Client factors associated with psychotherapeutic process and outcome: A concept analysis

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Abstract

Background and objective

Common factors theory proposes that clients make significant contributions to psychosocial change processes and outcomes in psychological therapy. However, the client factors concept contains such a wide range of client activities, characteristics and extratherapeutic circumstances that without some form of structural logic, it is difficult to understand how clients contribute to change processes, or how counselling psychology theory might be shaped to work with the most potent client factors. Using first-hand participant experience and published peer-reviewed psychotherapy outcomes research, this study sets out to identify client factors associated with psychosocial change and non-change, and to organise them into a conceptual framework.

Method

A deductive qualitative ‘hierarchy of abstraction’ concept analysis method is used to interpret and organise data from nine participant interviews and 68 research studies. Graphic frameworks derived from each data source are compared, then combined into a single reconstructed concept framework.

Findings

The resulting conceptual hierarchy model presents client factors associated with change and non-change over four levels of abstraction. The detail of experience is located at the least abstract elemental and categorical levels of change-related activity and inactivity; then abstracted to stages of change and non-change; then further abstracted to two broad client factors. In this provisional model, the first of these factors is client use of available social support resources, which inspires and reinforces the second factor, which is reflective and experiential learning. Inadequate social support is implicated in the learning and experiential stagnation associated with non-change. The adequacy of the reconstructed concept is assessed against seven criteria; and by comparing its fit with two social learning theories.

Conclusion and implications

In view of the importance of reflective and experiential learning in this conceptual model, social learning theory is proposed as relevant for informing future developments in counselling psychology theory and research. In this model, the term ‘social learning factors’ more accurately points to the potentially major constellation of wider client and extratherapeutic social contributions to therapy outcomes currently indicated by ‘client factors’ in common factors theory.

Key words: client factors; concept analysis; concept adequacy; psychotherapy process; psychotherapy outcome; common factors theory.
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**Dedication**
This research is dedicated to the memory of a participant.

**The Author**
I earned my Master’s degree in Counseling Psychology (M.Ed) from Rutgers University, New Jersey, USA in 1994. I earned another Master’s degree in Counselling Studies (MA) from University of Manchester, UK in 2010. I have worked in full-time practice in a range of mental health settings since 1994. Since 2006 I have worked in social sector counselling service development and leadership. My academic research to date includes this thesis; and my 2010 Master’s thesis on the cost-effectiveness of a guided self-help intervention. I have published articles, guidance and textbook chapters in the area of counselling psychology theory and practice including social entrepreneurship.
CHAPTER 1: INTRODUCTION

1.1 Chapter overview
This chapter aims to orient the reader to the study. It is set out over five sections. In the first I explain the problem this study addresses, which is the disorganised state of the client factors concept within common factors theory. I justify the need for an evidence-based conceptual framework that accommodates a wide range of known client factor dimensions, states and behaviours over various levels of conceptual abstraction; that accounts for the temporality of change processes; and that includes unhelpful as well as helpful factors.

In the second section, to reduce possible doubt for the reader about why I chose a concept analysis methodology for this study, I explain why I treat the term ‘client factors’ as a concept. I then explain why empirical concept analysis is a better fit than more ‘mainstream’ qualitative methodologies including thematic analysis, interpretive phenomenological analysis and grounded theory. I also explain the tradition and context for the reconstructive ‘ladder of abstraction’ concept analysis used here.

In the third section I detail the study’s two-fold purpose, which is to reconstruct the client factors concept and then to consider the utility of the reconstructed concept to counselling psychology theory. This section also includes the four research questions that guide me in achieving these aims.

In the fourth section I define and discuss key terms including concepts; psychotherapy; causal syntax; and outcome.
The chapter concludes in the fifth section with an overview of the study’s chapter layout and content.

1.2 Study problem
Sometimes, when reading textbooks and research articles that are relevant to my work, I encounter an abstract technical term whose precise meaning, structure or function is not fully explained. When I am particularly committed to the topic, I am troubled by an under-defined term. It is likely to be derived from a detailed set of conceptually interrelated phenomena, but I cannot extrapolate its significance if I don’t understand what the concept encompasses, how its components hang together, or where its mechanisms of action lie. For me, ‘client and extratherapeutic factors’ is such a term. I became interested in it as an important but incoherent concept when, around the turn of the century, I enthusiastically read *The Heart and Soul of Change*, Hubble, Duncan and Miller’s (1999a; updated by Duncan, Miller, Wampold and Hubble in 2010) textbook about the common factors that enable psychotherapy to achieve its results. Two key messages in this book deeply influenced my subsequent thinking and work as a psychotherapist. The first, from Tallman and Bohart (1999) is that the client is more responsible than the therapist or therapeutic approach for making therapy work. The second, from Hubble and Duncan and Miller’s (1999b) concluding chapter, is that the practice of therapy should not be about classifying disease but about facilitating change. Here they use the term ‘client and extratherapeutic factors’ to encompass client characteristics that impact outcome; aspects of client activity within and beyond the therapy relationship; and social and emotional resources that clients may use to facilitate change. Overall, 18 disparate client and extratherapeutic factors can be summarised from chapters contributed to this textbook by Asay and Lambert (1999), Tallman and Bohart (1999) and Hubble, Duncan and Miller (1999b):

1. Duration and severity of client’s problem
2. Pre-treatment change
3. Stage of change
4. Motivation
5. Hopes and expectations
6. Helpful behaviours outside therapy  
7. Nature, strength and quality of social support  
8. Client’s theory of change  
9. Self-expression and self-disclosure  
10. Using self-help media  
11. Participation and openness  
12. Clarity of goals  
13. Agency in pursuing goals  
14. Active learning  
15. Creative conceptualisation and re-conceptualisation  
16. Reflexive self-understanding; gaining new perspective and realisations  
17. Exposure and extinction  
18. Reality testing, mastery and corrective experiences  

In the textbook’s second edition (Duncan, Miller, Wampold and Hubble, 2010) Bohart and Tallman (2010) add a further seven client factors gathered from literature review:  

19. Suitability for therapy  
20. Cooperation and interactive collaboration  
21. Contribution to the therapeutic bond  
22. Perception of therapy  
23. Resilience and post-traumatic growth  
24. Early change  
25. Higher level of distress  

Bohart and Tallman (2010) describe this known constellation of client and extratherapeutic factors as a “potpourri of findings from unrelated research areas” (p.94). A less charitable metaphor than a bowl of dried flowers and cinnamon sticks could be applied. For me, the primary problem with this list is its disorganised randomness. It includes behavioural and cognitive functions, active and passive states, intra-therapeutic and extratherapeutic elements; intimations of different theories such as ‘stage of change;’ various degrees of abstraction from lived experience; temporally determined aspects such as ‘pre-therapy change’ and ‘early change;’ and difficult-to-
measure categories such as ‘suitability for therapy’ (see for example Laaksonen, Lindfors, Knekt and Aalberg, 2010 for discussion of a ‘suitability for therapy’ scale that predicts outcome on the basis of participant personality function). This potpourri does not tell me how change comes about, nor why some clients find change difficult to achieve. In other words, it does not, by itself, offer a cohesive theory of ‘the active client’, despite its appearance in a textbook dedicated to illuminating conceptual mechanisms of client change. It requires some sort of analytic technique to render theoretical coherence to its components.

To this end Tallman and Bohart (1999) briefly hypothesise (after Kolb, 1984) that client change happens in cycles of thinking, behaviour and experience which lead to shifts in problem and solution conceptualisation, which in turn lead to further thinking. To assist reader comprehension I have adapted this change model into the graphic shown in figure 1.

*Figure 1: Thinking, behaving, experiencing, reconceptualising cycle*
I find this conceptual model of client change inadequate for five reasons. Firstly, it is over-simplified and does not show where the range of 25 client factors summarised above might fit in, or how they make a difference. For example, the influence of social support is missing. Secondly, it cannot distinguish, accommodate or organise the various levels of abstraction inherent to the listed client factors. For example, ‘active learning’ is a more abstract term (i.e. a general category of activity) than ‘exposure’ (i.e. a behavioural technique associated with active learning). Thirdly, it does not suggest where this cycle sits in wider temporal planes of change. For example, the client factor ‘stage of change’ implies that different tasks, frames of mind, states of awareness, or activities are present at different times in a change process. Does this cycle happen early or late in a change process? Or does it represent the entire change process? Fourthly, the model does not account for why people struggle, or fail, to make desired changes, which might be even more important for therapists to understand than how people successfully change. Lastly, Tallman and Bohart state that there is “no specific evidence” (p.113) to support their use of the thinking-behaving-experiencing cyclical model in this way. Further work is required to render theoretical coherence to the concept of client factors and its component parts.

Client factors as a concept

Before I explain why I chose concept analysis to help me construct a client factors theoretical framework, I first explain why I believe the term is a concept.

In this study concepts are defined as abstract linguistic entities (for example, nouns) that mediate between collections of interrelated embodied experiences, and the meaning or interpretation that is made of them in mental representations such as thoughts and ideas (Rundle, 1995). Concepts lend themselves to analysis and structural mapping to assist with theorising and knowledge synthesis (Fauconnier and Turner, 1998; Knafl and Deatrick, 2000). As this study will show, it is possible to create a structurally logical framework to map the meaning of the term ‘client factors’ through a process of organising findings from quantitative research, thus determining it is a concept (Laurence and Margolis, 1999).
The structural prototype that best describes the client factors concept is Laurence and Margolis’ (1999) ‘containment model:’ an abstract concept that is a composite of multiple other interrelated, less abstract concepts, as is the case with ‘client factors.’

**Concepts as legitimate subjects for research enquiry**

Much psychotherapy research over the past fifty years has been devoted to understanding which therapeutic approaches and therapist attributes produce the best outcomes. But this vast literature, according to Kazdin (2009), offers little explanation about why psychotherapy works, or how client change comes about. Kazdin suggests that “fresh approaches are needed in conceptualisation” of key change mechanisms (p.419). Similarly, Beutler (1991) asserted that while a wide range of client variables are theoretically important predictive constructs, they lack consensual or consistent meaning, are poorly defined, and have weak conceptual linkages to psychotherapy theories. These views indicate that client factors are worthy of improved conceptualisation.

My starting point with this study is that I believe Bohart and colleagues are right: as conceptual entities, client and extratherapeutic factors make more difference in therapy outcomes than therapist or technique factors. By extension I also believe that the client factors concept must point to a complex theoretical architecture of process mechanisms in which most if not all of the factors identified above (and potentially others not listed) must fit in a logically interrelated manner. I require an analytic method that enables me to redress the five limitations with the thinking-behaving-experiencing-reconceptualising model shown in figure 1. So, it must permit me to (a) consider the boundaries of the concept and the associated rules by which member objects are included and excluded (even if the rules are provisional and experimental); (b) distinguish and accommodate various levels of conceptual abstraction amongst the member objects; (c) create a graphic illustration of influential relationships between member objects in a way that respects and highlights the temporal nature of human psychosocial change processes; (d) include non-change factors as well as change factors and, if possible, illuminate relationships between these; and (e) ensure that the framework is evidence-based.
1.3 Why concept analysis

Rennie (2012) helpfully distinguishes three types of qualitative research and the varieties of methods that suit each type. The first type, ‘experiential’ research, conceptualises reported experience into structures or categories using methods such as narrative analysis (McLeod and Balamoutsou, 2006), grounded theory (Strauss and Corbin, 1998) and interpretive phenomenological analysis (Smith, Flowers and Larkin, 2009). The second type, ‘discursive’ research, is applied to the study of language use, with methods such as conversation analysis (Sacks, 1972) and discourse analysis (Parker, 1998). The third type, ‘experiential/discursive’ blends these two, and according to Rennie is characterised by two methods, thematic analysis (Braun and Clarke, 2013) and case studies (Stiles, 2003) because each has been applied to both the experiential and discursive types of research.

This study lies in the experiential type, as its purpose is to conceptualise experience reported by participants and published literature into a theoretically-informed structure. In this study, if I had wanted simply to qualitatively describe, list or thematically organise influential client factors that might be located in research literature or participant experience I might have chosen thematic analysis, interpretive phenomenological analysis (IPA) or grounded theory. Any of these methods would facilitate an evidence-based analysis, but I will here explain why each approach is not the right fit for the aims of this study, which is to create a tentative theoretically informed framework for the client factors term.

Why not thematic analysis

Thematic analysis is unsuited to this study’s aims for several reasons. Rennie (2012) notes that it is best suited to discursive and experiential/discursive - and by extrapolation, not experiential - types of qualitative research. Although Rennie does not explicitly explain why he makes this assertion, I wonder if it might be because thematic analysis is not designed to create, develop or improve theory (University of Auckland, no date). It tends to suit inductive research (Braun and Clarke, 2013) that creates concepts from various forms of discourse analysis (Rennie, 2012). By contrast, my theory-engaged study requires a deductive approach that starts with an existing
theoretical concept and critically examines the particulars of qualitative and quantitative evidence for the theory. Furthermore, thematic analysis lacks strategies for distinguishing different levels of conceptual abstraction or temporal zones, and thus forces the researcher to work within a single plane of interpretation (University of Auckland, no date). In short, while thematic analysis is useful for locating and analysing themes and patterns in qualitative material, it is not designed to deal with abstract, theory-bound concepts.

**Why not IPA**

Considering IPA next, Rennie (2012) suggests it is useful for experiential qualitative research that creates structured conceptualisations. IPA permits two levels of thematic abstraction - emergent and superordinate. But these functions cannot adequately accommodate the multi-layered abstraction inherent in the client factors concept. Moreover, IPA tends to focus on the individual participant (Larkin, Watts and Clifton, 2006) which is not suited to the aim here. On a personal note I would not choose IPA because I do not agree with some terminology used by its proponents. For example I do not believe that themes ‘emerge’ as foregone ontological entities waiting to be discovered (see for example Smith and Osborn, 2007) but are epistemologically created by the researcher. Additionally, I do not like the idea of the IPA researcher claiming the power to give ‘voice’ to participants (see for example Larkin, Watts, and Clifton, 2006) especially when participant contributions are sometimes heavily interpreted through the IPA researcher’s frame of reference.

**Why not grounded theory**

Grounded theory at first seems an appropriate qualitative methodological choice. It comprises a taxonomical, hierarchical analytical process, which identifies and organises associated categories and properties of data under conceptual labels. It deals well with analyses of social processes which can be translated to graphic models (Morrow and Smith, 1995). It produces a discursive set of theoretical propositions that account for causes and consequences related to the examined phenomena (Strauss and Corbin, 1990). It has been adapted for use in research which (as I explain further in Chapter 3, is the case with this study) is rooted in critical realist ontology (e.g. Hoddy, 2018). It
includes criteria for judging analytic adequacy including fit, relevance, workability and modifiability (Glaser, 1998). However, upon further consideration grounded theory also proves inappropriate. Where grounded theory starts with raw data from which it seeks to inductively draw up abstract concepts, in this case I am starting with an abstract concept and require a methodology that deductively drills down, examines and maps its structure and generative mechanisms using selectively chosen data. It is not possible for me to ignore literature or theory in the topic area (as suggested by Glaser and Strauss, 2000). Indeed, the starting point for the study is my knowledge of, and reference to, an influential body of existing theory and research on client contributions to therapy process and outcomes.

**Why concept analysis**

My research position is illustrated by the Tennyson poem that opens this chapter. The mystery of the flower growing in the crack in the rock is like the concept of client factors in the puzzle of what makes therapy work. If I can pull up and examine the root structure of this concept I might achieve a better understanding of what clients do to bring about psychosocial change, as a fundamental aspect of human adaptation and survival.

And so I arrive at concept analysis as the favoured qualitative methodology. Although in Chapter 3 I describe and distinguish between different types of concept analysis and related methodologies, and explain the ‘reconstructive hierarchy of abstraction’ method (Sartori, 1984) chosen for this study, I here briefly orient the reader to concept analysis methodology. For the avoidance of confusion, it is important that I first distinguish 'concept analysis' as an empirical research methodology (as used here) from ‘concept analysis’ as a process of defining and clarifying key terms at the outset of a study (as used, for example by Aveyard, Payne and Preston, 2016). Empirical concept analysis research methodologies are traditionally employed in nursing scholarship (e.g. Rodgers and Knafli, 2000); sociology (e.g. Fredericks and Miller, 1987); political science (e.g. Collier and Gerring, 2009); cognitive science (e.g. Laurence and Margolis, 1999); and gender studies (e.g. Goertz and Mazur, 2007). Each of these disciplines tends to prefer its own philosophical and ontological schools of thought on the nature of concepts and the purpose of concept analysis. This study employs a form of concept analysis derived
from the political science work of Sartori (1984) and Gerring (1997; 2012).

‘Reconstructive’ concept analysis aims to map relevant data units to a theoretically informed hierarchically abstract definitional framework, and also aims to assess the pragmatic adequacy of the result. Reconstructive concept analysis offers a critical approach to understanding conceptual terms that have become arbitrarily fixed to empirical findings, which I will argue later, may be the case with the term ‘client factors.’

As I discuss further in Chapter 3, counselling psychology has yet to engage with concept analysis methods, even though our work is concerned with innumerable relatively abstract concepts such as ‘emotional distress,’ ‘resilience,’ ‘collaboration,’ ‘facilitation’ ‘goals,’ ‘family’ or ‘multiculturalism.’ Such concepts are ‘tools of the trade,’ but the scientist-practitioner’s ability to teach, practice, research and theorise effectively using these tools depends on a precise, deep and clear understanding of their meaning and referents, as well as the ability to measure them or assess their impact in people’s lives. Achieving such clarity, in turn, depends on research methods that enable analysis of conceptual structure and linkage to theory.

**Empirical concept analysis**

One starting point for understanding the role of concepts in language is to distinguish ‘referents,’ ‘concepts,’ and ‘meanings’ (Jackson, 1984). Referents are contextual, social or personal characteristics, dispositions, processes, events and other phenomena that are most directly visible in lived experience. Concepts are verbal denotations (linguistic representations or symbols) for these phenomena. They are created though social convention. Meanings are the individual and collective mental constructions predicated by concepts. They are developed socially and are vulnerable to misunderstanding or distortion if not adequately researched, taught or communicated. Figure 2 provides an illustration of the relationship between referents, concepts and meanings.
In this diagram we can see that concepts are tools that bridge referents and their meanings. By extension, concept analysis is a methodology that maintains conceptual tools in an “orderly condition” (Jackson, 1984, p.206) by epistemologically mediating the relationship that referents have with their meanings, and by enhancing contextual clarity and definitional specificity, particularly as a preparatory step where a concept is required to form part of a scientific investigation. Some types of concept analysis also strive for ontological depth by pointing to possible mechanisms of action or the nature of a process in order to advance existing theory (Risjord, 2009), which is the case in this study. Figure 3 provides a basic illustration of the mediating role of concept analysis research between concepts and theory development.
1.4 Study purpose and questions

Bohart has noted that “the role of the client as an active change agent who makes significant contributions to the change process has been neglected in the psychotherapy literature” (2004, p.119). He recommends, “There are now many reviews of specific aspects of client functioning but none give a comprehensive picture of the client in therapy….It seems more useful to investigate what these characteristics mean.” (Bohart and Wade, 2013, p.221, 246).

This study takes up Bohart’s research recommendation. It has two aims. The first, as previously noted, is to sort out the jumbled meaning of the ‘client and extratherapeutic factors’ concept by creating a provisional theoretical model of how people participate (or not) in processes of psychosocial change. The second is to consider the utility of the concept for counselling psychology theory. I explain these aims further, then detail the four research questions used to address them.
**Aim 1: Analysis and reconstruction of the client factors concept**

Clients operate in patchily mapped conceptual space in terms of their contribution to psychotherapeutic process and outcome. One possible reason for this is that client factors discussed in empirical or theoretical literature can sometimes be chosen or described from a ‘therapy-centric’ position (Bickman and Salzer, 1996; Bohart, 2004). Therapy-centrism refers to an assumption that the therapist (or therapeutic approach/model, or therapeutic relationship), is the primary active agent in psychotherapeutic work. Authors adopting a therapy-centric perspective tend to acknowledge client influences on psychotherapeutic outcome only insofar as they provide a *raison d’être* for the therapist (e.g. functional deficits). Therapy-centrism tends to position the client in a more passive or impaired role compared to that of the therapist. Therapy-centrism also refers to professional blindness to these assumptions.

The first aim is therefore to bring a coherent structure to the client factors concept while attempting to avoid compounding therapy-centrism. To achieve this, it is important to be careful in choosing the epistemological frame and data sources for the analysis (which I discuss in Chapter 3). But I acknowledge at the outset that as a therapist myself I cannot eradicate my personal aim to serve therapy by trying to improve my knowledge certain theoretical directions in psychotherapy literature.

Concept analyses traditionally examine the context, use, variants and/or definitions of the concept in question, in data samples drawn from relevant disciplinary research (for example Olsson, Bond, Burns, Wella-Brodrick and Sawyer’s 2003 study on adolescent resilience; Burrows’ 1997 concept analysis of facilitation; and Ridner’s 2004 analysis of psychological distress). In this case, because ‘client factors’ is a multidimensional containment concept, the aim is to create an organising structure that adds definitional specificity while respecting its contextual dimensionality.

Once the concept has been analysed, clarified and in some cases tentatively re-defined through literature review, some researchers use case studies to demonstrate how concept components work (for example Knafl and Deatrick’s 1990 concept analysis of family styles for managing life with a chronically unwell child; and Brush, Kirk, Gultekin and Baiardi’s 2011 concept analysis of overcoming). However the addition of case study
material does not use participant experience to define and structure the concept, only to illustrate it once it has been derived from the literature.

Penrod (2007) observes that concept analyses derived solely from professional literature can lack pragmatic utility because the results do not necessarily fit with people’s experiences. I agree with Penrod’s position, in that some psychotherapy research focuses too narrowly on professional activity to the exclusion of client activity, and thus misses valuable information about the mechanics of change. I make an assumption at the outset of this study that research based solely on diagnostic or psychometric data, or on therapy-centric questions about therapy’s effectiveness, will yield some useful information about client characteristics and activities that influence processes of psychotherapeutic change and outcome. But because this body of research tends not to explore the extratherapeutic resources and activities clients use to make desired changes while in therapy, it does not provide a well-rounded picture of the active client.

In this study I follow Penrod’s (2007) proposal to ‘advance’ literature-based concept analysis by contrasting and combining the categorical framework derived from published research data with a similarly-structured framework derived from participant interview data. In my study, the participant framework is ‘dominant’ (in line with Morse and Penrod, 1999) – in other words it forms the primary analysis against which the literature conceptualisation is compared and contrasted (this will be explained further in Chapter 3). During the process of comparison, the conceptual frameworks are held over each other to determine which components are shared and which are unique to their data source. To enhance the reliability of the results (Stavros and Westburg, 2009), the two are then integrated in a form of data triangulation to advance a single concept (Hupcey and Penrod, 2003; selective mapping of conceptual properties from different source domains into a blended space is described further in Fauconnier and Turner, 1998). In the present study, this methodological triangulation approach is used, but consistent with terminology adopted in Sartori’s (1984/2009) hierarchical concept analysis methodology (explained further in Chapter 3), the process is termed ‘concept reconstruction.’ This term will be used for the remainder of the study.
Aim 2: Consider the utility of a reconstructed client factors concept in counselling psychology theory

An organising framework for understanding, structuring and synthesising the operational contents of the client factors concept could offer a range of opportunities for the advancement of counselling psychology theory. Counselling theories are intended to guide the counsellor’s role, attitude, skills and techniques in the therapeutic encounter, based on organising principles that represent interpretations of client problem presentations (Drapela, 1990). Counselling psychology is aligned with humanistic and integrative counselling theories with various problem-oriented principles. Without wishing to over-simplify the differences between these theoretical approaches, nor to trivialise their philosophical rigour, nor their helpful contribution to people’s lives, I suggest that psychodynamic variants are devised around redressing problematic attachment history; cognitive-behavioural variants around adjusting maladapted reactive thoughts and actions; person-centred variants around releasing thwarted emotions; narrative approaches around externalising and re-authoring the problem and so forth.

To my mind the organising principle of a counselling theory devised around a coherent and comprehensive client factors concept would focus less on interpreting problems and more on harnessing psychosocial processes and resources associated with generative change. It might also inform the counsellor how to help counteract factors associated with therapeutic failure.

Research questions

Four questions guide me in reaching these aims:

1. What do participants describe as salient factors in their efforts to make desired psychosocial life-changes, and how are these best conceptualised? This data informs the primary concept framework.
2. How are client factors represented in psychotherapy research? This data informs the comparator framework.
3. What are the key helpful and unhelpful components of a reconstructed client factors framework?
4. What is the utility of the reconstructed concept to counselling psychology theory?
The study’s first aim is addressed and answered by the first three study questions, and in particular the third question which represents the combination of information from the first two questions. Its second aim is addressed by the fourth question. The answers to these questions are discussed in Chapter 5.

1.5 Key terms
In this section I define and discuss five relevant terminological areas: Concepts; psychotherapy; causal syntax in psychotherapy; and outcome.

Concepts
Here I describe the role of concepts in mental health theory; the relationship between concepts and theory; and some difficulties inherent in their abstract nature.

