a threshold (or exceeding a threshold?)</i>	justat the end of February I was just so exhausted	171
	the exhaustion was just..there was..there was too much going on in my head and there was too much going on you know, I'd have to be there then there then there then there then there. It was just (pause) there was no time to relax	397-401
<i>Experiencing change as a gradual process</i>	and then probably by about mid March, it sort of...everything started to subside and I started to feel more comfortable	91-93
	[..] I could start working on the problem [...] and figuring out and [...] and I think that's been quite a long process [.....]	536-540
	erm and things have sort of (pause) er decayed exponentially [...] (laughs)	1331-1332
<i>Dealing with uncertainty</i>	just fed up and I jus..didn't know where I was. I didn't know [...] sort of ..what what was happening	174-177

	in my life	
	it..it started to work on this problem of feeling that nothing was stable anymore [.....].	524-525
	so I mean at th..the time, because I..I had no perspective [..] I think it was..I think yeah, I didn't know where..where I stood, or what was gonna happen in the future [.....]	1777-1782
<i>Experiencing issues of control</i> <i>(or experiencing a loss of control sub theme & experiencing issues of control as a superord theme?)</i>	just fed up and I jus..didn't know where I was. I didn't know [..] sort of ..what what was happening in my life	174-177
	erm so yeah, I guess time [..] just letting time pass by, letting these things resolve coz I wasn't in control	1188-1191
	No. Not...not really so much..I..I was just thinking, you know, these are things that are happening to me 'Ah' (laughs)	1759-1761
<i>Being stoical</i> <i>(or getting on with it)</i>	but it didn't feel like I couldn't cope. I just got on with it	203-204
	'sort of.. you feel rubbish, which is fine' [..] 'but just, you know, get on with it' [..] seemed to be how I was thinking	311-315
	erm and (pause) yeah it..I just..I had to rely on myself [..] for everything then and it just ..that stress, I suppose	436-438
<i>Putting the problem into perspective?</i> <i>(theme seems linked to rational/logical thinking/self-coaching)</i>	I mean..I.. my sort of prevailing thoughts were 'it's not the end of the world. There are more..[..]'there are people worse off than you'	306-309
	this film, weirdly helped me [..] just think yeah, it..it's just..it was what it was and now you're out the other side of it and you know, something will happen again. Life goes on.	924-928
	[.....] it wasn't like, the direction of my life wasn't, it wasn't spiralling into despair or anything,	1226-1228

	it was..it was..it was ok	
Reaching a place of acceptance	she didn't really want to follow me around...[..] the field..so I sort of accepted that but the the timing was awful (laughs)	355-358
	and I remember the feeling I had after watching that and [...] I just felt ok with the whole thing.	883-886
	Erm (pause) so, but I mean the whole situation with her is just, she's..I've ..just let everything go really [...] I mean there are no feelings there anymore erm [.....]	1595-1598
Rationalising/ Employing logical reasoning	yeah it was it was a bit of a surprise but I just sort of accepted it because her reasons were good and erm (pause) ..I guess I knew her well enough and loved her enough that I could just let her [...] just.. you know..I knew that was what was best for her	373-378
	and life goes on and actually watching that (<i>film</i>) made me apply the same sort of reasoning to my situation and I felt a lot better about things	907-909
	So, I..I..I can rationalise the situation but, I don't know, I think there's still this need for this sort of sign almost	1629-1631
Thinking (about the problem?)	something like that, it was ..it was also nice to have the time to start thinking about the problem	511-512
	least I could start working on the problem [...] and figuring out [...]	536-538
	rather than feeling sort of I don't know, dispossessed of a future [...] as perhaps I'd been doing. I..I knew that wasn't a sensible thing to think [...] but at the same time I was thinking about it. [.....]	911-917
Distracting thoughts from the problem (by working?)	ignored it by working, which I think was a good thing in a lot of ways	445-446
	Mm yeah so erm that..that was pure distraction really I mean it was something that was necessary but it was distraction [...]	783-785
Identity Past self vs new self	it's a bit of a different world [...] between being 17 and being 23 now	689-691
New self	It was good because I think all this stuff sort of hardened me to these sort..sorts of things	724-725
Past self vs new self	but yeah, whereas at the time I thought I was maybe a bit silly the way I was thinking about	1674-1677

	things and [...] sort of...I feel like I've matured as a result erm [...]	
<i>Laughing it off</i> (part of coping)	[.....] she broke up with me, then I came back on the train and that was difficult because I'm on public transport trying not to cry (laughs)	615-617
	er and afterwards, now, erm I sort of view..I..alm..I.I can almost laugh at some of these things, in fact I do now and again	1670-1672
<i>Distracting thoughts from the problem</i> (with socialising?)	I think it also helped that.. so when I was with people, I wouldn't worry about things	505-506
(part of coping)	[.....] I have some good friends as well, so they were always around. It's good to spend time with them [...] mostly because they just wouldn't talk about it	730-734
	So that..that was good as well coz it was distraction [...] so when I was with them I was talking about normal things and you know, having a laugh	795-798
<i>Contemplating the future</i>	[...] so, that was when I started thinking about these things more and trying to fit them into the context of sort of what my life was gonna be like in the future	517-519
	rather than feeling sort of I don't know, dispossessed of a future [...] as perhaps I'd been doing. I..I knew that wasn't a sensible thing to think [...] but at the same time I was thinking about it. [.....]	911-917
<i>Addressing the problem</i> (thinking)	[...] so I still didn't know where I was, but I felt like at least I could start working on the problem	535-536
(thinking)	so it..it was all part of that [...] that was, yeah making sure I knew where everyone else was in my life and where I was	600-603
<i>Becoming accustomed/getting used to the new situation</i> (seems important part of change process)	and sort of well, get used to being single really [...]	684
	Yeah and also sort of [...] exploring (pause) thi.. this sort of new life I had, that was helpful	1088-1088
	and everything from then on was just, like I say,	1326-1329