Concepts in mental health theory
Concepts facilitate communication within a knowledge community by linking a class of referents to their meaning by one (or in the case of ‘client factors’, two) words. Concepts in mental health care include, but are not limited to, practices, aims, traits, actions, states of being, and social positions related to the roles of caregiver or care recipient. A concept is best described in a brief statement of necessary and sufficient conditions. However, the meanings of concepts in mental health care are rarely so definitionally or ideologically ‘pure.’ Definitionally they overlap with related terms arising in practical use in specific contexts over time. Ideologically they represent the language of professional interests and then enter research analysis and theory as facts of life (Pilgrim, 2016, 2017).

Building blocks of knowledge? Or theoretical niches?
Concepts have been described by some authors as building blocks of theory in the social sciences because of their inherent explanatory powers (e.g. Chinn and Kramer, 1994; Pintrich, Marx and Boyle, 1993). From this viewpoint, concept research extends theory by bridging the gap between current theoretical understandings, and intellectual goals in theory development (Rodgers, 2000b). On the other hand Paley (1996) reverses the concept-theory equation, stating that theory creates concepts to occupy
meaning ‘niches.’ Paley asserts that “the only way to clarify a concept is to explicitly adopt a theory that determines what its niche will be” (p.577).

In this study I take the ‘either/both’ ground by conceiving theory and concept development as interdependent activities. Concepts are the ‘offspring’ of theories in that theorists invent niche concepts to explain aspects of observed or imputed cause and effect. For example, ‘client factors’ is an offspring of common factors theory (this will be discussed further in Chapter 2). Once ‘born’ concepts exert formative influence on their theoretical ‘parents.’ For example, if one theorises that client factors exert considerable influence on outcome one can examine and adjust common factors theory in light of new knowledge about client factors.

It is helpful to remember here that the purpose of theory, and associated concept clarification, is the advancement of practice. Careful and thorough work on evidencing, justifying and clarifying concepts makes them better tools with which to reflect on and refine the theories and practices with which they are associated, but they must be associated with a theory, even if not the originating theory, to make this work meaningful.

**The problematic nature of concepts**

As useful as concepts are as communication devices and holders of meaning, I briefly discuss here two difficulties inherent in their use and development in psychological science: *contextuality*: how concepts are defined by power-interests; and *obscuration of connotation*: how vagueness shrouds meaning.

*Contextuality*

Mental health concepts are created and shaped by the knowledge-contexts in which they are used. The substantive content of scientific conceptual models, and what is accepted as ‘core knowledge’ are influenced by sociological and historical factors (Pintrich, Marx and Boyle, 1993). For reasons I shall explore further in Chapter 2, common factors theory provides relatively little information about the client factors concept, although it is potentially the most potent of all the common factors. Thin descriptions of key concepts within a theory leave room for the representation of
incorrect information or the incorporation of “a false belief or two into [the] essence placeholder for a concept” (Laurence and Margolis, 1999, p.48). As I will argue further in Chapter 2 the belief, strongly held by some psychotherapy professionals, that the therapeutic relationship directly ‘accounts for’ client therapeutic change (see for example Patterson, Uhlin and Anderson, 2008), while unsubstantiated by research evidence (Ardito and Rabellino, 2011), represents an example of therapy-centric extrapolation of common factors theory.

**Obscured connotation**

Although the client factors concept appears to introduce client activity and characteristics into a causal argument about the efficacy of psychotherapy, it also linguistically obscures the magnitude and diversity of client influence on the process. As abstractions, concepts lose the detail of their implications, particularly where there is little consensus on their meaning even within their contexts of origin (concepts described by Pilgrim and Bentall as “woolly,” 1999, p.271). The client factors concept is such a case, where even in psychotherapy literature, the term does not comprehensively or coherently point to its connotations, including sociological matters. Shrouded concepts are uninformative and limit the theorising that can be done with them. On the other hand, overly narrow or rigid conceptual definitions exclude knowledge development from diverse sources.

**Psychotherapy**

In this study the term psychotherapy encompasses the work of qualified and in-training professionals including counsellors, psychologists, CBT therapists, occupational therapists, social workers, psychiatrists and others who may not uniformly call their work ‘psychotherapy,’ in assisting individuals, families, couples or groups with a recognised method of talk-therapy to improve mental health; to change problematic behaviours, personality difficulties or relationship patterns; and/or to pursue personal growth: “self-efficacy, competence, and mastery” (Luborsky, Crits-Christoph, Mintz and Auerbach, 1988, p. 165). Furthermore, psychotherapy is viewed a relationally-based joint activity that depends considerably, if not primarily, on the quality of client involvement for its effectiveness (Bohart and Tallman, 1999; Duncan, Miller and Sparks, 2004).
‘Client’ as a problematic term

‘Client’ connotes the passive role of a person being dealt with by social or medical services. It is derived from the Latin ‘cliens’ which means “a person under the patronage or protection of another;” and in ancient Rome referred to a “plebeian under the protection of a patrician” (Oxford English Dictionary, 2017, no page number). The term also, less obviously, connotes co-dependency: psychotherapists depend on clients to make a living; and clients depend on psychotherapists to help with their emotional and behavioural problems.

Use of the term ‘client’ lends patronising power to the person who uses it to describe someone with whom they have a working relationship. Psychotherapists commonly use the term ‘my client,’ as if the client is blessed by ‘belonging’ to ‘belonging’ to the therapist.

‘Client’ also connotes participation in marketised care services in which the ‘customer’ has a choice of provider when they pay privately. But people who access publicly-funded mental health services are rarely given much choice over type of therapy or provider. In looking to alternative terms, ‘service user’ and ‘patient,’ are more commonly associated with public sector services, but are even less apt descriptors for people who partner with psychotherapists to achieve desired changes in life. McLaughlin (2009) criticises the term ‘service user’ for prescribing a limited identity that points to the person’s use of disability services and obscures their preferred, able statuses - which may involve admirably resourceful and engaged ways of living. The term ‘patient’ is derived from medicine and invites the sort of ‘pathologisation’ and ‘treatment’ of individuals and groups of people with mental health difficulties from which some (but not all) counselling psychologists seek to distance their practice (Woolfe, 2016).

There is no commonly used term for people who access psychotherapy relationships that does not imply - and maintain - a power difference between the participants that privileges the therapist as the agent most responsible for outcome. The absence of an egalitarian term for therapy participants points to a “conceptual practice” (Harding, 2004, p.30) which is complied with by therapists and clients alike. However, with regret, I have chosen to retain the term ‘client’ in this study because ‘client factors’ is the subject of the concept analysis. In Chapter 6 I address changing the concept title.
Where an author whose work I describe in some detail refers to ‘patients’ (e.g. Orlinsky, 2009) I retain this terminology in those passages.

Causal syntax in psychotherapy
Bohart, Tallman, Byock and Mackrill (2011) argue against the use of experimental and randomised controlled trials to judge whether, how, or which psychotherapy or client factors ‘cause’ changes in client presenting problems. They contrast psychotherapy to cancer treatment. Radiation might ‘cause’ cancer cells to die in a direct and linear fashion. But psychotherapy is a complex interactive process in which the relationship between inputs and outcome is “fundamentally probabilistic” (p.105). Bandura (1978) also dispenses with unidirectional causal models of human behaviour, and instead describes how people’s personal and cultural characteristics and social roles may determine the interaction between environmental events, and internal cognitive processes such as reflective thought, selective attention, planning and foresight, beliefs and preferences, incentives, self-evaluation and self-efficacy. In Bandura’s ‘reciprocal determinism’ model (1978), individuals influence environments and vice versa. Certainly if one thinks about events in one’s daily life they are hardly separable from preceding events, cognitive states, free will, chance, social context and so on. The idea that something happens, or changes because of one entity’s sole influence on another does not match phenomenological experience.

However, we cannot completely rid psychotherapy theory of an ontology of causality, because without it, there would be no way of understanding how psychotherapy helps, or indeed, why it should exist. In this study I suggest that the best we can do is point to aspects of ‘causal influence’ and ‘causal probability’ in psychotherapy process and outcome. To describe these we need causal syntax.

Gerring (2012) provides a clear explanation of causal syntax in social science which I briefly summarise in the remainder of this section.

Independent and dependent variables
Dependent variables are the measured outcome of therapy (Kazdin, 2009). Independent variables are causal inputs and generally take the form of client and
therapist cognitive, relational or creative activity. Making any causal argument, even about probable influence, requires one to be able to say that a change in X (independent variable, input or predictor) generates a change in Y (dependent variable, outcome or response) relative to what Y would be without the change in X, given certain background conditions and the scope of the empirical phenomena of interest. How X changes Y may be obvious and straightforward; or it can occur over a pathway of intermediary mechanisms. So, the distance between X and Y can be anything from proximate (i.e. few if any intermediary factors) or distal (indirect effects with complex and multi-staged mechanics). Intermediary generative mechanisms in the process of change are known as mediators; while intervening variables and pre-existing conditions that change the relationship between X and Y are known as moderators (moderators and mediators are explained further in Appendices 6 and 7 respectively; and a summary of definitions for mediators, moderators and predictors is available in Appendix 23). Predictors of treatment outcome are conceptually similar to moderators but are associated broadly with outcome across all treatment conditions. For example, the client’s problem complexity or chronicity will have a direct bearing on outcome regardless of the type of therapy provided (Beutler, Clarkin and Bongar, 2000; Beutler, 2016). Predictors are naturally occurring variables that can be measured and statistically calculated in experimental research. They may include aspects of therapy, client factors originating in or before therapy, or extratherapeutic factors.

Causal factors, as independent variables (X) be capable of change, and mediators capable of activation, even if such dynamism is only a potentiality or cannot be directly manipulated for example in experimental conditions. Gerring includes a range of related terms for causal influencers, such as variables, conditions and factors (2012, p.202). Furthermore, the outcome Y must be clearly specified and in some way measurable. Gerring also asserts that important, or ambiguous background conditions ought to be explicitly mentioned. Finally he argues that self-maintaining processes are not causal because in these cases, X and Y are insufficiently distinguished. Figure 4 shows causal influence in a flow diagram:
In this causal syntax diagram, X (causal factors) lead to M (mechanisms of change) which in turn leads to Y (changes in outcome). B (constant background factors) have an antecedent and indirect effect on X and therefore an even less determinable effect on Y.

**Incorrect causal assumptions**

Beckwith, Dickinson and Kendall (2008) provide an illustrative example of how incorrect causal inferences arise. An individual attends a smoking cessation class and subsequently quits smoking (outcome Y). A causal inference could be made that the causal factor (X) was the individual's adoption of information and advice provided by the class, as shown in Figure 5.
In the Beckwith et.al. (2008) scenario, the causal influence had actually been the participant’s partner’s insistence that he quit smoking. If the outcome Y (quit smoking) happened irrespective of the advice provided in smoking cessation classes, or any other facilitative factor, the causal assumption diagram would be as shown in figure 6.
One can make further causal extrapolations beyond those made by Beckwith et.al. (2008), if additional facilitative factors leading to the participant quitting smoking are considered. For example, background factors include a government campaign to place graphic health warnings on cigarette packaging. Additionally, alongside attending classes which the participant found helpful, he obtained a nicotine replacement patch from his GP which reduced his urge to smoke. He had managed to quit smoking a few years ago and so had self-efficacy for quitting. The causal assumption diagram for this scenario is shown in figure 7, where (M) mechanisms of change (or non-change) may be mediators or moderators.
Outcome

In this study, outcome is defined as changes to client symptoms, diagnosis, behaviour, attitude or psychosocial functioning as a result of having undertaken psychotherapy. In distinguishing process from outcome, Orlinsky, Grawe and Parks (1994) propose that process includes all in-session impacts, including the immediate effects on the client of therapist interventions. Describing outcome, Orlinsky (2009) distinguishes between outcomes and outputs. Outcomes relate to the aim of therapy (for example reduction in presenting problems). Outputs are further-reaching consequences on clients' life-trajectories and social productivity.

Clients may experience a range of meaningful outcomes and outputs, in addition to the ones they sought psychotherapeutic help to achieve, or different from those measured by the therapist or researcher. For example Binder, Holgersen and Nielson, (2010) and Castonguay et.al. (2010) found that clients deemed good outcome for mental health psychotherapy to include new ways of relating to others, and improved self-confidence.
It is possible that some clients may only experience or become aware of certain outcomes and outputs months or years after therapy is complete.

In the current study, where participants could discuss the ‘outcome’ of their choice, some discussed clinical ‘outcomes’, while all described ‘outputs.’ Several also said the core problem for which they sought therapy was not fully remitted, which is also an ‘outcome.’

Outcome is a particularly nebulous and unreliablely formed concept in psychological research. Here I briefly describe four problems with the outcome concept: Mis-conceptualisation; reporting bias; unclear definition of improvement; and the non-linear nature of change.

**Mis-conceptualisation**

Outcome mis-conceptualisation refers to an incorrect assumption that an observed effect or change is an outcome of psychotherapy. It can be seen, for example, when an aspect of therapist or client experience in therapy is described as an outcome but is actually a process effect that dissipates soon after therapy ends (Nilsson, Svensson, Sandell and Clinton, 2007). It may be possible to distinguish 'lasting outcome' from process effects by gathering follow-up data some months after participants finish therapy in outcome research (Hill and Lambert, 2004).

Another form of mis-conceptualisation is the erroneous conflation of client positive feedback with therapeutic improvement. Studies have found no relationship between client satisfaction and treatment efficacy (Stiles, Shapiro and Firth-Cozens, 1990; Lunnen and Ogles, 1998; Pekarik and Guidry, 1999). Lastly, Kenniston, Boltax and Almond (1971) explain how what is described as an outcome might actually be a reflection of the quality of client participation in the social structure of therapy.

**Reporting bias**

Client change might be judged from the perspective of the researcher, the therapist, an observer, or the client, but it has been found that therapist and client views of ‘success’ in therapy do not necessarily correspond (Cartwright and Roth, 1957). As Mintz (1972)
showed in a study on the determinants of global outcome, judging ‘successful’ improvement is a process particularly vulnerable to therapist bias. Mintz found that therapists thought clients who started therapy relatively well and made minor changes were more ‘successful’ than those who started with more troublesome problems and nonetheless made unexpected gains. This suggests to me that ‘success’ might sometimes be conflated by therapists with ‘easier therapy.’

Results of psychotherapy effectiveness studies can be negative or null; but such findings are less likely than positive results to be reported in the research literature (Lilienfeld, et.al. 2014). Likewise there is a risk in psychotherapy outcome research that causal significance can be incorrectly attributed to therapy rather than to potentially greater influences that take place outside the consulting room (Lilienfeld, et.al. 2014).

Unclear definition of improvement

Examples of studies included in this concept analysis that clearly indicate thresholds for improvement are Dow et.al., (2007), whose marker of ‘improvement’ was ‘35% reduction in Y-BOS questionnaire’; and Alonso, Muchon, Pifarre, Malaix-Cols and Torres (2001) who indicated ‘absence of panic attacks over past 2 weeks.’ Other studies such as Kleindienst et.al. (2011) indicate that a ‘statistically significant’ change has been achieved. However, 48/68 (70.6%) of studies did not include a specific threshold for defining improvement either in terms of changes in outcome measures from start to end of therapy, or changes in problems reported by other means. Without such markers it is unclear when outcomes are reported as ‘better’ or ‘worse,’ what the relative value of this change is.

The non-linear nature of change

Hayes, Laurenceau, Feldman, Strauss and Cardaciotto (2007) discuss how outcome research might accommodate the idiosyncratic nature of psychotherapeutic change. Using dynamic systems theory (Thelen and Smith, 1996) they explain how human cognitive and behavioural change processes tend to be triggered by critical fluctuations or disturbances in a person’s life that are in turn set off by events that arise in highly interdependent social systems. Such fluctuations might treated as ‘error’ or ‘noise’ in
traditional pre-and post-therapy designs, which, for convenience, conceptualise change as gradual and linear. But these disturbances give vital clues to the transformative impact of destabilisation and reorganisation in clients’ lives. Hayes et.al. (2007) suggest that if we want to understand what mobilises client change we must study ‘transition points’ rather than relying solely on time course outcome data. I consider these in the concept reconstruction.

1.6 Study structure
This doctoral study is presented over six standard chapters: Introduction; Literature Review; Methodology; Results; Discussion; Conclusion. Here I briefly explain the writing style in which this study is presented; and then provide an overview of each chapter.

Style
In terms of structure, all chapters start with an overview but for the sake of parsimony, do not end with summaries.

In terms of research design, the job of clarifying what ‘client factors’ are, and how they can be synthesised into a coherent framework requires a deductive, qualitative, exploratory and graphically rendered methodology that considers the interrelated functions of different types of client activities and resources within and beyond psychotherapy processes. This research approach might be thought of as a counselling psychology equivalent of a map maker surveying and sketching up a broad and diversely featured landscape.

In terms of language use, I use first person voice in order to take responsibility and ownership of the views expressed, while also acknowledging that my work rests on important ideas rooted in my readings of influential authors in and around psychotherapy research.

In terms of authorial stance, I examine the client factors concept and its uses in psychotherapy literature in explicitly critical ways. A fundamental supposition (following Bohart and Wade, 2013) is that client factors are considerably more potently associated with process and outcome than most psychotherapy research accounts for. Sometimes where client factors are identified in the literature they may be those that endorse the
therapist’s role as skilled helper (e.g. ‘preference for type of therapist,’ Beutler, Harwood, Someah and Miller, 2016) and client’s role as functionally impaired (e.g. ‘resistance,’ Beutler, Harwood, Michelson, Song, and Holman, 2011). Incomplete and biased conceptualisations of client activity in and beyond therapy limit therapists’ (and clients’) capacity to perceive and criticise taken-for-granted assumptions about ‘what works’ in therapy (Beck, 2013).

Consistent with this critical approach I do not bracket off my assumptions about the topics addressed here as some qualitative researchers advise (e.g. Tufford and Newman, 2010). I have instead attempted to transparently incorporate them into the text as I go along, because my views infuse my curiosity about client factors with investigative vigour. To suppress them would be a form of self-denigration, and a denial of the socially experiential approach to knowledge-development used here (Fivush, 2000; Rennie, 2012). My assumptions are included to help the reader understand the perspective from which I interpret the material handled here.

**Study overview: Chapter 2: Literature review**

The literature review develops my argument for the need for an organising conceptual framework for client factors. It does this by first situating the client factors concept within common factors theory, and then by scoping the diversity of client factor dimensions in relevant literature. I highlight the disjointed nature of knowledge about the active client. I then look at another common factor, therapeutic alliance, which has received more research attention than client factors. I find it to be poorly conceptualised. I discuss evidence that it may not directly influence outcome. I round out the chapter by introducing change process theory but critiquing the conceptualisation of client factors found in Orlinsky’s (1986/2009) process model.

**Chapter 3: Methodology**

The methodology chapter opens with an explanation of the critical realist ontology that informs my handling of causality in this study. This is followed by a reflection on why and how the study is shaped by a ‘muted group’ epistemology (Ardener, 1975; Kramarae, 1981). My selection of a deductive qualitative ‘hierarchy of abstraction’
concept analysis method (Sartori, 2009) is justified in spite of its absence from counselling psychology research, and in light of the unsuitability of proximate qualitative analytic approaches. I explain the seven stages of concept analysis fashioned here to manage, organise, analyse and interpret data from interviews with nine people who recently completed psychotherapy, and data extracted from 68 psychotherapy outcome studies, to reach a ‘reconstructed’ concept framework. I explain the structure and colour-coding used to organise this framework over enhanced fishbone diagrams.

In Chapter 3 I also explain steps I took to ensure research rigour and credibility. I then conclude with consideration of the ethical issues involved in completing this study including my deliberations on the death of a participant.

Chapter 4: Results

The results chapter examines and explains the contents of the reconstructed concept hierarchy. It is divided into two sections: helpful and unhelpful client factors. Each section is subdivided by four temporal stages of change/non-change. In each stage the component categories and elements are detailed with evidence from participant and research data. Each section concludes with a summary of key findings.

Chapter 5: Discussion

To commence the discussion I review and answer my four research questions on the basis of study results. Then, in order to fruitfully challenge the concept reconstruction I subject it to analytic review using seven criteria for concept adequacy devised by Gerring (2012). This review comprises the majority of the chapter. Within the review the most substantive criterion is considered first, i.e. the concept’s utility for counselling psychology theory. In this part of the discussion I review causal syntax diagrams that summarise the study’s findings in relation to client contributions to psychotherapeutic process. I then discuss the remaining six concept adequacy criteria, including domain, fecundity, differentiation, resonance, consistency and operationalisation. The chapter then moves on to discuss recommendations. I propose that social learning theory is an important area of study for counselling psychologists. The discussion concludes with a non-exhaustive summary of the study’s limitations.
Conclusion

Concluding the study in Chapter 6, I briefly describe three contributions to knowledge: a provisional client factors process model; a tentative adjustment to change process theory that requires further testing and validation; and the introduction of concept analysis as a potentially relevant methodology for counselling psychology theoretical research. Finally, the results are reviewed in relation to the aims of the study.
CHAPTER 2: LITERATURE REVIEW

2.1 Chapter overview
The aim of this literature review is to locate and describe the relevance of client factors in common factors theory and psychotherapy process theories, and to deepen my explanation for why I think the client factors concept requires an organising framework. The chapter unfolds over four sections. The first section provides a brief history of the development of common factors theory. I contrast Lambert's (1992) and Wampold’s (2001; Wampold and Imel, 2015) theories of the relative distribution of various common factors in psychotherapy outcome variance. I explain why I think the study of client factors is important to further development of common factors theory. In the second section I provide a brief history and meanings for the terms ‘client factors’ and ‘extratherapeutic factors,’ and explain why, in this study, the latter is discarded. I examine some diverse dimensions of the client factors concept and then provide some examples of under-conceptualisation of client factors in recent studies. In the third section I review erratic conceptualisations of the related common factor ‘therapeutic alliance.’ I review some problems with research on the role of therapeutic alliance in psychotherapy outcomes. I explain why I think therapeutic alliance might be a reflection of client and therapist relational factors and other client work factors, rather than a causal factor in its own right. In the fourth and final section I explain the relationship between client factors and psychotherapeutic change processes. I illustrate further consequences of under-conceptualisation of client factors via critique of the treatment of client activity and social factors in Orlinsky's (1986/2009) transtheoretical process model. I conclude the chapter with a brief explanation of why Pascual-Leone, Greenberg and Pascual-Leone's (2009) ‘task analysis’ method of psychotherapy process theory development might be better suited to accommodate client factors, and how this study might form a preliminary stage in such an endeavour.

2.2 Common factors theory
Common factors theory proposes that different types of therapy have elements in common that account for why, according to some research, they produce generally equivalent results. This phenomenon is coined the ‘dodo bird hypothesis’ based on a
reference to Lewis Carroll’s *Alice in Wonderland* made by Saul Rosenzweig in a prescient, and now famous, 1936 paper. In this story, the dodo bird judged that all competitors in a race had won. Rosenzweig suggested that the equivalent benefits of different psychotherapies are caused by “unrecognised factors in any therapeutic situation that may be even more important than those being purposely employed” (p.412). He posed a question that has inspired many subsequent studies: “what do therapies have in common that makes them equally successful?” (p.413).

A landmark text in the development of common factors theory is Frank and Frank’s 1993 comparative study of psychotherapy, *Persuasion and Healing* (following Frank, 1973). Frank and Frank (1993) suggest a wide range of generic patient, extratherapeutic and therapy factors are responsible for patient healing in various types of psychotherapy. Patient factors include expecting to improve; remoralisation; confession; learning, self-reflection; attitude change; and commitment to new values. Extratherapeutic factors include peer and family influences; and stressful life circumstances and events. Therapy factors include the patient-doctor relationship; provision of education and encouragement for patient behaviour modification; stimulation of patient emotions and self-reflection; and collaborative construction of new plots for patient life stories that sustain better patient self-image. Frank and Frank (1993) describe the psychotherapist as not so much an applied behavioural scientist, as a hermeneutic interpreter of ‘clients as texts’ of their own life stories: a view that positions the client as the primary author and the therapist as perhaps a temporary editor. But they also identify psychological healing with the aid of a therapist as just one of numerous types of ‘ritual’ people might undertake to achieve the same, or similar aims of healing – activities that express, connect and reinforce one’s belonging in a wider socio-ideological group. Opportunities for experiential learning that enhance mastery and self-efficacy are available through such formal and informal social memberships. Social memberships, it seems to me, in themselves comprise both the means and the ends of social help-seeking.
Relative contributions of common factors to variability in outcome

Beside Frank and Frank (1993), other researchers have developed conceptual schemes for understanding the common mechanisms of client change across various schools of psychotherapy (for example, Goldfried, 1980; Orlinsky and Howard, 1986; Grencavage and Norcross, 1990; Kolden, 1991; Castonguay, 1993; Garfield, 1995; Asay and Lambert, 1999; Lambert and Barley, 2002; Castonguay and Beutler, 2006. See Wampold and Imel, 2015 for a brief history of common factors conceptual model development). A commonly cited conceptual scheme was devised by Michael Lambert (1992) (coined ‘Lambert’s pie,’ see for example Cooper, 2008, p.56). Lambert attempted to quantify the relative contribution of pan-theoretical factors to variability in outcome: in other words, the determinants of whether therapy works well or not. He proposed that 30% of “improvement in psychotherapy patients as a function of therapeutic factors” (p.97). These he described as therapist variables including warmth, empathy, acceptance, which he subsequently relabelled “therapeutic relationship” (Asay and Lambert, 1999, p.31), although this usage indicates only the therapist’s contribution to the therapeutic relationship and does not account for the client’s contribution. Additionally he attributed 15% to techniques of specific therapies; 15% to client expectancy and 40% to what he described as “extratherapeutic change” (p.97) including client factors such as ego strength; and contextual factors such as social support.

Lambert’s 1992 ‘percent of variance accounted for’ common factors model is problematic for a number of reasons. I will touch on four here. First, “no statistical procedures were used to derive the percentages that appear in [the figure], which appears somewhat more precise than is perhaps warranted” (Lambert, 1992, p.98). Compared to subsequent meta-analytic research by Wampold (2001, discussed below) Lambert’s model considerably over-estimates the variance in outcome attributable to therapist and techniques. Second, it obscures client agency by inserting client factors under the label “extratherapeutic change” which includes spontaneous remission and fortuitous events (Asay and Lambert, 1999). Third, where specific client factors are mentioned they are only cursorily described, such as capacity for a meaningful relationship with the therapist, maturity, motivation, quality of social support and “personality makeup and ego organisation” (Asay and Lambert, 1999, p.32). Finally,
DeRubeis, Gelfand, German, Fournier and Forand (2014) criticise the ‘percent of variance accounted for’ model because some of the factors, for example, therapist technical skill, are not necessarily characterised by high variance within and across studies, although still representing an essential - and potent - ingredient of therapy. They suggest that this model also does not account for variability amongst clients in the degree to which the quality of therapy provided to them will effect their outcomes – in other words, client factors that render them, as DeRubeis et.al. (2014) describe, ‘spontaneous remitter,’ ‘easy,’ ‘pliant,’ ‘challenging’ or ‘intractable’ patients. DeRubeis et.al. (2014) also note that Lambert’s common factors model does not facilitate understanding of causal links between therapy factors and outcome, or the potential for “patients to improve with the passage of time, irrespective of the quality of therapy provided to them” (p.421). Regardless of these criticisms, Lambert has continued to describe his 1992 model as offering an “empirical point of view” showing “percent of improvement in psychotherapy patients as a function of therapeutic factors” (Lambert, 2013, p.200).

In 2001 Wampold re-evaluated common factors outcomes on the basis of rigorous meta-analysis. Wampold radically re-drew variance attributions, with significantly diminished variance attributable to therapy factors, which I will now explain in some detail, as my argument for the potency of client factors in this study rests in part on Wampold’s influential work.

**Wampold’s pie**

Wampold (2001, Wampold and Imel, 2015) developed a common factors conceptual scheme called the ‘contextual model’ which accounts for the benefit of therapy over three pathways: first, the foundation of a therapeutic relationship; next, through client expectations of therapy; and finally, through client mobilisation of “treatment actions” (Wampold and Imel, 2015, p.53).

Wampold’s statistically transparent, stable and robust research on the relative contribution of therapeutic common factors found, in line with the ‘dodo bird hypothesis’ “small, if not zero” (2001, p.118) differences in outcome between a variety of treatments in comparison trials. He also proposed that a range of common factors (not just the
therapeutic relationship as in Lambert’s 1992/1999 model) account for a greater proportion of variance in outcome than specific components of different therapies.

Wampold (2001) says 13% of variability is due to psychotherapy and the remaining 87% is due to client and extratherapeutic factors. “Variance attributable to clients is great” (Wampold, 2001, p.204).

Wampold breaks down psychotherapy’s 13% of variance in somewhat complicated terms. Factors common to most types of therapy account for approximately 70% of the 13% (in other words, approximately 9% of the whole). These include several therapist factors: competence, congruence, empathy, affirmation (Wampold and Imel, 2015, p.209, p.258), allegiance/adherence to a “model” (2001, p.205; Wampold and Imel 2015, p.258) and the ability to culturally adapt the model to fit the client (p.209).

Wampold and Imel (2015) also include two client-therapist collaboration factors: goal consensus and therapeutic alliance; and two client factors: expectations and placebo effects (p.258).

Factors attributable to specific therapies account for approximately 8% of the 13% (approximately 1% of the whole) (Wampold, 2001, p.207). The remaining 22% of the 13% (approximately 3% of the whole) Wampold (2001) says is “unexplained variance” which he attributes to client factors. Client and extratherapeutic factors account for 90% of variance (87% + 3%).

Figure 8 shows a graphic representation of variance attributions in ‘Wampold’s pie.’
While it is useful to see how important client and extratherapeutic factors are to psychotherapeutic process and outcome, Bandura (1986) commented that “research aimed at estimating the relative percentage of behavioural variation due to persons or situations is ill suited for clarifying the transactional nature of human functioning” (p.29). This suggests that pie charts showing proportional contributions of different variables to psychotherapy outcome cannot capture the socially interactive determinants of psychosocial change. Bandura recommends that social research should examine the interdependency of causal factors; and the conditions in which people both create and are influenced by their social climates “in an ongoing sequence of events” (p.29). The client factors reconstruction created in this study achieves this.

Why study client factors

While psychotherapy outcome research continues to focus attention on the relative effectiveness of competing models of psychotherapy (Wampold and Imel, 2015) “the increase in knowledge from this vast enterprise has not been commensurate with the
investment of time, effort and money and the sophistication of the researchers. Different studies often yield inconsistent findings, and most of the relationships found, even those reaching the conventional level of statistical significance, have been too weak to influence practice” (Frank and Frank, 1993, p.18). It follows from this that common factors research needs a path to influence practice more meaningfully. I have so far described two important signposts. First, it is clear from Wampold’s research that variability of outcome due to the ingredients of psychotherapy is relatively slight. Second, it is clear from Bandura’s criticism of pie charts that, rather than asking which type of therapy gets better results, it might be more helpful to study key processes in client extratherapeutic social interaction. I will now add a third signpost: Clarkin and Levy (2004) assert, in their authoritative scoping review of influential client factors, that “non-diagnostic client characteristics may be more useful predictors of psychotherapy outcome than DSM-based diagnoses,” (p.214). They suggest research “focussed on a constellation of salient [client] variables will be likely to show the greatest impact on treatment process and outcome” (p.215). They do warn, however, that “one is faced with an overwhelming number of client variables to consider” (p.214).

So, in calibrating these three signposts to form a direction for this study, it seems important first to grasp which non-diagnostic client and extratherapeutic factors most strongly or generally determine psychotherapy outcome. Then it seems important to represent client contributions as a cohesive framework of social interaction, influence and transition points. Task complexity and methodological unfamiliarity do not deter my aim to make progress in this area.

2.3 Client factors
In this section I first offer context for the terms ‘client factors’ and ‘extratherapeutic factors,’ before providing a review of diverse known helpful and unhelpful phenomena that comprise the term. This section concludes with some observations on the obscuration of client factors in common factors studies. Further description and analysis of specific aspects of the client factors concept found in this study comprise Chapter 4: Results and Chapter 5: Discussion.
Context

The term ‘client factors’ may have entered published psychotherapy research terminology around the mid-1980s (e.g. Hoffman, 1985), following ground-breaking meta-analyses of client variables published by Garfield in 1971 and 1978. It contains and obscures a large constellation of client activities and circumstances that may influence outcome in psychotherapy. In medicine, psychiatry, occupational and physical therapies the concept may be termed ‘patient factors,’ or more specifically, ‘patient health behaviour.’ The concept is similarly used in nursing and midwifery studies (e.g. Cox, 1982; Forchuk, 1994; Amoakoh-Coleman et.al. 2016); disability studies (e.g. Scheirs, Blok, Tolhoek, El Aouat, Glimmerveen, 2012) and management consultancy (e.g. McLachlin, 1999) but does not have much meaning beyond these professional fields.

The term ‘client factors’ includes, but is not limited to, client demographic background and socio-cultural identity; quality of social support; expectations and preferences for therapy; motivation and readiness to change; learning in and outside sessions; resilience to adverse life events; and severity of impairment (Beutler, 2016; evidence for each of these areas will be discussed in the review of client factors that follows).

Extratherapeutic factors are more arbitrarily defined. Some authors (e.g. Addis and Cardemil, 2006) state that client factors and unexplained and error variance are all ‘extratherapeutic.’ Others (e.g. Wampold and Budge, 2012) combine some therapy-related factors (client motivation and involvement) with some non-therapy related factors (social support and spontaneous remission) within the term. I argue here and in more detail later in the study, that the term ‘extratherapeutic factors’ is redundant, as it forms a part of client-related influence over the process and outcome of therapy. However, I retain it where referenced authors have used it.

Review of the diversity of client factors

How clients use therapy depends on their beliefs about ‘normal and healthy’ psychosocial functioning. What clients want from therapy depends on how far their experience deviates from perceived norms, or is causing suffering to themselves or
others (Boorse, 1976). Additionally, how and when clients access therapy is shaped by availability, culture and context (World Health Organisation, 2013). So, potentially influential client factors have diverse sources. For clarity I have broadly organised this section of the literature review into helpful and unhelpful factors. Firstly I review helpful demographic, social, cognitive and emotional, behavioural, and learning factors, agency, and resilience with life events. Then I review unhelpful social, cognitive and emotional and behavioural factors; and severity of impairment.

**Demographic factors**

In demographic terms, outcome has been found to be influenced in certain circumstances by client gender and age (Woodhead, Cronkite, Moos and Timko, 2014). On the other hand, Clarkin and Levy (2004) found no relationship between age and outcome except for younger clients with substance abuse, who had worse outcomes than older clients. Other studies have found no difference in outcome for people of different ethnic groups (Lambert et.al., 2006), marital or employment statuses (Davidson, et.al. 2004) or socioeconomic backgrounds (Garfield, 1994; Robinson-Whelen, Hughes, Taylor, Hall, and Rehm, 2007). Garfield (1994) found a small positive relationship between client educational level and treatment completion but on the other hand Yu (2011) found a statistically insignificant link between lower client educational attainment and therapy dropout.

In general, studies of the relationship between a range of demographic factors and outcome offer inconsistent or contradictory findings (Bohart and Wade, 2013). It might, then, be extrapolated that demographic factors per se are not necessarily a useful client factor category.

**Social factors**

Outcome has been found to be affected by the nature and quality of clients' social support. For example, Bankoff’s (1996) quantitative study of engagement with 57 psychodynamic psychotherapy clients found that strong pre-treatment social network support had a significant positive association with therapeutic bond, client self-relatedness and therapeutic realisations in the initial phase of therapy.
More recently, Roehrle and Strouse (2008) conducted a meta-analysis of 27 studies on the effects of social support on psychotherapy outcomes, and found a modest correlation (r = 0.13) between social support and outcome, which they note is a similar level of correlation as that found between therapeutic alliance and outcome. They make a number of assumptions, including that the influences of social support are similar to therapeutic help in certain aspects such as empathy and attachment, advice, social coping and social skill development, and encouragement to put change into practice. They also note negative social etiological factors, where aversive or controlling interpersonal relationships, or insufficiently helpful social relations may be a reason people seek help from a therapist. Roehrle and Strouse recommend that further studies should examine the interaction effect of social support and therapeutic alliance.

Helpful cognitive and emotional factors

In an influential coding review intended to locate therapeutic common factors present in a sample of 50 research articles, Grencavage and Norcross (1990) identified client “positive expectancies and hope for improvement” (p.374) as a distinct common factor. This finding is problematic because it can be argued that ‘hope’ and ‘expectancy’ are different constructs. The study’s findings are additionally difficult to interpret because the authors do not include references or specific inclusion/exclusion criteria for the literature sample they assessed. I therefore focus on expectancy here, as it may have a wider evidence base than hope (see for example meta-analyses by Kirsch, 1990 and Constantino, Arnkoff, Glass, Ametrano and Smith, 2011).

The concept of client expectation can be crudely divided in two definitional realms: firstly the extent to which clients expect to actively work to bring about desired change; and secondly, how much they expect the therapist’s help will enable change. On the latter point, Frank and Frank (1993) found that outcome can be influenced by clients’ expectations that they will be helped by the therapist. This finding may be related to how credible the client found the therapy or therapist as a helping medium (Hardy, et.al. 1990). On the former point, Patterson, Uhlin and Anderson (2008) found that clients who expected that in their role as client, they would have to work hard and attend
therapy regularly, experienced better alliance. This finding may be related to how well-socialised the client was to the nature or type of therapy offered, or how much control they wished to exert on the process (Greenberg, Constantino and Bruce, 2006). Alternatively it may reflect how well client and therapist mutual role expectations were matched or suited (Arnkoff, Glass and Shapiro, 2002); or how well client preferences for type of therapy or therapist behaviour were met (Swift, Callahan and Vollner, 2011). Other studies, however, have found minimal predictive capacity for expectancy or treatment credibility (Ladouceur et.al, 2000; Borkovec et.al., 1987, Borkovic et.al. 2002; referenced in Newman, Crits-Christoph, Gibbons and Erickson, 2006). In summary, expectation, treatment credibility, or client preference do not consistently relate to treatment response (Newman, Crits-Christoph, Gibbons and Erickson, 2006).

Looking next at motivation, this too is a multi-faceted concept. Bohart and Wade (2013; after Donovan and Rosengren, 1999) differentiate motivation to obtain help from motivation to change. Motivation has elsewhere been described as a set of dimensions not limited to readiness to change but also including self-efficacy, decision balancing, goals and values, and reasons not to change (Substance Abuse and Mental Health Services Administration, 2012). Perhaps not surprisingly, Lombardi, Button and Westra (2014) assert that motivation to change is difficult to measure. They found that in-session client language (‘change-talk’) was a better predictor of outcome in cognitive behavioural therapy for generalised anxiety than formal self-report measures, but that arguments against change (‘counter-change talk’) more consistently and potently predicted negative outcome than arguments in favour of change predicted positive outcome. Furthermore, Vogel, Hansen, Stiles and Götestam (2006) found that high motivation to change was not significantly related to outcome in cognitive behavioural treatment for obsessive compulsive disorder. Inconsistent findings may to some extent be related to wide variability in term definition and operationalisation.

A concept related to readiness to change but more action oriented, is goal-directedness. People who are more goal-focussed in therapy may experience early change in therapy, which has in turn been associated with positive outcome (Hansen and Lambert, 2003).
In particular, clients who articulate ‘approach goals’ rather than ‘avoidance goals’ were found by Elliot and Church (2002) to have better outcomes.

Self-esteem is noted as a client factor by Bohart and Tallman (2010). A study by Rice, Ashby and Slaney (1998) found that self-esteem mediated the relationship between maladaptive perfectionism and depression, through a buffering effect. However this was not a psychotherapy outcome study. Self-esteem is studied more commonly as an outcome of psychotherapy rather than as a mediator or moderator of outcome (Smith and Glass, 1977). In short, self-esteem does not have a strong evidence base as a client factor associated with variability in outcome.

*Helpful behavioural factors*

The association between quality of client participation in psychotherapy and outcome has been made by Orlinsky, Grawe and Parks, 1994; Kazdin and Wassel, 1999; and Littel, Alexander and Reynolds, 2001. Client willingness to talk about and explore emotions and experiences, along with willingness to try new behaviours are highlighted by Bohart and Tallman, 2010. A meta-analysis by Mausbach et.al. (2010) found a significant association between homework completion in CBT and positive outcome, although their moderator variables were types and sources of homework completion ratings rather than types of client homework activity. In terms of specific homework activities, various forms of client self-monitoring have been associated with positive outcome in studies by Clarke, Rees and Hardy (2004), Stirman et.al. (2018) and Khattra et.al. (2017). The latter study also found that relaxation skills learned in therapy helped clients make meaningful changes in coping. Problem-resolution (Paulson, Truscott and Stuart, 1999) and associated coping strategies (Carver, Scheier and Weintraub, 1989) may be taught and assisted via therapeutic intervention, but their operation and long-term adoption relies on client perseverance and resourcefulness.

*Learning, agency and resilience to life events*

A key element of problem resolution is client learning (Gershefski, Arnkoff, Glass and Elkin, 1996). Attainment of insight, new realisation or understanding has been found by numerous researchers to help people adopt a revised view of reality, and of themselves,
which in turn leads to more constructive or congruent lifestyle choices (see for example Brady, 1967; Elliott, 1985; Frank and Frank, 1993; Garfield, 1994; Hanna and Ritchie, 1995; Timulak, 2007; Bohart, 2007; Higginson and Mansell, 2008). On the other hand, a study by Llewelyn, Elliott, Shapiro, Hardy and Firth-Cozens (1988; referenced in Barkham, 2002) compared therapist and client views of helpful events in therapy. The study found it was therapists who rated the development of insight as the most helpful element of therapy, whereas clients rated problem evaluation and resolution as most helpful.

Gibbard (2014) found clients achieved new realisations through writing, reading and thinking; self-expression, self-reflection and self-acceptance. These findings are echoed in studies by Elliott (1985), Clarke, Rees and Hardy (2004) and Binder, Holgersen and Nielsen (2009) whose participants described how reflexively talking about thoughts, emotions and experiences led to creating new meaning and improved self-understanding.

A particular form of reflexive insight described by Rennie (1992, 2002, 2010) is client agency: a sophisticated form of active learning in which clients intentionally participate, interpret, assess and transform relational interactions in and beyond therapy in order to achieve their aims and practise new behaviours. An unpublished study by Greaves [Wade] (2006, noted in Bohart and Wade, 2013) demonstrates how actively clients use relationship building skills to develop rapport with their therapist, including building a common language base, honest engagement, expression of vulnerability, hope and appreciation. Clients also use agency beyond managing their relationship with their therapist. In a study of client retrospective narratives about therapy experiences, Adler, Skalina and McAdams (2008) summarise how their participants described “a struggle with a discrete and personified problem which is …ultimately vanquished by a reempowered, agentic protagonist….Their therapeutic work continues even though they have stopped meeting with a therapist” (p.730) [the protagonist being the client themselves]. It is my interpretation that participants in this study seemed to own their process of change, and conceptualised it as a larger and longer process in which therapy had played a smaller and shorter part. However, despite evidence for the
construct of client agency, Coleman and Neimeyer (2015) found, in a review of psychometric properties of client agency measures, that associated studies showed that while agency was positively associated with therapeutic alliance, it did not directly affect therapy outcome. A qualitative study by Mackrill, 2008 examines client reports of agency and associates these with specific client-reported goal attainment (but not psychometric outcomes). Mackrill found that therapists sometimes did not notice client-reported change strategies. It would seem important therefore, where researchers wish to develop knowledge of client agency and its impact on outcome, that they analyse direct client reports in relation to specific outcomes, rather than solely depend on therapist opinion or experience of client agency (for example as described by Williams and Levitt, 2007).

Resilience is noted as a client factor by Bohart and Tallman (2010) and Beutler (2016) however, it is not necessarily well-conceptualised in psychotherapy literature (Fougere, Daffern and Thomas, 2012). It may refer to a personality trait, an outcome, or a process of adjustment to adversity (Helmreich et.al., 2017). For example, in a study unrelated to psychotherapy outcome, Ong, Bergeman, Bisconti and Wallace (2006) provide multiple definitions for resilience including an outcome: achievement of “positive outcomes in the face of untoward life events” (p.730) and a capability: “to maintain and preserve the boundaries between positive and negative emotional states” (p.730). Yi, Vitaliano, Smith, Yi and Weinger (2008) found that resilience capability mediated the relationship between psychological adjustment and physical health in patients with diabetes through a buffering effect. However this too was not a psychotherapy outcome study. Resilience is studied more commonly as an outcome of psychotherapy rather than as a mediator or moderator of outcome (see for example Helmreich et.al.’s 2017 protocol for a future Cochrane Review of psychological interventions for resilience enhancement in adults; and a meta-analysis of resilience training interventions by Joyce, et.al., 2018). As with self-esteem, resilience does not have a strong evidence base as a client factor that mediates variability in outcome.
Unhelpful factors

In a literature review seeking to understand client experiences of hindering factors in therapy, Henkelman and Paulson (2006) note that researchers find it difficult to elicit information about unhelpful factors from clients. However, there are some hindering client factors within and beyond psychotherapy that have been acknowledged in research.

Unhelpful factors are here divided into social, cognitive and emotional, behavioural factors, and severity of impairment.

Unhelpful social factors

There is possibly clearer evidence of the detrimental impact of unsupportive, neglectful hostile or stigmatising client social ecology on psychotherapy outcomes than there is for the beneficial impact of helpful social ecology. In a trial of psychiatric clinic treatment for generalised anxiety disorders, Yonkers, Dyck, Warshaw, and Keller (2000) found a diminished likelihood of remission was associated with poor spousal and family relationships. Probst, Lambert, Loew, Dahlbender and Tritt (2015) found that inpatients undertaking psychotherapy treatment were more likely to experience extreme negative deviation from normal outcomes when they experienced poor social support and adverse life events. Probst et.al. (2015) recommend that, to improve treatment outcome, therapists should help poorly responding patients to deal with life events and build social networks.

Social isolation has been identified as a major health risk (Pantell et.al. 2012) that inhibits regulatory functions necessary for self-reparatory change (Baumeister and DeWall, 2005). Related to social isolation, Joutsenniemi, Laaksonen, Knek, Haaramo and Lindfors (2012) found that lone parents and divorced people were significantly less likely to benefit from therapy, or else needed long-term therapy. Castonguay and Beutler (2006) identified associations between financial or occupational difficulties and worse outcome in therapy. They also identified that clients with dysphoric disorders are less likely to benefit from therapy when they are from underserved ethnic or racial groups. Cochran and Cauce (2006) found that drug and alcohol misuse severity may be exacerbated by client minority sexual or gender identity, and suggest that “coping with
stigmatised sexual identity, dealing with stressors of being a minority group, and internalising negative feelings towards the self are possible explanations" (p.144).

Unhelpful cognitive and emotional factors

Client hopelessness, passivity, and self-protective resistance to change negatively impact client efforts to change (Bohart 2010). Carver et.al. (1989) identified emotional or behavioural disengagement, denial, and substance misuse as unhelpful to outcome particularly when participants felt they had low control over adverse stressors.

Laaksonen et.al. (2012) found that participant inability to clearly define a problem-focus contributed to lower levels of symptom change at one-year follow-up. Low goal-directededness has been linked in older adults with higher levels of stress and lower levels of engagement with social support (Payne, Robbins and Doughty, 1991). Walker and Rosen (2004) identified client self-blame or self-criticism as precursors of poor outcome; and similarly Powers, Milyavskaya and Koestner (2012) found self-criticism to be negatively associated with goal progress across a variety of domains. Unwanted thoughts were reported by Llewelyn et.al. (1988) as correlated with negative outcome. Kim, Zane and Blozis (2012) found that somatic symptoms were negative predictors of outcome.

Severity of impairment

Outcome may be negatively impacted by client initial symptom severity or functional impairment. Lorenzo-Luaces, DeRubeis and Webb (2014) found that people with three or more prior depressive episodes were significantly less likely to benefit from CBT, regardless of the quality of therapeutic alliance. Castonguay and Beutler (2006) found evidence that, regardless of diagnosis, clients are less likely to benefit from therapy when they have higher levels of impairment; have been diagnosed with a personality disorder; have low internal locus of control; or “negative self-attribution” (p.356). Similar findings regarding severity of impairment have been described in studies by Keijsers, Hoogduin and Schaap, 1994; Yonkers, Dyck, Warshaw, and Keller 2000; and in analytic reviews by Clarkin and Levy, 2004; Keeley, Storch, Merlo and Geffken, 2008; and Beutler, 2016). However, research findings relating to the impact of severity of
impairment on outcome should be interpreted with caution. Bohart and Wade (2013) note that “when discussing the relationship between initial levels of disturbance and outcome it is important to know if outcome means amount of change, or final status (return to normal levels of functioning)” (p.227). Earliness of change is another outcome-influencing variable related to severity of impairment. Hansen and Lambert (2003) found that “a patient’s pretreatment functioning…influenced time to change, with higher pretreatment distress producing more immediate change than lower pretreatment distress” (p.7). In summary, severity of impairment is not necessarily a unilaterally negative client factor. As a client factor associated with outcome, severity can be mediated by other factors including client motivation to reduce distress; or the curative effects of client efforts to curb more extreme problem behaviours.

**Obscuration of client involvement in therapy**

Clients' views of how and when change occurs, and which changes are important can differ from psychotherapists' views (Kazdin, 1999). Similarly, clients' views of what is helpful and unhelpful in therapy can differ from therapists' views (Wark, 1994). When clients' views on their role in therapy are considered, their participation can sometimes be downplayed. For example, a study of helpful therapeutic processes by Watson, Cooper, McArthur, and McLeod (2012) says the research allows “clients’ contributions to the change process to come to the fore” (p.77). But in the resulting analytic map, therapist speaking activity is expanded to 13 discrete categories, while client speaking activity is reduced to just one, ‘talking’ (p.84).