	putting things into perspective [...] and getting used to it	
Time as a healer?	[.....] erm er yeah just (pause) yeah a lot of it was letting the dust settle [.....]	575-576
<i>(this theme-different to experiencing a gradual process of change? – sub theme?)</i>	erm so yeah, I guess time [...] just letting time pass by, letting these things resolve coz I wasn't in control	1188-1191
	Yeah, time..time passing er definitely helped	1210
Needing to feel in control? <i>(part of experiencing issues of control theme)</i>	I..I guess that's in..in part a way that I cope with things [...] is just to know where I am. I like knowing where I am	579-581
	[.....] er so yeah but once, once things settled down, once these bad things started happening [...] er stopped happening rather [...] er (pause) yeah, then..then I could (pause) start really trying to deal with it	1528-1534
Talking to others about the problem <i>(communication theme)</i>	sort of went to see one of my friends in his room [...] who I lived with at the time and just explained it to him [.....]	620-623
	yeah I sort of talked to my friend..I mean..I mean really just yeah talking about it even if I..I don't think it was very sensible talk at all	645-647
	So but again that was sort of yeah, talking to people about things. [...]. Yeah that did help	1081-1084
Taking action <i>(Socialising/meeting new people)</i>	but now I wanted to go out more and meet new people [...]	679-682
<i>(Socialising/meeting new people)</i>	sort of, yeah, talking to friends, meeting new people [...] also put it into perspective	938-940
<i>(dating)</i>	er yeah, so yeah, going on dates was..it was like well, you know, at least I can do it	1230-1231
Perceiving the experience as positive/beneficial	erm (pause) the..the way I see it is everything helped in some way whether it was positive or negative because it just added to the experience [...]	751-753
	but yeah, whereas at the time I thought I was maybe a bit silly the way I was thinking about things and [...] sort of...I feel like I've matured as a	1674-1677

	result erm [..]	
	I...I realised that I've perhaps become a better or more settled person as a result [..]	1768-1769
<i>Experiencing the natural resolution of problems?</i>	erm and also what helped was just when the problems went away	803-804
	erm so yeah, I guess time [..]just letting time pass by, letting these things resolve coz I wasn't in control	1188-1191
<i>Experiencing change as a sudden moment</i>	and I remember the feeling I had after watching that and [..] I just felt ok with the whole thing.	883-886
	so I just remember after watching that film feeling very relieved (laughs)	930-931
	as soon as I broke up with my girlfriend, that was the end of the turmoil	1323-1324
<i>Employing positive thinking/focusing on the positive?</i>	you're out the other side of it and you know, something will happen again.[.....]	927-928
	er yeah, so yeah, going on dates was..it was like well, you know, at least I can do it	1230-1231
	so that was..that was good erm er yeah, going out with my friends more so you know, so I can have fun	1233-1234
<i>Being ready to address the problem</i>	[.....] to begin dealing with the problems I sort of needed this..I needed to have the problems in front of me to deal with, I needed to know fully what the problems were [..]	1504-1507
	yeah, that was..I..I couldn't...couldn't even really begin [..] until those things were (pause) resolved	1515-1519
<i>Experiencing new insights/experiencing a shift in awareness? (realising)</i>	[.....] so I've sort of realised how much I do rely on other people [...] in some ways and I've also realised that I have to rely on myself more for sort of emotional support and that sort of thing, sort of realising that that was underdeveloped in me	1728-1731
	it's just realising things about why almost, because I think everyone goes through sort of similar things at various points in their life [..] and sort of not..I guess not...not feeling like there was anything too different about me, it was just part of the way things are	1745-1751

Appendix 11: Preliminary Table of Group Super-ordinate and Sub-themes

THEMES ACROSS CASES AT 2/11/12

Super-ordinate themes	Sub-themes	Participants
<i>Coping with the problem</i>	Undesirable emotions	All except P1
	Issues of control	2,3,4,6,7,8,10
	Being supported by others	1 (minor), 2,4,6,7,8,9,10
	Distracting thoughts from the problem	2,4,5,7,8,9,10
<i>Experiencing turning points</i>	Threshold	1,3,4,6,10
	Strong undesirable emotions	1,3,6,10
	New insights	1,5,6,10
	Becoming motivated to address the problem	1,3,5,6,7,9 (minor) 10
<i>Addressing the problem</i>	Thinking	All
	Taking action	All except P5
	Experiencing a gradual process of change	All
	Experiencing a sudden moment of change	2,4,5,6,7,8,9
	Personal qualities	2,3,4,5,6,7,8
<i>Appraising the experience positively</i>	Learning from the experience	2,3,4,6,8,9,10
	Past self vs New enhanced self	All except P5. (P8 = minor)