To conclude this section on known client factors, I suggest that common factors theory 'short-circuits.' It shows that the client is the most potent common factor in psychotherapy outcome, but it does not fully explain how and why that is the case, and what could be done with this knowledge to improve therapy. Castonguay observed in 1993 that “not all of the common factors identified at a conceptual level have been the object of thorough empirical investigation….Among the variables that need to be better understood are the cognitive, emotional and behavioral aspects of client’s [sic] involvement in therapy” (p.275). Perhaps more research attention has been paid to a single therapy factor, therapeutic alliance, than to all client factors.
2.4 Therapeutic alliance

Common factors theorists have tended to focus on the importance of the therapeutic relationship, with ensuing debates about how to conceptualise it (Gaston, 1990; Horvath and Bedi, 2002); measure it (Lambert, 2010; Ardito and Rabellino, 2011) and optimise it (Wampold, 2008; Rousmaniere, 2016; Castonguay, 2017). This focus may be because the working relationship is the factor some therapists believe they have the most responsibility for, or control over.

By way of brief definition, therapeutic relationship is an umbrella term for what some authors following Greenson (1967) have broken down into three components including transference, alliance and ‘real relationship.’ Each of these components could be viewed as inconsistently conceptualised, as I will now explain.

**Transference**

Transference has been defined as client activation and application of the mental representation of a significant other to the therapist (Glassman and Andersen, 1999). However King and O’Brien (2011) suggest that transference is difficult to differentiate from other aspects of therapeutic relationship and constitutes only “a small part of the feelings that exist between therapist and client” (p.12).

**Alliance**

Alliance is contrarily defined across the psychotherapeutic literature. For example Gelso (2014) says it is the “joining together of the reasonable self or ego of the client and the therapist’s analysing or therapizing side for the purpose of the work.” Bordin (1979) suggests it is client-therapist development of a trusting bond, and joint agreement on goals and tasks of therapy. Some non-directive approaches might not recognise task assignment as a purpose of therapy. Horvath and Bedi (2002) acknowledge that there is no universally accepted definition of the alliance concept.

**‘Real relationship’**

Turning to the third component, the ‘real relationship’ is also nebulously and potentially controversially defined. Gelso (2014) says it is the combination of client and therapist
'genuineness’ with their ‘realistic perceptions’ of one another. Genuineness is a contextually determined construct. On the therapist’s side it is certainly delimited by judicious self-disclosure required by the professional role; and on the client’s side by their knowledge that therapy is a temporary working relationship within which they perform to the therapist’s evaluative gaze (even ‘unconditional positive regard’ has conditions). ‘Realistic perception’ is impossible to assess or measure as our intersubjective ideas about others are socially constructed, highly idiosyncratic, and in constant flux.

Contested research on the role of alliance as a common factor

Major research contributions on alliance (e.g. Horvath, Del Re, Flückiger and Symonds, 2011) are correlation studies, which suggest only an association between alliance and outcome, not a causal influence. Wampold and Imel (2015) provide a lengthy appraisal of various other methodological problems with alliance research including halo effects, rater bias, publication bias, research allegiance, inappropriate timing of measurements, and differential importance of the alliance within various approaches. While alliance may be important to most therapists, Bachelor (1995) and Bedi, Davis and Williams (2005) found that therapists and clients hold divergent understandings of relationship factors, with some clients paying little regard to collaboration with the therapist.

Studies of therapist and client relative contributions to therapeutic relationship produce conflicting findings. For example Krupnick et.al. (1996) found that client early-treatment contributions to the therapeutic alliance were significantly related to therapeutic outcome, while therapist contributions were not related to outcome. Contradictorily, Baldwin, Wampold and Imel (2007) found that while therapist variability in therapeutic alliance affected outcome, client variability in therapeutic alliance made no difference to outcome, leading Wampold and Imel (2015) to conclude, “there is no relationship between the patient’s contribution to alliance and outcome….The alliance, with the possible exception of the bond, is not directly therapeutic. Agreement on the goals and tasks of therapy are needed to ensure that collaborative work proceeds in therapy” (pp.190, 194). An inference I make from these findings (which I develop further in Chapter 5: Discussion), is that the effectiveness of the therapeutic alliance mirrors client
social adjustment, capacity for initiation of relationships, and perseverance in using relational social learning both within and beyond therapy. Therapeutic alliance is from this standpoint an indicative client factor rather than a therapy factor. It is my view that client relational skill generates numerous causal influences on the process and outcome of therapy, and may go some way to explaining the correlation between alliance and outcome. This view is supported by discussion of the impact of client ‘social ecology’ on therapeutic bond by Bankoff (1996), who found that clients who formed a better therapeutic bond at the beginning of treatment “entered treatment feeling cared for by each of their significant ties. They are people who discussed entering treatment with their romantic partner, and who eventually did enter with the support and blessing of their [parents], their romantic partner and their two best friends. They are people who also felt pressured by their friends to get help through therapy” (p.58) and ultimately “got much more out of their therapy” (p.59).

2.5 Change process theory
This literature review has so far examined knowledge and conceptualisations of client factors associated with psychotherapy outcome. The chapter concludes by looking at how client factors are positioned in change process theory, and in particular, Orlinsky’s (2009) well-known ‘Generic Model of Psychotherapy.’

Orlinsky’s Generic Model
Orlinsky’s process framework maps the interrelationships of “all the actions, events and experiences that occur in psychotherapy – and the individual and social contexts in which psychotherapy occurs” (2009, pp.321-322). Based on meta-analysis of a substantial number of studies, the first version appeared in Orlinsky and Howard (1986) and has since been developed in stages over several decades. The purpose of the review that follows is to explain the model but also to critique its passive conception of the client and its restricted view of social influences surrounding the therapeutic process. In this way I further build my argument that client factors require clearer conceptualisation before they can inform and evolve psychotherapy process theory.
Orlinsky distinguishes between the systems of action that take place in therapy, and those that take place in the social milieux surrounding therapy, which I explain in turn.

**Systems of action within therapy**

Orlinsky, Grawe and Parks (1994) describe six aspects of process that appear in all forms of therapy: contractual implementation (in particular, patient suitability and therapist skill for therapy); technical operations (in particular, interpretive conversations about life problems and core personal relationships); interpersonal bond (in particular, the patient’s perspective on their therapist’s usefulness); intrapersonal self-relatedness (in particular openness to experience versus defensiveness); clinical in-session impacts (particularly insight, emotional relief and hope for the future, and negative 'psychonoxious' impacts); and sequential flow (the timing of significant events early, middle or late in therapy).

**Systems of action in the social milieux**

Orlinsky acknowledges that therapy process is influenced by the patient’s social conditions and the “adequacy and predictability of support from the economic, political and social structures that support communal life” (p. 338) prior to entering therapy. Orlinsky calls these influences “inputs” (p.332). Consequences resulting from the patient’s engagement in psychotherapy process are “outputs” (p.332). These include some influence over the quality and character of the patient’s “involvements with family, friends and intimates and a public life of dealings with teachers, employers, colleagues and officials in varied organisations” (p.335) but he does not discuss how these relational involvements might have a reciprocal influence on what happens in therapy.

**The powerful therapist and the passive patient**

My first critique of Orlinsky’s (2009) process model is that it describes the role of the patient in explicitly passive and receptive terms. The “compliant and cooperative” (p.324) patient shows the “ability to perceive and absorb the input stemming from therapeutic operations and from the quality of the therapeutic bond” (p.327). Furthermore, Orlinsky’s framework diagram positions the therapist’s contribution to the therapeutic bond as the most potent ‘active ingredient’ in therapy, while the patient’s
contribution – notwithstanding its essential nature in therapy - is omitted. Nonetheless Orlinsky obliquely alludes to the power of the client’s contribution, when he proposes that the ‘dodo bird effect’ in common factors theory is caused by the benefit derived by “well-disposed, high functioning persons” from “almost any sort of therapeutic intervention….yet even very skilful and experienced therapists find it difficult to succeed with patients (e.g. ‘borderlines’ or psychotics) who have difficulty forming a secure therapeutic bond” (p.330). This interpretation of the ‘dodo bird hypothesis’ illuminates the flawed logic of privileging the therapist’s contribution to the therapeutic bond if it is the client’s disposition that more powerfully predicts the outcome of therapy.

**Separation of therapy from social context**

My second criticism is that Orlinsky distinguishes therapy as a social activity separate from the rest of the patient’s life, while nonetheless asserting therapy has a primary impact on the patient’s capacity for engagement with “the ‘never-ending story’ of finding, fostering or failing in intimate relationships” (p.338). He positions the ‘treatment milieu’ as the therapist’s office rather than the client’s social life. He does not directly consider the possibility that, for the client, therapy is just another ‘intimate relationship’ which reflects, more than it changes, their capacity for relational engagement - although he notes that therapists encounter difficulties forming therapeutic bonds with clients who have difficulties forming bonds outside therapy.

In summary, Orlinsky’s model in my opinion inadequately accounts for the influence of client factors on therapy process.

**Task analysis: Towards a process model for the active client**

Research that seeks to answer ‘how did the client and their social context (in which therapy plays a part) achieve that outcome?’ might employ task analysis as a method for mapping and understanding psychotherapy change processes.

Pascual-Leone, Greenberg and Pascual-Leone (2009) describe task analysis as a three-step research method, involving discovery, validation and dynamic modelling phases. It starts with a declared set of theoretical assumptions and uses these in the discovery phase to inform observations from the top down, while using systematically
gathered empirical data to deductively inform the model from the bottom back to theory. It values the subjective experience of the client and positions client work within internal (cognitive-affective) and external (social) worlds as the “true causal mechanisms for the individual expression of internal experience and of outward behaviour” (p.528). Task analysis places the therapist in the “conceptual background in order to focus on optimal client processes” (p.532). It aims to illuminate how clients approach specific tasks in therapy, in order to build more abstract causal models “that hold true for clients in general.” Empirical concept analysis, as used here, is an essential preliminary step to provide process context, before task analysis can produce process detail.

I expect that by clarifying the concept of the active client, change processes will also be observed and clarified. In this case, once the concept analysis is complete, Pascual-Leone, Greenberg and Pascual-Leone’s (2009) three-phase task analysis approach informs possible next steps for validation, then dynamic modelling for the development of measurement tools for further research as potential follow-on projects to this thesis.
CHAPTER 3: METHODOLOGY

3.1 Chapter overview
This chapter provides a full explanation of how the concept analysis was carried out, presented over twelve sections.

The first section explains why a critical realist ontology is useful for exploring the influence of client factors in research. The second section describes my epistemological assumption that knowledge creation occurs through social processes. I describe muted group epistemology and explain why I have chosen it for this study. I counter some criticism of muted group theory.

In the third section I describe the concept analysis design used here. I first explain concept analysis as a deductive qualitative method. I then explain the relevance of concept analysis to counselling psychology and remark on its absence from counselling psychology literature. I rule out concept mapping, content analysis, framework analysis and evolutionary concept analysis. I then differentiate replacement from reconstructive concept analysis and explain why I chose the latter, in particular Sartori’s (1984/2009) method. The section concludes with an overview of the stages and tasks of concept reconstruction Sartori recommends.

The fourth, fifth and sixth sections deal with participant data management for creating the participant-informed concept framework. In particular in the fourth section I explain participant recruitment, characteristics and data collection. I also cover the semi-structured interview design, interview style and transcription method. In the fifth section I explain how I summarised interviews, created a data extraction and analysis spreadsheet and organised data hierarchically through processes of data cleansing and data immersion. In the sixth section I explain data interpretation through the creation of a fishbone framework for organising and representing the data, and the delineation of four levels of concept abstraction.

The seventh, eighth and ninth sections deal with research data management for creating the research-informed concept framework. In particular in the seventh section I explain the study selection process and characteristics of included studies. In the eighth
section I explain how I extracted research data to an extraction spreadsheet. In the ninth section I explain research data interpretation to its own fishbone framework.

In the tenth section I explain the process of contrasting the participant-informed and research-informed frameworks, and the removal of elements deemed marginal due to contradictory evidence. I then explain how the two frameworks were combined into one, using color-coding to differentiate the elements and categories that were based on (a) participant-only data; (b) research-only data; and (c) participant and research data.

In the eleventh, penultimate section I explain how I ensured research rigour including data triangulation, researcher reflexivity, audit trail, participant checks and catalytic validity.

The chapter concludes in the twelfth section by explaining ethical issues including approval, consent, confidentiality and risk, as well as a researcher dual role and a participant death.

3.2 Critical realism and theoretical assumptions
The need to balance clarity against flexibility in conceptual research is an ontological matter: it requires a philosophy of the nature of being and reality. Concepts are abstract, definitional, theoretical words; but they find their expression and formation in everyday human activity and conversation which is naturally pragmatic, diverse, local, and evolving. So, the process of analysing and developing concepts requires the researcher to take a position on the nature of reality: Do concepts point to fixed, timeless, decontextualized truths; or are they culturally-rooted linguistic constructions that only exist insofar as the words and their meanings usefully promote the interests of a particular power-group?

The former position is compatible with ‘realist’ or ‘essentialist’ philosophies, which hold that reality exists in a pure or essential form independent of human representations of it. The latter is more compatible with ‘relativist,’ ‘interpretivist’ or ‘social constructionist’ views which hold that reality is created through shared human activity, values and languages; or ‘phenomenological’ views, which hold that knowledge is related to human consciousness and objects of direct experience.
A strength of the ‘realist’ position in concept analysis is that it seeks to precisely define and locate concepts in order to render them researchable ‘scientific’ entities. A weakness of the ‘realist’ position in social science more generally is that it can reduce reality to observable events, and discount theoretical entities with material impact such as paradigms (Mingers, 2006).

A strength of the ‘relativist’ position is that it respects historically and culturally specific social processes and language in the creation of knowledge. It allows some scope for non-dominant representations in the production or sharing of knowledge (Crombie and Nightingale, 1999). A weakness of the ‘relativist’ position, according to critical realist philosopher Roy Bhaskar, is that several forms of ‘reality’ cannot be accounted for as products of discourse. These include materiality (such as atomic structures) and physical realities (such as gravity), and some moral and political ‘realities’ that ensue from human activity such as social, financial and military power and oppression; and more positively, trust and solidarity. A further weakness of the relativist position is that it cannot fully accommodate a possible intransitive “ontological domain separate from the activities and cognitions of human beings” (Mingers, 2006, p.20). Consequently relativist knowledge of reality can be mistaken for reality itself; and thereby ontology confused with epistemology.

**Critical realism**

It is of course possible to hold an ontological position in relation to concepts that lies somewhere between the ‘realist’ and ‘relativist’ realms. Bhaskar’s critical realist ontological model is useful here. A ‘critical’ ontology is appropriate in this concept analysis because it attempts to detect and redress beliefs and practices that lead to psychological therapy research focussing preferentially on therapy factors over client factors (Usher, 1996). A ‘realist’ ontology is appropriate, because although absolute knowledge of the real is impossible, it is possible to research social potentialities that may or may not be galvanised in psychotherapy and the wider material and social context in which psychotherapy takes place.

Critical realism stands in opposition to empiricism that reduces reality to observable events, and posits instead that reality exists over three stratified and inter-related levels:
the ‘real,’ the ‘actual’ and the ‘empirical.’ Here I will explain these three realities and how they apply in critical concept analysis of ‘client factors.’

**The Real**

Critical realism proposes that reality is the potentiality of causal properties and mechanisms that shape the world as we experience it. However, this potentiality is independent of human experience; it is transcendental and extra-linguistic. Its properties are emergent, and may change their nature. However, we can materially transact with the mutable nature of reality, and to some extent change its manner of emergence.

Contextual, relational and individual agency are ‘real’ in that they are intrinsically implicated in causal processes (Parr, 2015), although these processes may be only partially – or incorrectly - understood in socially constructed terms. I can assert that aspects of psychosocial un-wellness, and people’s efforts to address them, point to the ‘real’ in that they make a profound material and social difference in people’s lives, irrespective of socially constructed debates about diagnostic labels or psycho-medical mental health theory and treatment.

**The Actual**

The activation of generative potentialities under certain temporal, local or social conditions produces changes in states of affairs. It is only in such actual activity of the world that the unseen mechanisms of the real might be detected. We create and refine imaginary models (theories) about causal realities on the basis of limited phenomenological perceptions and language. In the case of client factors research, it is in the context-bound manifestations of client change-work that we might find clues to generative properties and mechanisms.

**The Empirical**

Bhaskar asserts that the move from the ‘actual’ realm of imaginary models to an adequate account of ‘real’ causality is through empirical testing. “Science is an ongoing
social activity….Its aim is the production of knowledge of the independently existing and transfactually [structurally generative] active mechanisms of nature” (2008, p.138).

Realism thus becomes critical as it assumes the possibility of an intransitive realm of reality while also acknowledging the transitive dimension of human knowledge construction through culture-bound language systems. Concept development and theory improvement occur synergistically through analytic social research methods. So in this concept analysis, in order to try to capture the essence of client change processes and potentialities as they occur in clinical practice and research studies, I am limited to using the language and existing knowledge of my historical, social and cultural location, and the obtainable knowledge of others who have either studied or experienced aspects of the concept. It may also be, as is my intention, that in studying actual observations of the concept, I change the way the concept is formed in my own language and perspectives. Additionally, the activity and motivation of my research in itself may be reflexive evidence of “universals that are themselves implicated in their own identification” (Scott, 2005, p.637).

Social relationships and first-hand accounts as evidentiary in critical realist research

Critical realist research is suitable for counselling psychology because it accommodates social relationships as causal influences. Just as counselling psychology research prioritises and values individuals’ subjective and intersubjective experiencing (Kasket, 2016), Scott (2005) explains the importance of first-hand accounts in critical realist social research:

*Critical realists prioritise social actors’ descriptions of their experiences, projects and desires. This does not imply that social actors can always provide complete and accurate accounts of their activities, plans, projects and histories. However, critical realists argue that such phenomena are central to any investigation they may undertake* (p.644).
**Researcher theoretical assumptions**

In terms of research ontology I assume that properties and mechanisms related to client cognitive, behavioural and relational factors are an *actual* (in the critical realist sense) influence in psychotherapy processes. I assume that knowledge of the meaning, structure and implications of the client factors concept is underdeveloped because (a) the inherent diversity of its components makes it difficult to draw up what is known into a single theoretical framework; and (b) there is little professional incentive for psychotherapists to research clients’ role in making therapy work.

Furthermore, I think it is possible to hold a social constructionist epistemology in my development of psychological knowledge (elaborated in section 3.3) while also believing that aspects of the material and mechanical world are not socially constructed. The material world and its events would exist regardless of whether or not we talked about them; although language and human relations may be necessary for much of the material and mechanical world to have been created and activated. So for example, life and death are real, not socially constructed events - although our knowledge of them is understood through social means. Importantly, I believe God is real as a force of such generative magnitude that it (not he or she) remains largely beyond human comprehension or capability to describe, other than through the term 'love.' This understanding maps onto Bhaskar's transcendent realm of the real: “this is a beautiful world. If you go into anything deeply enough, you will find it there. You could describe it as inner emptiness, but I describe it as bliss…. I call this the 'cosmic envelope.' Spirit is real. At a very deep level we are all spiritual beings” (Bhaskar, 2014, no page number). Finally, I also believe, like Bhaskar, that “agency is real. We really do make a difference in the world. Within any social context we as agents must take responsibility for our action individually and collectively” (Bhaskar, 2014, no page number).

**3.3 Muted group epistemology**

In counselling psychology, a phenomenological perspective leads us to respect human subjective experience and consciousness as primary sources of knowledge about how our world works (McLeod, 2003). Bhaskar says, “You start from a human experience. You start from epistemology. That is where you are” (2014, no page number). While
some qualitative researchers assert that critical realism can function as both ontology and epistemology (e.g. Fletcher, 2017), in this study I differentiate critical realism as a relevant ontology of the nature of reality, from my epistemological stance on the nature of knowledge. I recognise that while the ultimate truth of existence may lie beyond human comprehension, I also believe human knowledge is constructed from subjective experience, and in particular, relational activity and language (Gergen, 2015).

**Epistemological assumptions**

As a practitioner I observe that therapeutic processes and outcomes are shaped by clients and their social circumstances, far more than by what I do to support their efforts to make desired psychosocial changes. My thinking about the mechanisms and purpose of psychotherapy is further influenced by Jordan’s (2010) relational-cultural theory; and forerunning collaborative theoretical work about women’s development in relationships from the Wellesley College Stone Center (e.g. Jordan, Kaplan, Miller, Stiver and Surrey, 1991). In particular I rely here on Miller’s idea that “official definitions of reality” (1991, p.26) do not sufficiently draw upon complex processes of knowledge development that occur in people’s day-to-day emotional and social connections with each other. While I acknowledge the practical feminist stance inherent in these epistemological influences, this study does not explicitly draw on feminist methodology and does not seek to make a particular contribution to the psychology of women.

While asserting that this study’s epistemology is based on an assumption that knowledge exists and is created in social interaction, I do not go quite as far as some postmodern feminists might by saying that “there are no criteria for determining which version of reality is better” (Fivush, 2000, p.88). If such total relativism were the case then there would be no point, for example, in qualitative researchers taking steps to demonstrate the trustworthiness of their work. Advances in knowledge would be impossible (Parr, 2015).

Lowman (2012) reminds us that the focus of the scientist-practitioner psychologist’s work should be to ensure that research informs practice in order to improve its usefulness to clients. I try here to re-present client experience (a) to earn the public trust placed in psychologists (Donati, 2016); and (b) to respect clients, their activity and
social contexts as integral to the construction of counselling psychology knowledge. I have tried to create a study that moves beyond therapist experience, and even beyond established therapy-centric perspectives of how people change in therapy.

This point leads to the relevance in this study of an epistemology derived from muted group theory (E. Ardener, 1975; Kramarae, 1981). This theory allows client autobiographic narrative as valid data for knowledge construction (Howard, Maerlender, Myers and Curtin, 1992; Fivush, 2000).

**Muted group theory**

Muted group theory was developed by anthropologists Edwin Ardener (1975) and Shirley Ardener (2005) as a theory of communication and language. It highlighted how socially subordinate groups are not permitted access to participate equally in the generation of categories of thought, conceptualisation, and ideas about social structures, and the encoding of these types of knowledge into discourse. The values and experiences of people in muted groups are thereby kept private, or inadequately recognised, or mis-represented in dominant communication, including in the design and presentation of social research. “The astounding deficiency of a method, supposedly objective, is starkly revealed: the failure to include half the people in the total analysis” (E. Ardener, 1975, p.4). Another assumption I make, in linking the muted group epistemology to the critical realist ontology adopted here (after Parr, 2015) is that despite the socially-constructed nature of knowledge, it is possible for us to distinguish between more and less successful methods for knowledge development (as Ardener did in the quote above). Consequently, in seeking to better understand client factors, this study asks clients directly what they do to make desired changes.

While muted group theory was subsequently adopted and developed as a feminist theory (Kramarae, 1981), I draw from it in its original form as a theory that befits any social group that is ‘spoken for’ by those with more social power. Ardener described the mutually affecting spheres of dominant and muted groups as “simultaneities” (Ardener, 2005, p. 52). Interdependency is acknowledged here because psychotherapists need clients to lend fundamental credence to their professional identity.
To illustrate how muted group theory epistemologically informs this study, I have replaced the terms ‘men’ and ‘women’ with ‘psychotherapists’ and ‘clients’ in muted group’s three main premises as follows (Oregon State University, undated):

1. **Therapists cannot validly speak for clients**: Psychotherapists and clients perceive what happens in therapy differently. They have different aims, perspectives and perception-shaping experiences.

2. **Therapists use therapy-centric language**: Psychotherapists enact their language in ways that perpetuate their power, while insufficiently querying, or being informed by, clients’ experiences about how the work of therapy is achieved.

3. **Client perspectives need translating if the dominant discourse is to adopt them**: Client agency in making desired life-change must be converted into psychotherapist language and publicised in psychotherapist media in order to be recognised.

While it may be challenging to practitioners to consider how these premises might apply in psychotherapy, it been observed that such power imbalances in psychotherapy and its research are subtle and pervasive (Harrison, 2013; Proctor, 2017).

**Criticisms of muted group theory**

Here I will address, insofar as they may impact its use in this study, three criticisms made about muted group theory: it essentialises men and women; it is not empirically tested; and it is dated (West and Turner, 2003).

*Essentialisation*

In this research I am not using muted group theory to consider male and female communication patterns. It is used in a focussed way to address the muting of clients and the side-lining of other forms of social support in psychotherapy research. I am not ‘essentialising’ that all psychotherapy research is therapy-centric; nor that all clients behave the same way in therapy. On the contrary, I am seeking to thicken what is known about the complexities of client influence on psychotherapeutic outcomes.
Empirically untested

An extensive body of literature supports and describes the use of muted group theory (see Ardener, 2005 for a bibliography).

Dated

If we did not use today ideas that were considered radical in the 1970s we would have abandoned the work of Carl Rogers and Aaron Beck. The dismissive accusation that muted group theory is dated possibly betrays a discourse that feminist theories should not age. “Many in our field have found that muted group theory has helped inform us about how power functions in our talk and writing, and language….It helps explain what’s going on in a way that is easily understood, believable and useful (Kramarae, 2005, pp.55, 56).

3.4 Concept analysis design

As explained in the introduction on pages 15-19 I have employed a reconstructive concept analysis method derived from political science (Sartori, 1984; Collier and Gerring, 2009) to define, map and assess the client factors concept. This work is intended to represent an initial stage before further research can validly explore or develop measures for its intrinsic phenomena (Sartori, 1970; Robson, 2002), for example by using task analysis as described on pages 62-63.

Before explaining concept analysis methodology and design in detail, I first explain the process by which I found and decided on this method. I initially proposed to create a client resources survey instrument that therapists might use in routine practice to understand the role of particular client factors in assisting and hindering client-desired change. This idea was not supported by my advisors who preferred I attempt a qualitative thematic analysis of participant interviews around client factors. During this developmental stage, with further reading into my topic and analytic strategy, it became clearer to me that the term ‘client factors’ represented an abstract, theoretical shorthand for a wide range of more specific categories of client experience and activity, and as such it was a concept (as I have justified on page 14). From here I fixed on the idea that the vagueness of the concept in itself posed the research problem I should tackle. After
undertaking training in thematic analysis with Virginia Braun, I observed that, despite its popularity in counselling psychology research, thematic analysis was not the ideal method for my task. Its principal aim is to identify and analyse patterns in qualitative data (Braun and Clarke, 2013; 2014), while I needed to create conceptual anatomical definition. In other words, I sought not simply to put ‘meat on the bones’ of the client factors concept but to describe its ‘musculoskeletal structure’: a theoretically and structurally coherent framework linked to existing theory into which to organise my analysis. I therefore needed an analytic method that respected concepts as multi-layered abstract linguistic entities, while permitting synthesis of findings from outcome studies with participant interviews. From here, my ongoing methodological reading brought me to Gerring’s (2012) appealing and relevant work on social science concept analysis. Gerring in turn pointed me to Sartori (1984; 2009), whose antipathy for vague concepts and practical methodology captured my imagination and determined the direction for the completion and write-up of this study.

**Concept analysis as a deductive qualitative method**

Hupcey and Penrod (2003) recommend qualitative methods for reconstructive concept analysis (which I have previously explained, aims to map relevant data units to a theoretically informed hierarchical definitional framework, then assess the adequacy of the result). Hupcey and Penrod (2003) combine source material from previous research with client knowledge. Furthermore, Gilgun (2014) recommends a deductive qualitative approach when working in theory-guided research with ‘sensitising concepts,’ which, as with ‘client factors,’ give only a “general sense of reference” and lack “specification of attributes and consequently [do] not enable the user to move directly to the relevant content” (Blumer, 1954, p.7). The purpose of deductive analysis is to clarify or revise the concept’s dimensions, and to show theoretical patterns in a way that “helps the researcher see what they might not otherwise have noticed” (Gilgun, 2014, p.5). The process moves from working first with thick descriptions, to interpreting an organising framework, then assessing the pragmatic utility of the framework against existing theory.
Concept analysis as a potentially useful method in counselling psychology

Concept analysis straddles academic and clinical knowledge development. Counselling psychologists could use it to improve the explanatory and predictive nature of theory-relevant concepts, with the ultimate aim of evolving practice (Forsyth, 1980) as relevant scientist-practitioner activity (Corrie and Callahan, 2000).

Concept analysis is not used in counselling psychology

A total contents search of The Counseling Psychologist and the Journal of Counseling Psychology conducted on 11.02.2018 located only one concept analysis study by Hogan (1975) which describes a Q-sort used to create an empathy scale. A method more commonly found is concept mapping (e.g. Goodyear, Tracey, Claiborn and Lichtenberg, 2005) which is used to illustrate knowledge structures underlying concepts through the use of diagrams of spacial and relational groupings of meanings. In this regard concept mapping might be useful here as a comparative method. However concept mapping is ultimately unsuitable for two reasons. First, it is an expository/descriptive rather than a critical method. Second, it is positioned as a ‘post-positive’ method that claims to “make use of an objective, impartial researcher and standardised procedures” (Goodyear et.al., 2005, p. 236). A key premise of this critical realist study is that no social research can be impartial. “Our theories and methods are shaped by social forces and informed by interests” (Pilgrim and Bentall, p.262).

Another related method used in counselling psychology research is content analysis. This may include the identification of conceptual themes relevant to the research topic, for example in a literature review, but without a specific methodological analysis or critical appraisal process (e.g. Shin, et.al. 2017; Pilgrim and Bentall, 1999; Olsson, Bond, Burns, Vella-Brodrick and Sawyer, 2003; Hargons, Mosley and Stevens-Watkins, 2017). Such an approach would be insufficiently rigorous for the purposes of this study as it is a form of literature review.

Framework analysis (Ritchie and Lewis, 2003) shares a similar method to concept analysis, but likewise does not appear to be favoured by counselling psychologists. It
starts with a conceptual framework to which data is tagged (an *etic* process, Morrow and Smith, 2000), whereas concept analysis (at least as I have used it as a reconstructive process) starts with organising the data into thematically related groups which are increasingly differentiated through processes of familiarisation, data cleansing, and conceptual structuring, before a suitably shaped, theoretically-informed framework is finalised towards the end (an *emic* process, Morrow and Smith, 2000). Framework analysis uses concepts as ‘givens’ against which to locate and organise appropriate data; while reconstructive concept analysis uses data units as ‘given’ connotations around which to locate and organise appropriate conceptual extensions to link with existing theory.

**Why I did not use a nursing concept analysis method**

Nursing concept analysis methods in the tradition of Walker and Avant (2014), Rodgers (1989) and Chinn and Jacobs (1987) provide clear descriptions of their analytic purpose and methods. However they were not chosen here for several reasons. Firstly, these approaches require the creation of ‘model’ or ‘exemplary’ cases. This points to their realist stance that ‘truth’ is a fixed or universal entity that can be pinned down with language and specifically located in experience. While this ontology may be suitable for mathematical and other hard science concepts it is not in my opinion fitting for social science concepts where meaning is fluidly context-bound (Duncan, Cloutier and Bailey, 2007). A criticism of nursing concept analysis methods, such as Rodgers’ ‘evolutionary’ approach (2000b) that rely solely on literature is that they can replicate professional bias. They do not actively address language ownership about client experiences (Wuest, 1994). Beckwith, Dickinson and Kendall (2008) argue that these nursing concept analysis approaches are uncritical and derivative simplifications of a textbook (Wilson, 1970) that offers a stepwise strategy for enabling grammar school pupils to pass Oxbridge university exams. They also propose that these analytic methods lack processes for evaluation of their findings.

**Replacement versus reconstruction**

The chapter now moves on to explain in more detail the concept analysis design used here. In concept analysis an early decision must be made whether the aim is to replace
a defective concept by formulating a new one; or to improve an existing concept through
reconstruction (Sartori, 1984). An example of replacement concept formation can be
found in Pilgrim and Bentall (1999), where concept analysis is described as a “strategy
for replacing biased or misleading concepts with ones that are more useful scientifically
and clinically” (p. 262). However, the purpose here, while still intending to improve the
concept’s scientific utility, is to reconstruct it by clarifying its meaning using multiple
perspectives (Caron and Bowers, 2000). In this way I lend epistemic privilege both to
first-hand participant knowledge and to processed research data on client factors in line

**Sartori’s concept analysis method**

Sartori’s concept analysis method (1984; 2009) derives from political science. His
‘ladder of generality’ method used here has been described by Goertz (2006) as a
“classic” (p.69) contribution to the literature on concepts. It fits a critical realist ontology
in that Sartori dismisses any notion that concepts are fixed definitions of essential
phenomena. As objects of language he describes them as “arbitrary conventions”
(2009, p.89). While I argue that language use in an epistemological sense is hardly
arbitrary but results from, and contributes to, complex social structures, the ontology is
appropriate for this study. Sartori devised a process for creating a ‘reconstructed’
information-organising concept hierarchy that values the discriminative use of qualitative
and quantitative data. A hierarchy of abstraction aims to define a concept over several
layers of connotations that are incrementally less ambiguous than their aggregated
‘parent’ terms. Furthermore, Gerring (2012) offers seven criteria with which to evaluate
the adequacy of a reconstructed concept (applied in Chapter 5). The Sartori method is
indicative rather than prescriptive, which is useful here as it offers the researcher some
freedom to adjust the process to the context. I have made alterations and additions in
order to complete this study’s objectives. The following process explains the Sartori
method and how I have modified it:

1. **Data collection:** To commence, Sartori (1984) calls the researcher to collect a
   “representative set of definitions” from “pertinent literature” (p.41). Because
   ‘representativeness’ has elsewhere been proscribed as too difficult to prove in
qualitative research (Barbour, 2001), I created a purposive literature dataset on the basis of inclusion/exclusion criteria I devised to locate a diverse range of client factors in outcome studies. Because ‘client factors’ is a term that encompasses many other concepts, instead of seeking definitions, I aimed to locate its component attributes and operations. Additionally Sartori recommends the researcher strive for “historical depth” (p.41) in the data sample. In this study this meant reviewing studies back to 1960 although in the included dataset the oldest article is dated 1983. Study selection is explained in section 3.8 (pp.103-108). My study is enhanced in line with Hupcey and Penrod (2003)’s advice to triangulate the concept analysis with participant data, which in this case, consistent with muted group epistemology, forms the primary structure for the findings and analysis. The collection of participant data is explained in section 3.5 (pp. 80-87; for an example of a Sartori-inspired concept analysis that follows his instructions without triangulation, see Knafl and Deatrick, 1990).

2. **Data extraction:** Sartori then calls the researcher to extract the relevant characteristics, although he does not explain how this might be done. I achieved this with the use of spreadsheets which are discussed and illustrated in sections 3.6 (pp. 88-92) and 3.9 (p.109).

3. **Data interpretation for concept hierarchy construction:** The next step is creating what Sartori calls a “ladder of abstraction” (p.44) ‘matrix’ diagram that organises denotative labels for clusters of included phenomena (‘intensions’ or ‘connotations’ of the concept, Sartori, 2009) over levels of abstraction. I replaced the term ‘matrix’ with ‘framework,’ because ‘matrix’ connotes a total source context while this study does not aim for comprehensive or conclusive findings. However I am looking for explanatory mechanisms, associations or tendencies between client input and therapeutic outcome where possible (Fletcher, 2017; Sartori, 2009). In terms of framework structure, following the rule that the more abstract the term, the fewer its connotations, the least abstract terms are granular context-specific phenomena. These are thematically clustered under category labels with mid-range abstraction. Further connotative reductions are made to link mid-range abstractions to the generalised original concept.
Hierarchical conceptualisation strategy yields maximal, mid-range and minimal definitions of the concept (Gerring, 2012). A further step in the structuring process is deciding the “conceptual frontiers” (Sartori, 1984, p.43): which phenomena and denotations are, and are not, part of the concept. In this study, factors with contradictory or marginal evidence were ruled out (this is explained further in section 3.11, pp. 115-117). In terms of language use within the concept framework, the coherence and precision of the “semantic field” (Sartori 1984, p.51) should be ensured. Jargonistic terms, which Sartori says “add to obfuscation” (p.54) should be avoided. Neighbouring terms within the hierarchy should relate well. Synonymies, which Sartori calls “terminological waste” (p.39), should appear neither laterally nor vertically in the hierarchy. In terms of visually presenting the findings, in this study I have used an enhanced fishbone graphic for displaying the interpreted frameworks, and this process is explained in sections 3.7 (pp. 92-99) and 3.10 (pp.109-115). Encouragingly, Sartori leaves organising matrices “to the perceptiveness and ingenuity of the analyst” (2009, p.116).

4. **Concept reconstruction**: In this study, the meaning of ‘reconstruction’ involves comparing and combining the participant and research hierarchies into a single final framework. This process is explained in section 3.11 (pp116-119).

Figure 9 summarises the study design’s parallel process in diagrammatic form over seven steps. Steps one to three, data collection, extraction and interpretation are conducted for participant data, then repeated over steps four to six for research data. In step seven the resulting concept hierarchy frameworks are compared and combined into one.
Steps one to seven are explained in the following sections 3.5 – 3.11, along with the labelling of the structural hierarchy at the more abstract levels. The content of the concept reconstruction is described in detail in Chapter 4.

3.5 Participant recruitment and data collection
In explaining how I handled Step 1: Participant data collection (see figure 9, p.80), I cover the following topics in this section: participant recruitment process; recruitment objective; participant characteristics; interview design; data collection; power dynamics; and interview transcription.

**Recruitment process**
In qualitative research the process of attracting participants is an important contextual aspect of the study. Participant sites determine to an extent who in included and therefore the nature of the light shed on the topic (Morrow and Smith, 2000). In this study I needed to talk to people who had recently finished a course of counselling. Following Spradley’s (1980) strategies for locating participants, simplicity, permissible accessibility and unobtrusiveness were key guiding principles. In spring 2016 I obtained
permission to recruit participants from a suburban third sector general counselling service with a primarily person-centred approach (TS1); and an urban university student and staff counselling service (US1) with generally short-term CBT and solution-focussed approaches. An additional suburban site (TS2) is a specialist third sector service I manage, which predominantly serves clients within an NHS adult community eating disorder service using integrative, CBT and group-based approaches. This service was chosen for ease of access and unobtrusiveness. I met with therapy teams from each service to provide a brief talk about the purpose and method of my research. I asked them to invite clients who were about to finish counselling to participate. I suggested 4+ sessions of therapy should have been completed, to roughly accommodate advice from Kadera, Lambert and Andrews (1996) that it takes at least 2 sessions, and for most clients, 8 or more sessions to achieve significant changes. I also placed recruitment posters (Appendix 9) in the waiting areas of TS1 and TS2 and the therapy room in US1.

**Dataset adequacy and the question of data saturation**

I aimed to recruit 12 adults aged 18+ which is the minimum recommended for qualitative research by Baker and Edwards (2012). However I stopped at nine (a) to manage the volume of data within project timescale (b) because nine came forward on my first recruitment exercise; and (c) upon data analysis it was clear that no further interviews would be needed, because in terms of dataset adequacy I was able to meet the information requirements of the study with the obtained sample, in that it was large enough to capture a range of experience but not so large as to be unduly repetitious (O’Reilly and Parker, 2012).

The question of achieving data saturation with participant interviews as a quality marker was problematic in this study for two reasons. Firstly, data saturation is described in grounded theory methodology as a process that assures theoretical categories are fully accounted for in theory-generating analysis of unstructured participant interviews (Aldiabat and Le Navenec, 2018). While this may be appropriate for inductive theory-building research, it is not necessarily a suitable notion in deductive theory-clarifying research (which is the purpose of this study). The nature and direction of data collection in deductive research (particularly within a critical realist ontology) means the
researcher cannot capture all possible categories of meaning. This renders the achievement of saturation “an unrealistic target” (O’Reilly and Parker, 2012, p.194). The second reason is related to the first. Data saturation is not a recognised aim of reconstructive concept analysis where instead, data triangulation is recommended (see p.23 in section 1.4 for Hupcey and Penrod’s 2003 triangulation recommendations). Fusch and Ness (2015) assert that methodological data triangulation “goes a long way towards ensuring” data saturation (pp.1411-1412).

In terms of data adequacy, my participant data analysis spreadsheet (figure 11, p.91) represented what Brod, Tesler and Christiansen (2009) have called a ‘saturation grid,’ albeit modified here for deductive research intended to locate categories rather than inductively validate categories determined from preceding interviews. The major categories and elements were listed on the columns and the participants were listed on the rows. All categories and elements represented in the reported results contained quotes from at least two participants, in line with Brod, Tesler and Christiansen (2009) who included data from at least two interviews per category.

**Participant characteristics**

I hoped for a diverse participant group, but recruitment was non-purposive due to the exploratory nature of the research design. Because I took no steps to ensure greater diversity, the actual self-selected group was comprised of white women aged from 18 years into their 30s. With hindsight it was predictable that the services I accessed would tend to yield participants in this stratum. The composition of this sample was determined by their having recently accessed counselling and having an interest in the topic of how clients make therapy work, and/or an interest in participating in research.

A homogenous comparison sample is an advantage in critical realist research where the investigation probes the mechanism of a generalised concept derived from research to see if it actually affects clinical outcomes as expected in specific contexts (Miller and Tsang, 2011). While my research focus is not concerned with specific contexts it could not evade the contextuality of the settings where I sourced participants.
Participants were predominantly highly educated, childless, working fulltime and in long-term relationships. Table 1 provides a summary of participant demographics. Categories were chosen to correspond to those frequently included in the research literature sample (discussed in section 3.8). I applied culturally appropriate pseudonyms to avoid the de-humanisation of numerical labels. Although Allen and Wiles (2016) recommend that participants choose their own pseudonyms at the outset, this issue only came to my attention at write-up stage.

Table 1: Participant demographic characteristics

<table>
<thead>
<tr>
<th>Participant number</th>
<th>Pseudonym</th>
<th>Interview schedule</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Age</th>
<th>Education</th>
<th>Employment</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Dana</td>
<td>A</td>
<td>F</td>
<td>White British</td>
<td>31-40</td>
<td>BA</td>
<td>Fulltime</td>
<td>TS1</td>
</tr>
<tr>
<td>2</td>
<td>Ella</td>
<td>B</td>
<td>F</td>
<td>White British</td>
<td>31-40</td>
<td>BA</td>
<td>No</td>
<td>TS2</td>
</tr>
<tr>
<td>3</td>
<td>Luka</td>
<td>B</td>
<td>F</td>
<td>White non-European</td>
<td>31-40</td>
<td>Doctorate</td>
<td>Fulltime</td>
<td>TS2</td>
</tr>
<tr>
<td>4</td>
<td>Kyra</td>
<td>B</td>
<td>F</td>
<td>White British</td>
<td>31-40</td>
<td>Masters</td>
<td>Fulltime</td>
<td>TS2</td>
</tr>
<tr>
<td>5</td>
<td>Lucy</td>
<td>A</td>
<td>F</td>
<td>White British</td>
<td>26-30</td>
<td>Masters</td>
<td>Fulltime</td>
<td>TS2</td>
</tr>
<tr>
<td>6</td>
<td>Zoey</td>
<td>A</td>
<td>F</td>
<td>White British</td>
<td>31-40</td>
<td>BA</td>
<td>Fulltime</td>
<td>US1</td>
</tr>
<tr>
<td>7</td>
<td>Thea</td>
<td>B</td>
<td>F</td>
<td>Mixed White British and other White European</td>
<td>18-25</td>
<td>A-Levels</td>
<td>Part time</td>
<td>TS2</td>
</tr>
<tr>
<td>8</td>
<td>Lily</td>
<td>B</td>
<td>F</td>
<td>White British</td>
<td>18-25</td>
<td>Masters</td>
<td>Fulltime</td>
<td>TS2</td>
</tr>
<tr>
<td>9</td>
<td>Esme</td>
<td>A</td>
<td>F</td>
<td>White British</td>
<td>18-25</td>
<td>Masters</td>
<td>Fulltime</td>
<td>TS2</td>
</tr>
</tbody>
</table>
**Interview design**

Briefly reviewing the structure of the causal syntax behind the concept analysis, a change in independent variable \( X \) is a mechanism directly or indirectly associated with a change in outcome \( Y \). In this case \( X \) is client factors, which I am seeking to elucidate. \( Y \) is conceptualised here as desired psychosocial life-change, which I am not seeking to elucidate. A generic outcome is used here for two reasons: (a) participants in this study had attended psychotherapy for help with a range of different psychosocial issues; (b) participants could pick the outcome that was meaningful to them, not necessarily the original reason they sought therapy.

In devising questions for a semi-structured interview to elicit from participants why, from their point of view, change did and did not happen in therapy, I ruled out some existing interview schedules. The Client Change Interview (Elliott, 1996) was unsuitable because it does not explore client perceptions of causality in therapeutic change (e.g. Klein and Elliott, 2006). I also ruled out the Helpful Aspects of Therapy (HAT, Llewellyn, 1988) and Patients' Perceptions of Corrective Experiences in Individual Therapy (PPCEIT, Constantino et.al. 2011a) because of their bias in eliciting therapy-validating information (e.g. Constantino et.al. 2017; Constantino and Angus, 2017). It was important to the concept reconstruction that participant narratives were not shaped by therapy-centric questions; and that the starter questions were not leading in terms of explanatory attributions for change or non-change. After piloting multi-question interviews with two doctoral student peers, I removed questions relating to whether participants thought personal demographics had a bearing on the therapy outcome because (a) they were leading and (b) participant feedback was that they were irrelevant.

I decided that a semi-structured interview format would provide flexibility for participants to expand upon topics of relevance to them while being guided by subject-relevance for the research (Kvale, 2007). This type of interview also permits the researcher freedom to tailor their responses to the participant (Morrow and Smith, 2000). I chose simply-framed interview questions that were tightly focussed to the aim of the study (Agee, 2009). These questions assumed that participants and their contexts had exerted
important effects on therapy outcomes, and that participants could identify and describe what these effects were. The ‘what’ changes and non-changes were not the objects of enquiry, but needed to be established in order to frame ‘why’ questions aimed to access participant experience of causal attributions for change and non-change processes (Swan, 2017).

Schedule A, used with four participants, comprised four open-ended interview questions:

1. Please describe one positive or desired change that has happened in your life since you started therapy
2. Why do you think this change happened?
3. Please describe one thing that hasn’t changed in your life as you hoped since you started therapy
4. Why do you think this change did not happen?

Schedule B, used with five participants, placed the non-change questions (3 and 4) first, followed by the change questions (1 and 2). This was done to balance the ‘warm-up effect’ in interviews where participants may provide information more freely in later stages of the interview (Mellon, 1990).

**Data collection**

No participant was excluded and none declined to take part once they had read the information sheet (Appendix 10). Interviews were set up at participant convenience to occur between one and six months after their last counselling session. This timeframe was chosen so that there was sufficient interval for participants to reflect on their role in therapy; while not being so distal that experiential memory might have faded. All participants were sent the interview questions (Appendix 11) at least a week in advance so they could think about them before their interview if they wished. All participants gave consent (Appendix 12) and provided demographic information prior to interviews commencing (Appendix 22, with results in Table 1, p.83).
Interviews were conducted in summer and autumn of 2016. One interview took place on Skype and the remainder in-person at TS2 in a confidential consulting room.

Interview lengths were determined by how much the participant had to say on each question although I more actively wound up two interviews in order to keep to an hour in line with the participant information sheet which said interviews would be 30-60 minutes. The shortest interview was 30 minutes (Luka) and the longest was 62 minutes (Esme). The average interview length was 46.7 minutes.

By way of interview manner my style is warm and relatively informal, although focussed on the job at hand without engaging in tangential chit-chat or offering information about myself other than an introduction to my role as student-researcher. Prior to commencing recording I started interviews with an explanation of the research topic and answered participant queries in relation to the topic or the information sheet provided. Upon commencing recording, besides asking the four interview questions my interjections were restricted to eight types:

- Summarising prompts intended to invite participant to discuss a relevant topic further (for example: *So all of these things you are attributing to helping you get to the point where things are really good now.*)

- Summarising interpretations seeking correction (Kvale, 2007) (for example, *So there was a sense of escape there…?* Dana: *Yeah! I think so. Well, not escape, but, just, new beginnings. Kind of, ‘yes I want to go away from here but I do actively want to go where I’m going.’)

- Questions inviting further discussion of a specific topic (for example: *How did you decide upon each one of those helpful activities?*)

- Questions seeking deeper meaning or relevance of the topic in the participant’s life (for example: *What does that mean for you making that really big decision, something that you’d been thinking about for a long time, that you were actually able to do it?*)

- Questions seeking clarification of a process (for example, *Do you think that’s as a result of sleeping better, feeling better, having taken the steps that you’ve taken? Or did that actually contribute to your being able to sleep better?*)
• Open questions testing for further information (for example: *Is there anything else about this process of change that you feel is important to tell me about?*)
• Directing the conversation to areas of relevance (for example: *Well, moving house was another decision there.*)
• Brief joining affirmations, emotionally mirroring something the participant said (for example: *Definitely! [Laughing with participant]*)

**Power dynamics**

I was aware of mild but not detrimental role power imbalances fluctuating between me and the participants (Vähäsantanen and Saarinen, 2013). Participants understood from the information sheet that it was my role to ask questions and theirs to share relevant personal experience (Kvale, 2007). Implicit in this arrangement was my role to listen, understand, interpret and learn (although this was not, and probably should have been spelled out in the information sheet). In terms of researcher power, I devised the questions, managed the commencement and conclusion of the interviews, the timing and introduction of the four questions, and I sometimes guided conversations to optimal relevance for the research topic (Kvale, 2007). In terms of participant power, I was dependent on their willingness to donate time and to provide analysable information. It is my observation that the interviews unfolded in a spirit of mutual cooperation, in which power balanced itself by homeostasis-seeking social grace. I felt it would have been inappropriate, in terms of my ethical obligation not to burden or exploit participants, to de-stabilise this power balance, for example by introducing my personal experiences into the conversations (Karnieli-Miller, Strier and Pessach, 2009).

**Interview transcription**

I transcribed all interviews verbatim within four weeks of their recording date while they were still fresh in my memory (Sreenan, Smith and Frost, 2015). Visible body language, facial expressions and hand gestures were not noted. Audible sighs, laughter and crying were noted, as were pauses lasting five seconds or longer. Participant anonymity was protected by the use of codes for diagnoses, services attended and named staff, geographical places. The names of significant others and types and places of work were removed. A partial transcript is available in Appendix 13. My decision-making
regarding removing diagnostic terms is presented in Appendix 14, along with how I handled transcribing local pronunciations, punctuation and speech fillers (Oliver, Serovich and Mason, 2015).

3.6 Participant data extraction
Step 2 (see figure 11, p.91) was carried out over the following stages: Interview summaries; data extraction spreadsheet; data cleansing; and data immersion. I will now explain each of these stages.

Interview summaries
While transcribing, I simultaneously kept a notebook of hand-written observations. These briefly summarised each participant’s answers to the four interview questions. I also noted some key themes along with initial interpretations which helped me monitor and limit my “intrusion into the text” (Borland, 1991, p.70). Figure 10 shows my notes on points Ella makes in her interview, plus observations, for example, that she did not seem to give herself credit for the changes she’d achieved; and that she said she sought security. I also jotted down ideas for working up the analysis, for example, that ‘personal factors’ and ‘relational factors’ are interdependent.
Once all interviews were transcribed I typed up summaries which are presented in Appendix 15. Six participants chose as their desired change the primary reason they attended therapy, while the remaining three chose other issues. In terms of changes not achieved, four participants said they had not satisfactorily reached the goal for which they attended therapy; and four identified other issues that remained unresolved. One participant said there were no outstanding issues after therapy.

**Data extraction spreadsheet**

While transcribing I simultaneously built a spreadsheet in which I organised and categorised all conceptual data related in any way to helpful and unhelpful factors participants described. Over a lengthy data extraction and analysis process these data were organised and re-organised into increasing levels of abstraction:
(a) **Elements** are mildly abstract, person-level, labelled groupings of direct activities and experiences associated with processes of change and non-change. Elements are built up from, and illustrated by non-abstract participant quotes. Quotes are the ‘thick descriptions’ with which Gilgun (2014) encourages the deductive researcher to start the analysis. I used at least one and in many cases, several quotes from one or more participants to illustrate each element. The labelling of elements represented the first stage of interpretation. Labels were revised several times over the course of data extraction to best summarise the meaning of the element.

(b) **Categories** are groups of elements that belong best together in classes of action or inaction, although it was only after some time working with the data that I discerned that action and inaction were defining pattern characteristics at the categorical level. Categories are labelled with terms that indicate the particular ‘state of doing’ indicated by their component elements on the helpful factors side; and the ‘state of being’ indicated by component elements on the unhelpful factors side. Abstracted away from actual experience, categories form chains of interrelated factors comprising processes of change on the helpful side, and non-change on the unhelpful side. The creation of categories represented a further stage of interpretation.

(c) **Super-factors** are highly abstract features of the most abstract term ‘client factors.’ Without a specific definition, super-factors depend on reader epistemic experience to extrapolate their meaning. These factors were derived from my interpretation and management of the data, informed non-specifically by counselling theory, and were imposed on the data at the outset to provide a preliminary deductive basis for concept categorisation.

Data was used at ‘face value’ as honest explanations of experience. I did not, as other qualitative researchers might, listen for ‘distortions,’ ‘self-deception,’ or ‘groundless assertions’ (Elliott, 2010). While my previous knowledge from personal and professional observations and reading about how people make desired life-changes informed this interpretive activity, I tried to minimize seeking, interpreting, interposing or inventing meaning beyond what participants said. In this way I assumed there was no
failure (or veiling) in participant communication of meaning nor in my listening and understanding. This was done to reduce risk of ‘therapy-centrism’ in my use of participant data. So my guiding questions as I familiarised myself with the interviews and developed the data extraction spreadsheet was, ‘What factors enabled this participant to make desired changes? What factors posed obstacles to change?’

Figure 11 shows how the hierarchy of super-factors, categories and elements were constructed within descending rows of the spreadsheet, with illustrative participant quotes within each element’s column.

**Figure 11: Participant data extraction spreadsheet sample**

Data cleansing

Once notations from all transcripts were added into element columns, I printed out the labelling rows of the entire spreadsheet (Appendix 16). This was then cut into manageable sections for close review and data cleansing, which involved collapsing
duplicates; re-positioning those that seemed to be under the wrong super-factor; renaming those that required more accurate labels; and deleting entries which, upon consideration, were not elements because, for example, they were not precisely evidenced by participant data.

Figure 12 shows my editorial notations on a section of the spreadsheet print-out.

Figure 12: Hand notations for spreadsheet data cleansing

Data immersion

To further immerse myself in the data I carefully re-read each transcript several times to locate exact quotes for the conceptual themes and added these to the spreadsheet (figure 11 on p.91 shows location of quotes). Over 270 quotes were added, although only 68 were chosen to present in this write-up. All participants gave clear and descriptive answers to each of the four interview questions. Material from all participants was well-dispersed across the spreadsheet. There were no participants whose data was sparsely represented.
3.7 Participant data interpretation
Step 3 (see figure 9, p.80) interpretation was carried out over two interrelated tasks: development of a fishbone framework diagram to illustrate the interrelationship of helpful and unhelpful client factors over time; and the delineation and expression of four levels of conceptual abstraction within the framework. While more detailed discussion of the contents of the framework is presented in Chapter 4, I explain here how I used the interview data as the basis for the fishbone structure. First I explain the central spine of the framework, then follow this with explanation of how the ribs were built up.

**Fishbone spine: Process of change over time**

All participants, in providing detailed accounts of how they made desired life change, naturally embedded significant events in unfolding time. The ‘time-stamp’ on key activities and experiences in client narratives permitted me to design the concept framework using ‘process of change over time’ as the spine. I could then position change and non-change elements in a general chronological order based on where they were positioned in participant life-narratives.

Temporal descriptions had various purposes. Most participants provided a timeline to orient me to the history of their problems as well as their decisions and efforts to change. For example, Kyra explained that she had recently left a job she had held for seven years, in which colleagues had accommodated her mental and physical health problems. She did not want these to carry on in her new job, *So I decided at the start of [the current year] that I probably needed some additional support to try and break the cycle for good...* *There’s been probably a lot of things over the past six to twelve months, that have accumulated in me thinking that I need to, I need to make some real life changes.* Zoey explained how several geographical moves over time were part of her increasing recognition of the need for help: *And then shortly after moving to [English city 2], about six months, I went to the doctor and asked for some more counselling.*

Change processes were described as requiring active work over extended periods of time during and after psychotherapy. For example, Luka said, *I’ve done probably quite a lot of work since it was a really, really bad relapse in Christmas, so last six months I’ve done*
quite a lot. And it just gradually happened. Kyra said, [my therapist] sent me an app to
download, that I’ve used. I’ve been using that for a good few months now [since therapy ended],
to look at, and then you can pull off your sheets of progress to see patterns of how you’ve been
feeling at the same time, and when you’ve had blips. Thea explained, Each time [I’ve had
psychotherapy] I’ve been a bit more able to try and get on board with [therapist suggestions].
Although it did take five-ish years.

Contrasting how slowly positive changes came about for some participants, Lily
described how quickly problems emerged: I just didn’t get...how things could change so
quickly from one month, in January, feeling completely fine and [asymptomatic] on Christmas
Eve, then five months later, [symptomatic of D3] and terrified of anything. Others reported a
chronic pattern of difficulties going back to childhood. For example, Lucy said, I want to
break away from all the rules and restrictions that I’ve imposed on myself for so many
years....I’m confronting years and years and years of behaviours that have become so
engrained.  Zoey explained, I went to see...my mum, and I said, ‘I’m not coming round here
anymore.’ There’s been over the years, so many conversations.

Some participants recounted time lost within developmental trajectories due to the
impact of recurrent or debilitating problems. For example, Dana explained how she had
to take time out from her training course and work: I was missing a lot of time off work and I
had major stomach upsets and, that I’ve now recognised was [D2] and [D1]. Ella said, I’d gone
from [less improved to more improved].... That was last Christmas, not the Christmas just gone,
the Christmas before. Or was it this Christmas? No it was last Christmas. So then I [relapsed]
beginning of the year. Thea explained how she had had to defer starting university a few
years previously, due to mental health problems: I couldn’t do my personal statement so
that’s why I couldn’t apply to Uni the first year.

Another form of reflective time description related to how long participants had recently
enjoyed the fruits of their change efforts. For example Dana said because I’ve been
sleeping well for a good couple of months I can now watch the news and then go to bed.  Luka
said, I very rarely, actually, for the last few weeks I think, I’ve not thought that I hate myself.
Some participants remarked how long it had been since they had last functioned as
well. For example, Ella said, *I saw people I’ve not seen for twelve months on Saturday night. We had a big reunion.* Thea noted, *A few months into the relationship with [girlfriend] I managed to go for a month without [specific difficulty occurring]. Which was the longest it had been in six years.*

Some participants described reflecting back to the past to see how far their life had changed for the better, to motivate themselves to keep going. For example, Ella said, *All I have to do is look back at those times and think, ‘do you really wanna be there? Do you really want to be the ones that you felt sorry for in [Service A programme]? Do you really want to feel as low as them, as isolated as them?’* On the other hand, Esme projected into the future to motivate herself to make changes: *So in ten years, do I want to be childless, friendless, still [unwell], miserable? No.*

In summary, participants described taking a series of large and small, complementary steps over quite lengthy periods of time before they achieved their desired aim; and in aggregate these steps brought about wider changes in their quality of life and relationships.

**Fishbone ribs**

Once the data extraction spreadsheet was complete, using A3 paper I sketched out and worked up a provisional framework in order to clarify and organise all aspects of the hierarchy and its component categories and elements. Meaning was created from participant material at the elemental level. Quotes from at least two different participants were required to qualify each element. Meaning elements were grouped via a mildly interpretive process into categories of activity and inactivity. Categories and elements were reviewed and adjusted in terms of contents and labels until best fit was achieved. Categories were then further condensed and abstracted to stages of change, which were then abstracted to super-factors, in a process similar to content analysis (see for example Erlingsson and Brysiewicz, 2017). Figures 13 and 14 show some of this work in progress.
Figure 13: Initial sketching for participant-informed concept hierarchy
Through data extraction a fundamental distinction was made between helpful and unhelpful factors. Because these largely mirrored each other, a fishbone structure fit for interpreting and presenting client factors as components of a process that unfolds over time. The finalised participant-informed client factors hierarchy is shown in figure 15. It should be noted that this diagram is intended to be viewed in A3/200% size. It is reproduced here at A4 size to give the reader an indication of the fishbone but it is acknowledged that detail at the elemental level is lost in this format. Final elements are explained in detail in Chapter 4.
Figure 15: Participant-informed concept framework
Hierarchy of abstraction

The following description explains how the concept framework was built and labelled. This is a structural, methodological explanation which is distinguished from the results presented in Chapter 4, although for illustrative purposes I explain here the labels I used and why.

The blue-spined participant-informed concept framework shows participant social, behavioural, cognitive and identity factors organised into holistic chains of change and non-change occurring over time. The area above the spine of the fishbone shows helpful factors and the corresponding area below the spine shows unhelpful factors. The helpful and unhelpful sides are each divided vertically into four levels of conceptual abstraction from highly abstract super-factors, to moderately abstract stages of change/non-change, to less abstract categories of activity/inactivity and finally specific elements which are non-exhaustive connotations of each category. Elements include illustrative participant quotes and research findings which are the “real world counterparts” (Sartori 1984, p.22) of conceptual terms.

I will now explain the four levels of abstraction in turn. Each of the concept labels is shown in bold throughout the remainder of the write-up for highlighting purposes.

*Level Four: Super-factors*

Super-factors are the most abstract level of intension - or connotation - of the concept, of which there are two. Super-factor 1, **social support** is subdivided as (A) a moderator (inspiration), and (B) a mediator (facilitation and reinforcement) for super-factor 2, which is **reflective learning**. These helpful super-factors form a concatenated trajectory that leads to ongoing inter- and intrapersonal growth cycles across the lifespan.

On the unhelpful side of the framework, super-factor 1: **inadequate social support** refers to various types of non-generative relational impairment or injustice in the familial, community or cultural context. An impoverished social environment contributes to, and is reinforced by super-factor 2: **psychosocial stagnation**. Here this term refers to living in a state of cognitive and social inflexibility that hinders reflective learning and adaptive growth.
Level Three: Stages of change/non-change

Connotations of the super-factors are visible at the mid-range level of abstraction, which I have conceptualised as stages of change/non-change. There are four stages A-D on both the helpful and unhelpful sides of the fishbone. An emphasis on a dynamic ‘state of doing’ is apparent in stages on the helpful side, as well as gradual social resource accumulation over the lifespan.

Super-factor 1A (social support moderators) is connoted by Stages A and B. Stage A is problem recognition prompted and assisted by social contacts. Stage B is a pivotal process of committing to change initially through recognising the importance of one’s relationships with others, then deciding to make changes to improve one’s situation for oneself.

Super-factor 1B (social support mediators) is connoted by Stage C, which is a particularly active process of engaging with sources of targeted help and social activity which confer interrelated benefits in reinforcing movement into and through Stage D. Stage D is the connotation for super-factor 2 (reflective learning) and is characterised by exploratory psychosocial change and growth.

Figure 16 shows the relationship across helpful super-factors and between super-factors and stages of change.

Figure 16: Helpful super-factors and stages of change
On the unhelpful side of the framework, a less mobile ‘state of being’ is apparent in stages of non-change. Unhelpful super-factor 1 (Inadequate social support) is connoted by Stages A and B. Stage A Non-change is a **problem-maintaining social environment**. From this ensues Stage B Non-change which is characterised by **no commitment to change**.

Unhelpful super-factor 2 (psychosocial stagnation) is connoted by Stages C and D. In stage C Non-change, **no new generative social connections** compounds the effects of the previous two stages to propel the individual into stage D Non-change, a **cycle of resource depletion**, which re-connects with stage A Non-change. Here I define resource depletion as adverse socio-cultural or emotional circumstances that overtax one’s health, social support, coping skills, self-efficacy or sense of identity, to the point that one can no longer reflect, learn, explore or develop one’s potential.

Figure 17 shows the self-maintaining relationship across unhelpful super-factors and between super-factors and stages of non-change.

**Figure 17: Unhelpful super-factors and stages of non-change**

**Level Two: Categories of activity/inactivity**

The connotations of the stages of change are visible in the next less abstract level which comprises nine **categories of activity** on the helpful side, and nine obverse **categories of inactivity** on the unhelpful side. On the positive side, most categories are labelled with participles to capture the ‘state of doing’ that characterises participant work at this level.
Figure 18 shows categories of activity as connotations of respective stages of change.

*Figure 18: Categories of activity*

**Category 5 as a connotation of change Stage B and C**

**Categories 7 to 9 as connotations of change Stage D**

Figure 19 shows categories of inactivity as connotations of respective stages of non-change.

*Figure 19: Categories of inactivity*

**Categories of inactivity 1 and 2 as connotations of Stage A non-change**

**Inactivity category 5 as a connotation of stages B and C non-change**

**Level One: Elements**

Elements are the densest and least abstract level of the concept hierarchy because they are built from non-conceptual raw data. However, as interpretations from the data, they are mild abstractions. They are illustrated by constituent participant quotes and research references to assist the reader understand their formation. There are 38 helpful and 22 unhelpful elements, 60 in total. Element contents are described in Chapter 4.
Figure 20 shows a narrated screenshot of helpful elements that connote helpful categories 7, 8 and 9 (which in turn are connotations of change stage D).

Figure 20: Elements of helpful activity categories 7 to 9

Figure 21 shows a narrated screenshot of unhelpful elements that connote unhelpful categories 7, 8 and 9 (which in turn are connotations of non-change stage D).
3.8 Research data collection
Step 4 (see figure 9, p.80) research data collection is now presented over two parts: study selection; and a summary of characteristics of the 68 included studies.

Study selection
Study selection took place over four phases which are shown in the flow chart in figure 22 (adapted from Moher, Liberati, Tetzlaff and Altman, 2009). This chart is included to assist the reader in following the stages of the literature selection process. Although this ‘PRISMA’ style chart is commonly seen in systematic reviews it is stressed that the review conducted here was selective in line with concept analysis methodology (Sartori, 1984; Rodgers, 2000b) not systematic. Phases included identification; screening; application of eligibility criteria; and inclusion. Each phase is next described in further detail.
Figure 22: Study selection flow chart

1. Identification

- Articles located in search of PsycINFO (n=677), ScienceDirect (n=410), Mendeley Open Access (n=2056) & Sage Journals (n=197) (Total n=3340)

2. Screening

- Articles located in existing files and textbook reference lists (n=299)
- Articles screened for relevance by title (n=3639)
- Abstracts screened for relevance (n=697)

3. Eligibility

- Records excluded (n=3564)
- Articles located in systematic reviews and meta-analyses (n=49)
- Full-text articles assessed for eligibility against quality control criteria (n=124)

4. Included

- Full-text articles excluded (n=56)
  - Measures/ timepoints not specified (n=10)
  - Client factor not found, not described or not a significant predictor (n=9)
  - Predictor or moderator not clearly a client factor (n=8)
  - Outcome or predictor judged by therapist (n=7)
  - Client factor is an aspect of presenting problem (n=6)
  - Design or analysis does not explain change mechanisms (n=5)
  - Client factor not operationally defined (n=3)
  - Involuntary treatment participants (n=2)
  - Analytic focus on therapist action (n=2)
  - Minimum 3 sessions not specified (n=2)
  - Therapy not described (n=1)
  - Therapy outcome not specified (n=1)

Studies included in concept analysis (n=68)
Identification

The search for relevant research about client factors associated with process and outcome was conducted in January 2018. Three sources were used: databases, select textbook bibliographies, and my existing collection of articles.

In considering which databases to search, although Penrod and Hupcey (2004) advise that in concept analysis, multidisciplinary sources should be sampled in order to capture the concept’s use in different contexts, in this study, due to the discipline-specific nature of the client factors concept, databases were restricted to those likely to yield articles about client activity in psychotherapy. These included Sage Journals, Science Direct, PsycINFO and the Mendeley open access catalogue. The Science Direct search was limited to 2017-18 for manageability and to yield up-to-date indications of the concept while providing some balance with the text book searches which yielded older studies. Search terms were searched for within ‘all fields’ rather than restricted to ‘keywords’ and/or ‘title’ to increase the scope and credibility of the search (Rodgers, 2000b). Terms included 'client factors,' 'client characteristics,' 'extratherapeutic factors,' 'client agency' (altered in PsycINFO to ‘empowerment’), 'client variables,' 'moderators,' ‘mediators,’ and ‘predictors of therapeutic change.’ In PsycINFO these terms were exploded to additional relevant terms and then associated with exploded terms for ‘counselling.’ Appendix 1 shows screen shots of the searches conducted.

Textbook reference lists were searched including Garfield 1978, 1994; Clarkin and Levy, 2004; and Bohart and Wade 2013. These were chosen to ensure the inclusion of studies that preeminent researchers relied on for the concept’s development over time (a precedent for this type of hand search can be found in Bernd and Strouse, 2008).

Relevant articles from my existing library of research articles (collected in preparatory work from 2015-2018) were included.

Screening

3340 study titles were reviewed and 2643 were excluded as irrelevant. 697 were retained for abstract review against primary inclusion criteria (Appendix 2), and a further 608 studies were excluded. 89 studies remained.
Among the 89 remaining studies were 14 meta-analyses/systematic reviews. Because the final sample could include only primary research, 49 relevant primary studies were retrieved from the bibliographies of these studies, which were themselves removed (detail of studies included from removed meta-analyses is shown in Appendix 3). 124 studies remained for full text review.

Eligibility

Under full-text review the 124 remaining studies were subjected to quality control. The baseline quality threshold was the study’s publication in a peer-reviewed journal. Then, because I required data relating as exclusively as possible to client or extratherapeutic factors (rather than therapist, technique or diagnostic factors); and because I was seeking either statistical inference of mediation, moderation or prediction (rather than simple correlation); or client asserted association between client factor and outcome, further exclusion criteria were applied (detailed in Appendix 5. Results of exclusion are in Figure 22 ‘full text articles excluded’ text box).

Inclusion

After the application of these exclusion criteria, 68 studies remained for full data extraction and concept analysis. A distinction was made between those where outcome was analysed from follow-up data gathered at least 1 month after therapy finished (41.2%, n=28/68), and those where outcome was measured at the end of therapy (58.8%, n=40/68). Client factors reported from follow-up data might be less likely to be temporary artefacts of the therapeutic process. However due to the relatively small number of studies in each subgroup, I decided not to create concept analyses comparing any differences, but treated the 68 studies as a complete dataset.

Dataset adequacy

Study sample dataset adequacy in concept analysis is indicated by its capacity to support the study. The appropriateness of the sample is indicated by its capacity to offer a sketch of how the concept is operationalised (Penrod and Hupcey, 2005). Both requirements were attained with this sample. Penrod and Hupcey (2005) note ‘modest’ single-researcher concept analysis studies have included 83 and 107 studies, whereas
Rodgers (2000b) notes that an effective concept analysis may include anywhere from 30 to over 4,000 articles in studies that do not triangulate with qualitative interviews. The data from 68 included studies was triangulated in this study with nine interviews as discussed in sections 3.5–3.7 above.

**Characteristics of 68 included studies**

The following characteristics of included studies are summarised here: nationality, journals, participant demographics, presenting issues and type of therapy, study design and type of analysis.

**Nationality and journals**

15 countries were represented in the complete set of 68 studies although more than half (55.9%, n=38) were from USA. They appeared in a total of 35 journals with the most appearing in the *Journal of Consulting and Clinical Psychology* (42.9%, n=15). Publication dates spanned 1983 – 2018.

**Participant demographics**

The number of participants in each study ranged from 2 to 1383. Gender was specified in 86.8% of studies (n=59) from 0% - 100% female, with 92.6% of studies (n=63) reporting cohorts > 50% female. Participant ethnic background was reported by 42.6% of studies (n=29), ranging from 19.5% to 100% white/caucasian. Participant mean age was reported in 91% of studies (n=62) and ranged from 20.5 years to 69.2 years. Participant cohabiting/marital status was specified in 54.4% (n=37) studies, ranging from 0.8% to 100% cohabiting/married, with 37.8% (n=14) studies reporting more than half the participants were cohabiting/married. Education levels were specified in 42.6% (n=29) of studies either as mean years (ranging from 11.3 to 16.8 years) or percentage who had some university education or more (ranging from 14.8% to 85.3%). Employment status was specified in 23.2% (n=16) studies, ranging from 33.3% to 100% of participants in part-time or full-time employment.
14 specific problem areas were covered as well as cohorts with mixed diagnoses. The largest problem segment was depression (30.9%, n=21). In terms of types of therapy, 22 studies compared therapies using multiple orientations and the remaining 44 studies examined single therapies, with variants of cognitive and behavioural therapy predominating (77.2%, n=32). Therapy modality was stated in 53 (77.9%) of studies, including individual (58.5%, n=31), multimodal (22.6%, n=12), group (n=9) and couples (n=1). Treatment setting was mentioned in 48 (70.6%) of studies, the largest segment being university hospitals and research training clinics (56.3%, n=27). Participant cohorts in more than half the studies (n=38) were treated on an outpatient basis. 60% (n=41) of studies mentioned therapists’ professional disciplines including multidisciplinary teams (26.8%, n=11); qualified and trainee psychologists (24.4%, n=10), qualified and trainee psychological therapists (19.5%, n=8), and one study each for CBT therapist, psychiatrist and generic mental health staff.

Study design and analysis

The majority of studies (85.3%, n=58) were quantitative designs, with the remainder mixed methods (7.35%, n=5) and qualitative designs (7.35%, n=5). The qualitative studies used grounded theory (n=3), consensual (n=1) and thematic phenomenological (n=1) analyses. The majority of the remaining studies (76.2%, n=48) used variants of regression analysis including hierarchical linear, logistic, univariate, multiple, stepwise and Cox proportional hazards. “Hierarchical linear modelling allows coefficients to vary contingent on moderating and mediating effects at other levels of analysis and as such is [a] tool suitable for critical realist interest in testing the effects of intervening mechanisms on theoretical relations” (Miller and Tsang, 2011, p.151). In terms of types of causal relationships between client factor and outcomes, the majority (72%, n=49) were predictive. Associations, including those relying on participant reports, were identified in 14 (20.6%). The remaining five studies analysed mediators (n=4) and moderators (n=1) of outcome.
3.9 Research data extraction
For step 5 (see figure 9, p.80) I created a colour-coded data extraction spreadsheet in which I entered and organised relevant data from the 124 studies identified at eligibility stage. Appendix 4 shows a screenshot of a portion of this spreadsheet and lists all column headings. Identified client factors were listed according to whether the research found they were predictors, mediators, moderators or in other ways associated with outcome, although this distinction ultimately proved to be of limited utility because the majority (72%, n=49) were prediction studies.

3.10 Research data interpretation
Research data interpretation for step 6 (see figure 11) took place over the following phases: manual interpretation of findings tags; labelling the tags; entering the tags into the analysis spreadsheet; creating the research-informed concept hierarchy framework; and comparison of this with the participant-informed framework. I now explain these five phases.

**Manual interpretation of tags**

In order to work with the extracted client factor findings from the 68 studies included in the research sample, I printed these out from the data extraction spreadsheet, cut each into a tag, and arranged these over the large sketch which had formed the basis for the participant-informed concept framework (see figures 15, 16 and 17). In this way I privileged the participant framework as the organising principle for interpretation. Figure 23 shows this work in progress.
Figure 23: Manual interpretation of study data tags
Labelling the tags

Once all 68 research tags were organised into elements, I labelled them with sticky notes. Elements contained from one to seven studies. Figure 24 shows this job when it was finished.

Figure 24: Labelled research data tags

Entering the tags onto data analysis spreadsheet

I created a research data analysis spreadsheet labelled identically to the participant data extraction sheet, and entered the tags and associated references. A screenshot of a portion of the data analysis spreadsheet is shown in figure 25.
### Figure 25: Portion of Data Analysis Spreadsheet

<table>
<thead>
<tr>
<th>Stage F: Foreseen self-change through reflective learning</th>
<th>Stage F: Foreseen self-change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category 6</strong>: New, revealed, or improved social activity by distancing from others who one once associated with high-risk models.</td>
<td><strong>Category 6</strong>: New, revealed, or improved social activity by distancing from others who one once associated with high-risk models.</td>
</tr>
<tr>
<td>Being self-assessed, reflective feedback, changed behavior</td>
<td>Being self-assessed, reflective feedback, changed behavior</td>
</tr>
<tr>
<td>Exposure to biological information</td>
<td>Exposure to biological information</td>
</tr>
<tr>
<td>Writing, creating, sharing, learning about self and others</td>
<td>Writing, creating, sharing, learning about self and others</td>
</tr>
<tr>
<td>*Excessive learning strategy in self and others</td>
<td>*Excessive learning strategy in self and others</td>
</tr>
<tr>
<td>Being self-aware, using self-awareness skills</td>
<td>Being self-aware, using self-awareness skills</td>
</tr>
</tbody>
</table>

**Category 8**: Research only Mental health improving cognitions

- Acknowledging, understanding, and incorporating new information, beliefs, and attitudes
- Helping to understand the impact of past experiences

**Category 8**: Research only Mental health improving cognitions

- Acknowledging, understanding, and incorporating new information, beliefs, and attitudes
- Helping to understand the impact of past experiences

Higher baseline scores on the 10-item subscale of Connor-Davidowitz Depression Inventory (C-DI) were associated with better outcomes.Baseline scores on the 10-item subscale of Connor-Davidowitz Depression Inventory (C-DI) were associated with better outcomes.Baseline scores on the 10-item subscale of Connor-Davidowitz Depression Inventory (C-DI) were associated with better outcomes.

**Category 7**: Neg. Mental health improving cognitions

- Social reevaluation, meaningful participation
- Mental health improving strategies and behaviors

**Category 7**: Neg. Mental health improving cognitions

- Social reevaluation, meaningful participation
- Mental health improving strategies and behaviors

**Category 8**: Neg. Research Only: Mental health improving cognitions

- Obsessions, rumination, and worry
- Love and need for attachment

**Category 8**: Neg. Research Only: Mental health improving cognitions

- Obsessions, rumination, and worry
- Love and need for attachment

### Notes
- Significant associations were found between baseline scores on the C-DI and outcomes at follow-up. Higher baseline scores on the C-DI were associated with better outcomes.
- The relationship between baseline scores on the C-DI and outcomes at follow-up was significant, indicating that individuals with higher baseline scores on the C-DI had better outcomes at follow-up.
Creating the research-informed concept hierarchy framework

The red-spined research-informed framework, shown in figure 26, is structured over the same hierarchy of abstraction as the participant-informed framework. It should be noted that this diagram is intended to be viewed in A3/200% size. It is reproduced here at A4 size to give the reader an indication of the fishbone but it is acknowledged that detail at the elemental level is lost in this format. Final elements are explained in detail in Chapter 4.
Figure 26: Research-informed concept framework
Comparison of participant and research frameworks

Here I revisit the advice given by Hupcey and Penrod (2003; noted in Chapter 1), that the process of reconstruction involves comparing the participant- and research-informed frameworks to observe differences. The reader can do this by comparing figure 15 (p.98) to figure 26 (p.115).

In the research-informed framework, the super-factors remain the same as the participant-informed framework on both the helpful and unhelpful sides of the fishbone. There is generally good concordance between the participant and research-based frameworks on the other three levels of the hierarchy as well. However, the following differences appear at abstraction Level Three (stages of change).

Stage A (problem recognition) lacks connotative Category 2Positive: Hitting rock bottom. Stage B (commitment to change) is less dynamic, as it lacks connotative Category 3Positive: Precluding relational loss. Impoverishment of connotation in the early stages of change is because most included studies investigated what happened in, and in some cases, after therapy, not what prompted clients to access therapy.

The connotations for Stage C (new social connections) and Stage D (exploratory learning) replicate their counterparts in the participant-informed framework.

On the unhelpful side of the fishbone, Category 4Negative: Unready to change is missing from stage B Non-change (no commitment to change), because people uncommitted to change generally do not start or complete therapy, and my research sample excluded drop-out studies.

3.11 Combining participant and research frameworks
The seventh and final stage of the method (see figure 9, p.80) involves removing marginal denotations that do not fit an operational definition of the concept (Sartori 1984), then combining the frameworks into one.
**Removed denotations**

I removed four client factors comprised of contradictory evidence, all of which appeared in the research-informed framework (figure 26). These include education and age; therapeutic alliance and experiencing emotions.

*Education and age*

Two demographic factors, education and age appeared in the research-informed framework (categories 10 and 11 in figure 26 on p.115) but not in the participant-informed framework. However, the findings in both these categories were contradictory. For example, more education was associated with positive outcome in one study (Kyrios, Hordern and Fassnacht, 2015) and negative outcome in another (McCready, Hayaki, Epstein and Hirsch, 2002). Likewise younger age was found to predict better outcome in three studies (McCready, Hayaki, Epstein and Hirsch, 2002; Fournier, et.al. 2009; and Reddy and Jagannathan, 2017) potentially because of the advantages of early intervention. On the other hand Hendriks et.al. (2012) and Chambless et.al. (2017) found that later age of illness onset also predicted better outcomes, potentially because earlier-onset illness is more likely to become part of a person’s identity. Given the contradictory and treatment-dependent findings in the education and age categories, they were cancelled out of the framework.

*Therapeutic alliance*

In category 5, **counselling** appears at element 5F in the participant-informed framework (figure 15 on p.98) and 5B in the research-informed framework (figure 26 on p.115). As an aspect of counselling, therapeutic alliance was not included in either framework due to contradictory evidence in the research data and insufficient evidence in the participant data. Evidence in the research data for the predictive role of client contributions include studies by Hartmann, et.al. (2010) and Goldman, Greenberg and Pos (2007) who found therapeutic alliance was of little significance to outcome. Mallinckrodt (1996) found it was associated with outcome in so far as it promoted change in client’s social support outside therapy. Findings by Shahar, et.al. (2004), Hawley et.al., (2006), Liebert, Smith and Agaskar (2011) and Hartzler et.al. (2011)
suggested that participant contribution to the therapeutic alliance replicated participant relational engagement or difficulties in other areas of life and that these social influences in turn had a mediating impact on outcome. Castonguay et.al. (1996) and Zuroff et.al. (2007) reported a simple positive association between working alliance and outcome.

In terms of participant data on therapeutic alliance, although all participants mentioned the helpful and unhelpful influence of things therapists said, did and did not do, as well as their learning from regular counselling contact, only one mentioned their relationship with their therapist having an impact on the changes they made, which did not meet the threshold of quotes from two participants for element inclusion.

Element **8PositiveG: Experiencing emotions** in the research-informed framework (figure 26, p.115) was cancelled out due to inconsistent evidence. Goldman, Greenberg and Pos (2007), and Castonguay, Goldfried, Wiser, Raue, and Hayes (1996) found that experiencing emotions in therapy predicted positive outcome. Somewhat contradictory findings were presented by Dingemans, Spinhoven, and van Furth (2007), who found lower expression of emotion after treatment predicted better outcome at 1-year follow-up. Participant data lent further support to my decision to remove this category. No participants credited being emotional in therapy for helping them achieve change. On the contrary, one said she preferred online therapy because it helped contain emotionality.

**Combining participant-informed and research-informed frameworks into one**

The reconstructed framework (green spine) appears in figure 27. It should be noted that this diagram is intended to be viewed in A3/200% size. It is reproduced here at A4 size to give the reader an indication of the fishbone but it is acknowledged that detail at the elemental level is lost in this format. Final elements are explained in detail in Chapter 4.
Figure 27: Reconstructed concept framework
The reconstructed concept framework repeats the structure presented in Section 3.7 (see in particular pp. 99-104) for the participant-informed concept hierarchy. It relies on colour-coding at the elemental and categorical levels of the concept hierarchy to differentiate their evidence bases. Green categories and elements are those that contain both participant and research data. Blue categories and elements are those that contain only participant data. Pink elements are those that contain only research data. Figure 28 provides a screenshot from a portion of the (non-finalised) unhelpful side of the framework to show examples of colour-coding with explanations.

*Figure 28: Example of color-coding on reconstructed concept framework*
3.12 Rigour

Rigour in this study is defined as the quality control measures I took to ensure credibility and trustworthiness. These include providing sufficient raw data to evidence my interpretations; data triangulation; researcher reflexivity; an audit trail; and participant checks.

**Raw data to back interpretations**

In Chapter 4, I present the findings that comprise the categorical and elemental levels of the helpful and unhelpful factors sides of the reconstructed concept framework. All elements are explained with data examples: either participant quotes or key research findings and references, or both in many cases. Faithful inclusion of original material provides an indication of the interpretive process they have been subjected to (White, Woodfield and Ritchie, 2003).

**Data triangulation**

While triangulation in qualitative research has various definitions, in this study it means the methodological choice to use two data sources for contrast and complementariness (Jensen, 2008; see also section 1.4 p.78 above).

**Researcher reflexivity**

In this study I am careful to differentiate researcher *reflectivity* from *reflexivity*.

*Reflectivity* is here defined as the introspective activity of reviewing important episodes of personal or professional activity in order to make sense of how things happened and why certain choices were made (Dallos and Stedman, 2009). While my mind has certainly been preoccupied with this project for much of the past two years, I did not, as some counselling psychology researchers do, keep a contemporaneous reflective journal as a qualitative research tool (e.g. Demarco and Willig, 2011) due to uncertainty of its worth. I did however create hundreds of pages of ephemeral reflective notes in the writing-up process (example in Appendix 17). Overall, for me as I assume for others, academic writing involves innumerable reflective decisions about discursive expansion and editorial contraction.
Reflectivity is a thinking activity that both informs and critically reviews the action of reflexivity, which I discuss next.

*Reflexivity* in a critical realist paradigm involves critically attending to what our data, theories and concepts are claiming about the world, focusing particularly on explanatory mechanisms in social processes (Archer, et.al. 2016), as I am in this study. It also involves making conscious choices to either follow existing cultural practices, or else make efforts to change them (Archer, 2007). In this regard reflexivity is demonstrated in this study where, for example, I have transparently justified methodological choices to either align with, or divert from, the work of previous researchers, particularly other concept analysts. I have also assessed and explained the reflexive influence of my assumptions and experiences on this study. In its totality this study is a large reflexive act built on thousands of undocumented reflective actions. Reflexive practice demands honesty, courage and wisdom in order to make “changes, alterations and adjustments” (Pope, 1999, p.180) and to divert from taken-for-granted practices, which I have done by pursuing concept analysis in the first place.

**Audit trail**

Confirmability, as an aspect of credibility in qualitative research is demonstrated by an audit trail (Anney, 2014). This type of evidence makes the “building blocks used by researchers in arriving at their interpretations clearly visible to the reader” (Snape and Spencer, 2003, p.21). I have taken this instruction literally by providing in the body and appendices of this study, a number of screenshots and photos of work in progress, including the literature selection process (Appendices 1-5, 24). Additionally, regular, formalized debriefing sessions with fellow doctoral students helped me to describe and justify the developmental stages in completing this study, and deepen my reflexive analysis of the work (Anney, 2014; See Appendix 18 for anonymised minutes of a peer meeting).
Participant checks

To promote data dependability as an aspect of study credibility (Anney, 2014), I asked each participant to review their interview transcript for accuracy. This process is elsewhere referred to as a “member check” (e.g. Guba and Lincoln, 1982, p.247; Elliott, Rennie and Fischer, p.218). However, the term ‘member’ did not fit the context of this study, as participants did not identify as belonging to a common group (Billig, 1999).

I attached their transcript in an email to the participant with thanks for their participation and a request for transcript review and correction. All participants replied. Three added comments for clarity which were adopted into the transcripts.

In line with the muted group epistemology I requested participants do a follow-up check of my use of their quoted material in the results chapter. Five replied, two were happy with the text and three made minor clarifications that were incorporated.

Catalytic validity

Stiles (1993) suggests that research with catalytic validity will re-orient, focus or energise the participants. Regarding transcript checks, Kyra said, “It has been really interesting to reflect back on the interview with you.” Lily said, “That was such an interesting [read] and to see how things have changed (positively!) over the past few months.”

Regarding the interpretation checks, Zoey said, “It’s been quite a revelation reading this to confirm how much progress I have made since I did this interview with you.” Thea said, “I think reading this was very good for me, I will probably read it again.”

3.13 Ethics

This section explains how I complied with relevant British Psychological Society (2014) and University of Manchester (2014) codes of ethics for the conduct of research with human subjects. It includes my consideration of ethical issues related to the death of a participant during the completion of this study.
University approval

This study was approved as medium risk by the University Research Ethics Committee (UREC) in November 2015 with minor amendments approved in March 2016 (Appendix 19). No adults classified as vulnerable by UREC were recruited.

Informed consent

Prior to interviews, all participants were given an information sheet (Appendix 10) which presented information about the topic and purpose of the research, what they were being asked to do, method of data collection, risks of participating, confidentiality and right to withdraw. Consent was obtained from all participants (Appendix 12).

Confidentiality

Participant information and consent sheets were stored in a secure filing cabinet in my home. Interviews were audio-recorded to MP3 and stored in my secure dropbox. Transcription adjustments were made to protect participant anonymity. No person-identifiable information was used in the write-up of this study.

Risk to participants

Participants were informed there was a small chance of feeling upset when discussing the interview questions. Most interviews unfolded relatively unemotionally but Kyra cried when thinking about the potential loss of relationships she faced if she did not address her problems. Similarly Esme cried as she expressed regret about the impact of her illness on her life and relationships. Zoey cried when recounting family indifference to her poor mental state, and also when describing the impact of an adverse event on her life. I provided empathic responses. These participants self-stabilised and continued with the interview without further distress.

Risk to participants of becoming upset when reading the transcript came to light after I sent the first transcript to Dana for review. She was bothered by the number of speech fillers such as ‘um’ and ‘you know’ appearing in the verbatim script. I explained I would remove these. With all subsequent transcripts I removed these before sending to participants in line with the editing notes provided in Appendix 14.
Mitigating researcher dual role

In consideration of my dual role as researcher and manager at TS2 I prepared an action plan should a TS2 participant express a complaint about their therapy (Appendix 20; in the event no complaints arose). Although the focus of the research was not clients’ therapy experiences, I also considered the risk with TS2 participants knowing I was the service manager, that they might avoid saying if they found TS2 therapy or staff unhelpful in any regard which might skew the results. However I deemed this risk low because I was not asking about therapy experience. In the event 5/7 TS2 participants mentioned helpful therapy experiences and 1/7 mentioned a non-adverse experience of under-engagement with therapy.

Participant death

Thirteen months after her interview, while I was still working on study write-up, I was informed by a family member that a TS2 participant had suddenly and unexpectedly died. I had two ethical concerns related to this tragic event. The first was whether I ought to mention her death in the study. The second related to appropriate use of her data, because at that time participants had not yet been asked to review how I used their quotes in the analysis.

I discussed the matter with my research supervisor who did not feel university involvement was required in this instance. Neither the British Psychological Society Code of Human Research Ethics (2014) or the Health and Care Professions Council Standards of Conduct, Performance and Ethics (2016) mention participant death. Qualitative research around participant death is sparse, and what I found did not speak to my concerns. For example Burles (2017) discusses the impact of predictable participant death on the welfare of the psycho-oncology researcher, but she does not deal with ethical use of data from participants who die before the completion of a study.

I considered the following matters in favour of not mentioning her death in the study:

- News that she died did not come to me in my role as researcher, but in my role as director of the service where she had received care in previous years.
• Although I did not know the cause of death it clearly was in no way related to her participation in this study.
• Her death neither invalidated her data nor impacted the findings and analysis.

On the other hand, these facts were over-ridden by my belief that it would be disrespectful to not mention her death in the study. In critical realist terms, death is real. In personal and professional terms, it was terribly sad, and especially so for TS2 colleagues and clients who knew her well. Furthermore it was necessary to address in some way the difficulty that I could not ask her to review the final draft. For this reason I considered removing her data from the study, but as the analysis was at that point almost finished, it would have been difficult to un-weave her valuable contributions. A family member told me in a conversation following her death that it would have been very important to her that her contribution be included.

On balance, her original consent to participate in my mind over-rove her not being able to review the write-up. To further protect her anonymity I have deliberately not disclosed which participant she was.
CHAPTER 4: RESULTS

4.1 Chapter overview
The aim of this chapter is to explain in detail the content of the categories and elements in reconstructed concept framework. The chapter is organised over two sections: helpful client factors and unhelpful client factors. Each section is subdivided at the hierarchy level ‘stage of change’ of which there are four in each section. Within each stage I explain the meaning of the categories that comprise each stage. I then explain the elements that comprise each category, including whether they are evidenced by participant-only, research-only or participant and research data. I provide illustrative examples from participant quotes and research references for the 38 elements that comprise the helpful factors, and 22 elements that comprise the unhelpful factors. Each section concludes with a summary of key findings.

The results are presented with coded references to diagnoses to protect participant confidentiality. In line with the muted group epistemology, the results are presented with close reference to participant experience across all relevant elements, which makes their exposition lengthy.

4.2 Helpful client factors
In this section I provide detailed descriptions the elements for each category of action along the helpful factors side of the reconstructed framework, which for reader convenience is shown in figure 29, with the caveat previously noted that this should be viewed at A3/200% for clarity).
Figure 29: Helpful factors in the reconstructed concept framework
The following section is broken down by stages of change, of which there are four: Stage A: Problem recognition; Stage B: Self-commitment; Stage C: New social connections; and Stage D: Exploratory learning.

Stage A: Problem recognition

Stage A: Problem recognition is connoted by two categories: Trusting family and friends; and hitting rock bottom. I explain the meaning of each along with its connotative elements.

Category 1Positive: Trusting family and friends which means allowing and engaging in conversations with supportive family and friends around problem recognition. It is connoted by four elements: partnership quality, speaking to others about the problem; others speak to me about the problem; and spirituality.

1PositiveA: Partnership quality (participant and research data)

Five participants spoke about the importance of a loving long-term partner or friend in helping them overcome their problem. Dana said, my partner massively supported me, forever. Similarly, Zoey credited my best friend who has been an absolute rock to me throughout everything. The idea of her partner being a ‘rock’ was echoed by Ella: I’m lucky, my fiancé is an absolute rock. He’s an absolute star.

The association of clients’ marital quality with positive outcomes was supported by client reports in five studies, including Fournier et.al. (2009); Jarrett, Eaves, Grannemann, and Rush, A.J. (1991); and Hooley and Teasdale (1989). Studies by Renneberg, Chambless, Fydich and Goldstein, (2002) and McCrady, et.al. (2002) also made this finding, the latter at 6 months follow-up.

1PositiveB: Speaking to family/friends (participant-only data)

Opening up to trusted people was identified as an early step in problem recognition by all nine participants. Luka said, My sister was over and she noticed that I was really ill. And I did ask her, ‘do you think I’m ill?’ because I don’t think [I had] the realisation that I was actually really ill. And she said, ‘yeah, I think you are.’ And I did ask her, ‘Do you think I need to do
something about it?’ And when I decided...I really wanted to do something, then I think the changes slowly started to happen.

1PositiveC: Family/friends raised the problem (participant-only data)

Six participants spoke about the helpful impact of trusted people being prepared to raise and discuss the problem before they had fully acknowledged it to themselves. Lily said, *The first time [boyfriend] ever met me, he said, ‘that’s not [healthy behaviour].’ And then from then I felt like, he gets it. He encouraged me then to go to the doctor.* Esme said, *[My friends] learned they had to go, ‘You know what? You’re being ridiculous!’ And actually confront me with it. A lot of the time I just needed a good shake.*

Category 2Positive: Hitting rock bottom means experiencing a crisis as a result of the problem where ensuing contacts with healthcare professionals spur resolve to address the problem. It is connoted by two elements: accessing crisis services; and GP services.

2PositiveA: Crisis services (participant-only data)

Four participants identified health or psychiatric crises that propelled them to attend emergency services for help. These experiences were identified as turning points in problem recognition. Lucy said, *I was actually taken from work into hospital. And I think that was the wake-up call.*

2PositiveB: GP services (participant-only data)

Seven participants explained how conversations with GPs represented turning points either in problem recognition or in accessing help. Kyra said, *So I was referred through to [service A] by my GP because for quite a long time I’d had probably underlying [D3] and [D2] issues.* Zoey recalled, *[My GP] said, ‘just try [counselling] once more and see how you get on. And if it doesn’t work again, I’ll get you to somebody else.’ And she, the doctor, was amazing.

Stage B: From other-focussed to self-focussed commitment to change

The active Stage B: From other-focussed to self-focussed commitment to change is connoted by three ‘state of doing’ categories of action: Precluding relational loss; self-
reclamation; and persistently accessing help. Each is now explained along with its connotative elements.

**Category 3Positive: Precluding relational loss** means wishing to preserve and protect relationships from damage the problem has caused (or could potentially cause). It is connoted by two elements: current relationships and future relationships.

**3PositiveA: Preserving current relationships** (participant-only data)

The risk of one’s unaddressed problems damaging important relationships was highlighted as a motivating factor by six participants. Dana explained how her partner warned her: *She was like, ‘just stop it. It’s really, making me want to leave.’ I thought, ‘Ohh hoo – oh okay!’* Ella described her partner and father’s reactions when they visited her in hospital during a crisis: *And that gave me another kick just to say, ‘Look, you’ve got to get right.’ I can’t see him broken again. Really wrecked me, that. And my dad, his face just coming in.*

**3PositiveB: Protecting future relationship opportunity** (participant-only data)

In this participant sample, the wish to preclude loss also applied to future relationships. The importance of not losing the chance of parenthood was mentioned by four participants as motivating change. Kyra said, *I’m at an age where we might think about a family. And I worry about the impact of all the years of self-abuse on my chances of being able to have children. And I thought that if we even want to consider that angle, then I need to do something to change.*

**Category 4Positive: Self-reclamation** is a pivotal transition point of committing responsibility to salvage oneself from the problem. It is connoted by three elements: autonomous responsibility; intention; and maturity.

**4PositiveA: Autonomous responsibility** (participant and research data)

Stage B pivots from making changes for others to making changes for oneself. Autonomous responsibility requires a degree of self-worth that translates the value of preserving important relationships into self-mobilisation. Three clients expressed reaching a point of readiness to change for one’s own sake. Ella, who was initially
motivated by a desire not to hurt loved ones, said, *I wouldn’t have come out of it until I decided for myself.*

Two studies were represented in this element. In a qualitative study based on client report at end of treatment and 12-month follow-up, Khattra et.al. (2017) found that a cognitive shift from other-focussed to self-focussed motivation was associated by participants with leading to meaningful adjustments in coping. A similar finding was made by Zuroff et.al. (2007) based on end-of-treatment data.

**4PositiveB: Intention** (participant and research data)

This element encompasses self-determining motivation and commitment to change, expectancy that help will be effective, and willingness to do what is necessary to create a better life. Six participants described aspects of this experience. Luka said, *What made it possible? I think I was just really committed to get better, because I was really in a very bad place.* Lily said, *I was desperate, willing to do anything.*

Six studies are represented in this element. Hartmann, Orlinsky, Weber, Sandholz and Zeeck (2010) found that client positive expectancy early in therapy predicted symptom remission at 3-month follow-up. Similar expectancy findings based on end of therapy data are presented by Chambless, et.al. (2017) and Safren, Heimberg, and Juster (1997). Meyer et.al. (2002) found that the benefits of the therapeutic alliance on outcome were mediated by client expectancy.

Motivation was conceptualised by Keijsers, Hoogduin and Schaap (1994) as willingness to participate in therapy, and was associated with symptom reduction in therapy. Burns and Nolen-Hoeksema (1991) found that client willingness to learn new coping strategies was correlated with being less unwell at the start of therapy and with being more improved at 12 weeks. This suggests that people who are more prepared to change may seek help sooner.

**4PositiveC: Maturity** (participant-only data)

Seven participants asserted that an increasing sense of maturity in the form of their advancing age assisted their motivation to change. Kyra described it like this: *I’ve*
decided that I can’t go on in that cycle, I’m in my mid-thirties now, can’t continue to keep going round the same old vicious circle. And maybe (laughing), with age comes wisdom! Thea described how coping with mental illness also promoted maturity: I think the [D1] itself has made me wiser. So the [D1] in a weird way helped me get over it because I would not have got as mature without it.

**Category 5Positive: Persistently accessing help** is characterised by resourcefully tapping different types of social help, over time, with repeated attempts where approaches may initially fail or fall short. It is connoted by six elements, two of which contain participant and research data and four, participant-only data.

**5PositiveA: Help from family/friends** (participant and research data)

Four participants described receiving valuable emotional and practical help from family and friends after they had commenced a period of active change. For example, Ella said, My dad’s an angel. He worries as much as I do….He will say, ‘You alright, love? You sound a bit down.’ I’m like, ‘Dad, you alright?’ ‘Oh,’ he says, ‘I’m having a shit day!’ (laughing). Dana’s mother lent money to help her move, an important step in improving her situation.

Six studies support the element of help given by family and friends. Steinmetz, Lewinsohn and Antonuccio (1983) and Toth, et.al. (2013) found that client experience of family social support was predictive of better outcomes at 6-8 months post-therapy. Mallinckrodt (1996) made a similar finding without follow-up data. Drilling into specific types of helpful support, Davidson, Borg, Marin, Topor and Sells (2005) found participants’ significant others’ focus on their capabilities, interests and successes was associated with positive outcome, as was their help in making important decisions.

Leibert, Smith, and Agaskar (2011) found that participants with higher subjective social support had less severe symptoms when starting therapy. The authors suggested this means that socially supported clients may seek help earlier. Mallinckrodt (1996) found that the therapeutic alliance mediated participant social support by promoting it, but that the association between change in alliance and symptoms was not significant. This suggests that therapy outcome may be related to how much it helps people improve their social support, rather than directly linked to therapeutic alliance.
5PositiveB: Help from staff at school/work

5PositiveC: Self-help and social media including apps

5PositiveD: Support groups

5PositiveE: Medication

Use of each of these elements was endorsed by several participants, and all participants used at least one of them. Three participants received supportive help from staff at school or work. For example, Thea said: The school nurse supported me for the five years. I could always go to her for a hot chocolate or just sit in her room. Seven participants used a range of self-help media, for example Zoey wrote blogs and Dana read blogs for advice; Luka and Kyra used apps; Lucy and Thea used social media; and Zoey, Esme and Thea used books or other reading material. Five participants used support groups. Dana, Luka and Thea mentioned psychotropic medication as useful.

No studies are included in these helpful elements, although this does not indicate a lack of evidence for their role in supporting psychotherapy outcomes. The absence of studies in these areas is related to my study selection process. Self-help and support groups were excluded from the research sample, which only included professionally-facilitated treatments (further study in this area should include self-help activity). Medication outcomes were not included in data extraction, because in those studies where it was used (Hendriks, et.al. 2012; Fournier, et.al. 2009) medication was positioned as a comparison treatment factor rather than a client factor.

5PositiveF: Persistence with counselling (participant-only data)

This element refers to participant persistence with accessing counselling and also tenacity with forming and appreciating therapeutic relationships, sometimes in spite of previous experiences of unsatisfactory therapy encounters. All participants discussed persistence, which I have here divided into four areas to elucidate its dimensions.
Seeking and attending counselling

Participants demonstrated considerable perseverance in seeking and attending counselling. Ella, Kyra and Thea recounted having attended multiple services over time. Thea said: Starting with [service D] then going to [service E then service A]. And the same things have come up. And each time I’ve been a bit more able to try and get on board with them. Although it did take five-ish years.

Giving counselling another try

Kyra, Lucy and Zoey sought different types of therapy after previous sub-optimal experiences. Zoey recalled, I said [to my GP] I needed more than a counsellor. Because I wasn’t coping very well. The counsellors were nice, and they listened, and they tried to show support, but I needed someone…to give me direction and sort myself out. Then I started seeing a CBT therapist…..I started to make big steps forward. She was really good.

Trying counselling alongside other types of help

Dana credited her mental health improvement to using a range of different types of help simultaneously: As well as going to see the counsellor, I saw a homeopath, I’ve changed my diet, started doing yoga every day and I really did make changes. And I was on the medication as well.

On the other hand using several types of therapy simultaneously left Luka unsure which had been helpful. When not wholly satisfied with online therapy, she simultaneously sought and attended face-to-face CBT, and a support group. However, she said, Really hard for me to tell…what actually worked. I don’t know what specific, why, and what time.

Steinmetz, Lewinsohn and Antonuccio (1983) found participant reports of being in concurrent therapy predicted negative variance in outcome at 6-month follow-up.

Appreciating therapist contributions

Although the focus of this research is on client contributions to outcome it should be noted that all participants mentioned helpful or unhelpful contributions of therapy and therapists either in the therapy just concluded, or in previous therapy. Successful
therapist relational engagement was highlighted particularly where the therapist matched their approach to the participant’s preferred way of working. For example, Kyra said, *The thing with [therapist], she sussed me out quite quickly. So when we talked about methodology at the start, of how I can take some practical steps, she delved quite deep about my professional role and about how I work and how I think. And then approached the next few sessions in that way.*

**Stage C: New social connections fuel change**

*Stage C: New social connections fuel change* is connoted by two categories, first, accessing forms of help (category 5Positive above). Category 6: improving social activity also occurs at this stage and is explained here along with its connotative elements.

**Category 6Positive: Improving social activity** has the double meaning of actively extending, enriching or re-engaging with social life; and self-improving through broadened social contact. Social reinforcement and social self-efficacy energises motivation to make further changes. This category synergistically links participant efforts to access help with specific further self-improvement pursued in the categories that connote stage D: Exploratory learning. Category 6Positive is connoted by six elements: expanded sociality; engagement; secure home; new job; proximalising; and role models.

**6PositiveA: Expanded sociality** (research and participant data)

This element means the commencement of new (or resumption of old) social activity, including pro-socially helping others. Six participants described benefits of expanded sociality, Ella particularly persuasively: *The amount of sense of security I’ve had around me over these last two years [from family, friends, therapy and social life]. Without that whole structure I don’t think I’d have come this far. I’ve been going out loads at the moment….It’s probably helping as well. I saw people I’ve not seen for twelve months on Saturday night….So I felt more of the group.*

Three included studies supported this element. Binford et.al. (2005) and Zywiak, Longabaugh and Wirtz (2002) confirmed that participants who sought more social
contact directly after therapy had better outcomes at 6-month follow-up. Davidson et.al. (2005) found that clients associated prosocial behaviour with positive outcome.

**6PositiveB: Re-engagement** (participant and research data)

This element refers to client efforts to improve existing relationships with better communication skills, along with positive reception of these efforts by others. Four participants reported this element. For example, Dana said she had become more patient and respectful with her partner. Similarly Esme reported controlling her partner less. Both participants said these changes were appreciated by their partners and contributed to desired change.

Two studies supported this element. Constantino et.al. (2017) found that participants credited ‘corrective experiences’ for leading to positive outcome. These included reduced need for control, and improved communications such as disclosure, assertiveness and accommodation of others’ views. Khattrra et.al. (2017) found that participants who reported becoming more adaptive in interpersonal relationships also reported better therapy outcomes; but the authors solely credit therapy for this change without acknowledging that it could only have happened in the context of welcoming social milieux.

**6PositiveC: Secure private home** (research and participant data)

Dana and Zoey reported that improving their housing was important to the change process. This is supported by a study by Davidson et.al. (2005) who found that participants associated better outcome with having safe, private accommodation.

**6PositiveD: New job (or leaving bad job)** (participant-data only)

Six participants described how either getting a new job or leaving a bad job was a helpful step that indicated improvement in their situation and also propelled self-concept development (which is an element of **Category 9Positive: Reintegrating**). Dana said, *I’ve found a job that is perfect for me. I’m good at it....I can see very clear steps up the ladder.* Kyra explained how her new job helped her adopt a healthier identity: *It’s a positive thing that I’ve moved jobs. I leave quite a lot of the baggage...I’m trying to draw a line in the sand*
with the [D2] that I’ve suffered and how it’s impacted on my health and wellbeing….There are too many ghosts in the closet from where I’ve been for the last 7-8 years.

Ella explained how leaving a bad job opened space for therapeutic work: *I didn’t realise how exhausting it can be, getting better (laughing). But it is. And I’m so glad I’ve not been at work through it. She was an absolute cow I was working for. So, what did I do? She offered me voluntary redundancy because she knew damn well I wasn’t happy. So I took that and I thought ‘I’ll just have some months, me.’*

6PositiveE: Proximalising and distalising (participant-data only)

Three participants were attached to this element.

Proximalisation is a vascular surgery term for an arterial attachment and grafting procedure. Here it is useful for describing how participants moved geographically closer to well-loved family (‘my blood’) or to places of personal significance (‘my roots’) to improve or repair their sense of belonging. For example Lily said about moving near her family, *I’m moving down to [English city 1] in a few weeks and…I just feel so much more positive. And my sister said, ‘it’s so nice to have my sister back because you were just a different person a few years ago.’* Dana observed, *My roots are up here. We were so miserable in [English city 1]. And we have family up here. So we decided to move. I love it here.*

Distalising is the converse action of taking important steps to move away from unhelpful family or places associated with bad memories. Zoey said, *I needed to get out of [English city 6] because of just too many negative things and I didn’t know how to sort myself out living in it all. When I moved away…I came into my own.*

6PositiveF: Role models (participant-data only)

Four clients described using either positive or negative role models in a helpful way.

Lucy described the importance of having recovered people in her social network who she could emulate: *People who are living...who are where your goal is. Who are living life, and taking more of an advocate role.* Three participants described consciously endeavouring to not be like people they pitied or disliked. For example, Dana said, *I used my step-mum as a kind
of image of everything that I don’t want to be. I’m really horrified (laughing) to think anyone would think that I was like her.

Stage D: Reflective and exploratory learning

Stage D: Reflective and exploratory learning is connoted by three categories that represent inter-related types of work on oneself: Self-helping behaviours; helpful thinking; and re-integrating. Each category is now explained along with its connotative elements.

Category 7Positive: Self-helping behaviours are actions identified by participants as being directly helpful in obtaining desired change, primarily through experiential learning. Some, but by no means all can occur in the context of therapy. The occurrence of these actions depends on preceding conditions of social support in order to understand what might be helpful and to promote willingness to try them. There is an inherent interplay between self-helping behaviours and the subsequent category, 8Positive: Helpful thinking.

Category 7Positive is connoted by five elements: Journaling; insight-led change; exposure; exercise; and pacing.

7PositiveA: Journaling (participant and research data)

Five participants endorsed the value of reflective writing, including self-monitoring, journaling and blogging, to improving insight. Lily described how self-monitoring helped her externalise and de-fuse worry. It also helped her respond pro-actively to stress: On Monday when I got really lonely, I knew the triggers, where they were going to be, which I didn’t know before. And it meant I felt in control of what I was doing. It was so eye-opening.

Four studies endorsed this element. Participant reports in studies by Clarke, Rees and Hardy (2004), Constantino, et.al. (2017), and Stirman et.al. (2018) verified the therapeutic value of reflective writing. These results are further supported by Khattra et.al. (2017) in a study using 12-month follow-up data, who found that keeping thought records was associated by participants with achieving meaningful differences in coping.

7PositiveB: Insight-led behavioural change (participant and research data)
This element comprises a synergistic interplay of self-awareness, new behaviour and improved self-guidance and was described by eight participants. Thea described it like this: *I sometimes watch candles to self-soothe or listen to music. I was taking care of myself, it felt sort of like a mum taking care of you. But you’re doing it for yourself, making sure you get to bed nice and properly.* Lily observed, *I recognise where things might go wrong during the day, and I can just think, ‘right, you need to change this.’*

Four studies are included in this element. Simons, Lustman, Wetzel and Murphy (1985) describe ‘learned resourcefulness’ as an insight-led ability to minimise undesirable behaviours. Their study found that participant pre-therapy learned resourcefulness accounted for 57% variance in therapy outcome.

Matos et.al. (2009) describe ‘re-conceptualisation’ as a metacognitive ability to observe and describe personal change processes over time, which was associated in their study with better outcomes.

‘Mentalization’ is a label for the ability to understand how one’s own and others’ mental states and behaviour effect each other. It was operationalised as ‘reflective functioning’ in a study by Ekeblad, Falkenstrom and Holmqvist (2016) who found that participant higher baseline and mid-therapy reflective functioning predicted better outcome.

Hanna and Ritchie (1995) found that insight-led change was the most potent factor reported by participants in recounting helpful therapeutic experiences.

**7PositiveC: Exposure and flexibility** (participant and research data)

Exposure means pushing oneself out of ‘comfort zones’ to face and manage fears. ‘Psychological flexibility’ is defined by Gloster at.al. (2014) as the ability to mindfully accept cognitions and emotions to promote a meaningful life. Flexibility must be activated to prevent exposure strategies from backfiring.

In this participant group, exposure was demonstrated by five participants who described both honest self-examination, and courageous behavioural experimentation. Lucy said about the self-reflecting aspect of therapy, *It’s been a very difficult journey (laughing) and it’s probably been one of the hardest things I’ve had to do in my life. Because I’m confronting*
years...of behaviours that have become so engrained. Esme said that through planned behavioural experimentation she pushed herself to a position where I was uncomfortable and had to let go of control. Each time I did, it became easier.

Ella described psychological flexibility in this way: I think it’s pushing myself to go [to social activity] for the first time. Seeing it was fun, it was great. The world didn’t collapse because Ella left the house (laughing).

Exposure and behavioural activation were well-evidenced for predicting positive outcome by four studies in the sample, including Mörtberg, Hoffart, Boecking and Clark (2015); Ryba, Lejuez and Hopko (2014); Mörts and Wietersheim (2008); and Leung and Heimberg (1996).

7PositiveD: Exercise (participant-only data)

Three clients mentioned how an adjusted relationship with exercise promoted desired change. For Thea starting a new sport was not simply a means to fitness but an accomplishment: It was really good to be able to practise [new sport]. The achievement was quite, well, instantaneous. I was strong and getting stronger. For Lily, reducing her athletics was a precursor to improved self-concept: I like [sport E] being a smaller part of my life. I can go to work and...forget about [sport E] and not over-analyse it.

Category 8Positive: Helpful thinking includes imagining how and what to do differently; reflecting on the results of therapeutic and non-therapeutic behaviours; and changing thought climates to realise potential for emotional and relational growth. This category is connoted by five elements: helpful self-talk; thought stopping and restructuring; recognising accomplishments and self-efficacy; hopes; and gratitude.

8PositiveA: Helping self-talk (participant and research data)

All nine participants gave detailed descriptions of helpful inner dialogue, such as debates that spurred their ‘better self’ to make a decision. Some included using an ‘internal therapist,’ as Lucy described: There’s two sides to my thought process. There is the [D4] voice...and there is me, who actually is very logical....When those [D4] voices start to take over, it’s having that conversation...you’d have with the therapist, but having it with yourself! In
the sense of, ‘right, now this is what you need to do, actually this is the right decision and this is the reasons why, regardless of how you may feel.’

Two studies including Hartmann et.al. (2010) and Zeeck and Hartmann (2005) found that participant recreation of therapeutic dialogue predicted better outcomes.

8PositiveB: Thought-stopping and restructuring (participant and research data)

Seven participants described ways they actively averted unhelpful thinking. Ella said, I’ve been doing diversion. Trying to get my mind off. I’ll take the dog out around the block. You’ve got to find a way to ride over it. Esme said, I read about trying to recognise when your thoughts are [D3] thoughts, and then go, ‘well, you can ignore that then.’

Thea said she used cognitive restructuring. Neimeyer and Feixas (1990) define this as identifying and scaling intensity of upset, then identifying associated negative automatic thoughts, then developing adaptive alternatives. They found that participant use of this skill at the end of therapy predicted maintenance of treatment gains six months later.

8PositiveC: Recognising accomplishments and self-efficacy (participant and research data)

Eight participants expressed admiration for themselves, particularly in relation to achieving desired change. Ella said: When I noticed...that I was actually being logical, and I wasn’t feeling as down, I was like, ‘sommat’s good!’ I make steps myself to enjoy life, believe in myself more.

Self-efficacy, rather than being the retrospective confidence participants described, is a prospective expectation of being able to achieve specific goals in future. Interestingly no participants described this expectation. However, four studies noted its predictive power on outcome including Gomes and Pascual-Leone (2015); Kavanaugh and Wilson, (1985); Hartzler, Witkiewitz, Villarroel, and Donovan (2011) and Khattrra et.al. (2017) (the latter three based on follow-up data).
8PositiveD: Hope for the future (participant and research data)

Hopes were voiced by seven participants. They are similar to self-efficacy in intention, but more broadly aspirational. Dana intended to get married and have children. Lucy intended to return to work. Luka hoped she would fully recover. Esme used a negative life-forecast to prompt changes: So in ten years, do I want to be childless, friendless, still [unwell], miserable? No.

Davidson et.al. (2005) in their qualitative study of recovery processes found hope offered participants the possibility of an improved life.

8PositiveE: Spirituality (research-only data)

No participants mentioned that faith or spirituality played a part in their change process. However, three studies were included here. Rosmarin et.al. (2013a) found that belief in God improved client expectancy in therapy. Rosmarin et.al. (2013b) found religious coping predicted a positive therapy outcome. Similarly a qualitative study by Mohr et.al. (2011) found that at 3-year post-therapy follow-up, the subjective importance of religion in coping was a predictive factor for participant global wellbeing.

8PositiveF: Gratitude (research-only data)

Krentzman (2017) found baseline trait gratitude (a life-orientation towards noticing and appreciating the positive) was a predictor of positive outcome at six months after treatment but not 12 months. No participants expressed quotable gratitude although several had appreciative attitudes towards aspects of their life.

9Positive: Reintegrating has a dual meaning. The first is ‘coming into oneself’ in an evolved form; and the second, negotiating new relationships with one’s social contexts, including accepting the inevitability of discordance in life. While this category could be viewed as a plateau of attainment resulting from preceding participant efforts to change, the findings here suggest that it is actually a dynamic springboard for participants’ anticipated future personal and relational growth. Only one participant did not have data in this category but perhaps not coincidentally she decided to return to therapy around
the time she was interviewed. This category is connoted by five elements: owning evolution; self-acceptance; life on life’s terms; minding regret; and rejecting stereotypes.

**9PositiveA: Owning evolution** (research and participant data)

This element means a sense of ownership of a lifespan evolutionary process of ‘coming into oneself’ through new or reframed relationships. Seven participants discussed this element. Kyra was redefining herself using a preferred healthy identity in her new job:

*And it’s leaving that [troubled identity] behind, because in my new role I don’t want people to know that about me.* In Lily’s case this process meant negotiating family resistance to her evolving identity: *I can be anyone I want. I said to my mum ‘I can call myself Lily rather than [nickname]’ and she said, ‘no you’re [nickname], don’t do that!’ (laughing). But I thought, it’s nice, it’s so refreshing to think I can.*

In Constantino et.al. (2017)’s qualitative study of participant ‘corrective experiences,’ the findings are organised into two parts: (a) participant views of what was corrected; and (b) of how correction was caused. In the former section under the heading ‘A balanced outlook’ a participant is quoted, *“I finally found that balance where I can be me and I can be part of society and finding this mindset has made things a lot better”* (p.143). I interpret this quote as more than merely evidence of personal evolution, but a client factor belonging on the causal side of the analysis, where wider integration has the potential to promote further growth.

**9PositiveB: Self-acceptance** (research and participant data)

Four participants provided evidence of the role of improved self-acceptance in coming to terms with the flawed nature of life experiences. Luka said, *I am happy with what I am now, more or less....Just having my internal self-confidence constant and not being affected by...something else.* Ella invoked the ‘serenity prayer’ when she said, *Everything that I am able to change, I have changed. Things that I am unable to change I have to live with or find a coping mechanism.*

Goldin et.al. (2013) found that participants’ increased self-endorsement mediated therapy’s effect on outcome. It was also correlated with sustained improvement in
mental health at 1-year follow-up. However the authors did not examine the mechanism of action of self-endorsement on outcome, which I propose is, in part, its role in facing life on life’s terms, which forms the next element.

9PositiveC: Life on life’s terms (participant-only data)

This expression from the 12-Step tradition means acceptance that life is never problem-free and that one will continually encounter challenges that require personal adaptation. Three clients noted this element, with Lucy expressing it this way: Ownership...is the foundation of continuing [recovery], outside of the support network, when you...get back into society and you get back onto your life. Because I don’t know whether all these thoughts or voices will completely disappear....But it’s about coping with it.

Esme echoed this: You go to counselling, so you’ve obviously got a problem. But [after therapy] you’ve just got normal-people problems, that I’m going to have to deal with...like I did before.

9PositiveD: Minding regret (participant-only data)

This element represents an advanced accommodative step in personal evolution that involves coming to terms with, and seeking restoration from mental illness’ devastating toll on one’s life. Two participants expressed this point. Ella said: I feel...like I’ve wasted a big chunk of my life. And I don’t think I’ll ever get rid of that feeling, but I’ve got to just look forward. I can’t keep saying, ‘Right, you’ve wasted thirteen years.’ Now...is a hell of a better place than where I was.

Esme said, It’s the idea that you wasted your time and other people’s time, and hurt people and yourself, and put yourself through stuff that just didn’t need to happen. And then you come out of it the other end in the same place that you would have been if you’d just been like you were. Ultimately achieved nothing. I mean I probably have achieved something in a way....You’ve got to take the good things from it.
PositiveE: Rejecting unhelpful stereotypes (participant-only data)

This final helpful element, endorsed by two participants, represents being aware of and consciously disputing taken-for-granted social norms that might contribute to mental unwellness. Esme expressed this, with the following observation about body image consciousness: But I think I’m hyper-sensitive and opinionated on things about women and...well, not just women and body image - people and body image. And media and shit. And I think it’s almost sad that you’re in a culture where even once you’re healthy, you’re not happy. And I do think that’s the culture, it’s not people. Kyra said in rejection of a social expectation she felt that she should be preoccupied with dieting, I’m hoping I’ve thrown away all the whole problems I had with disciplined eating etcetera.

I will briefly summarise the key findings from the helpful elements, including a density table which shows the number of participants and studies that yielded findings for each helpful element.

I will then move on to describe in detail the unhelpful categories and elements.

Summary of key findings: Helpful client factors
1. Helpful client factors are conceptualised as a chain of causal influences over time. The chain is characterised by discernible transition points in client awareness, commitment to self and others, learning activity and relational engagement.
2. At the most abstract level of the hierarchy, various forms of engagement with social resources play a predominant role in promoting and supporting participant reflective and exploratory learning, which is both the product of, and the catalyst for, psychosocial growth across the lifespan.
3. I applied active, doing-as-being labels at the low-abstraction categorical level which captured the personal and relational evolutionary nature of participant change process narratives.
4. Even though the participant group was homogenous (therapy-seeking white women under the age of 40) and the research sample was heterogeneous, there was considerable overlap between the two data pools in the combined
(reconstructed) conceptual framework. To briefly summarise the non-matching areas, there was no participant evidence to support research evidence of demographic client factors, or the elements of spirituality and gratitude. There was no research evidence to support participant evidence of speaking with trusted family/friends to promote problem recognition; experiencing crisis as a turning point; sensing maturity; using self-help media; making occupational adjustments; relocating; using role models; addressing regrets; or rejecting social stereotypes.

5. Contradictory findings were rare, both within and across the participant and research pools. However, studies of the role of education, age, therapeutic alliance, and experiencing emotions on outcome yielded contradictory findings. These factors were therefore cancelled out of the reconstructed framework.

6. Participants were resourceful and persistent in making desired mental health changes, which for all, took several years, different forms of help, and/or multiple attempts. In narrating how they achieved their desired changes, all participants described using wide-ranging social gambits in which attending therapy took a partial, intermittent, minor and sometimes fallible role.

7. For participants, psychological therapy represented an occasional, partial or limited form of assistance in these long change trajectories. All participants described therapeutic work linked with their social contexts. In contrast to this, only 18/68 (26%) of the included studies found participant social factors predicted or were otherwise associated with outcome (see Appendix 24 for the list of these studies).

The helpful elements density table in Appendix 25 shows the number of participants and studies that yielded findings for each element.

I now explain the elements on the unhelpful side of the reconstructed framework.

4.3 Unhelpful client factors
In this section I provide detailed descriptions of the elements for each category of action along the unhelpful factors side of the framework, which for reader convenience is shown in its entirely in the screenshot in figure 30 (best viewed at A3/200%).
Figure 30: Unhelpful factors in the concept reconstruction framework

Super-factors << Stage << Categories << Elements

- Figure 30: Unhelpful factors in the concept reconstruction framework
The section is broken down by stages of non-change, of which there are four.

**Stage A Non-change: Problem-maintaining social environment**

**Stage A Non-change: Problem-maintaining environment** is connoted by two categories: Compromised support and no problem attribution. Each is now explained along with its connotative elements.

**Category 1Negative: Compromised support** means the presence of family care and communication characteristics in which the participant’s mental health problem is unrecognised or efforts to address it are unfulfilled. It is connoted by two elements: Difficult family relationships, and family mental health issues.

**1NegativeA: Difficult family/friend relationships** (research and participant data)

Four participants gave examples of family or friends not being helpful and/or not understanding their difficulties, which compounded their problems or posed obstacles to working on them. Zoey explained: *Every time I go speak to mum and try to get to the bottom of why I feel the way I feel, I’m constantly going round in circles, I’m crying all the time, I’m confused, I’m distressed. And every time I went to see her, I’d come out...more confused...more distracted and upset.*

Thea said, *We are not as close as most families....We had two family therapy sessions. They were very eye-opening but extremely uncomfortable....I didn’t enjoy those and I’d prefer my parents weren’t there or that I wasn’t there.*

The four studies offering research findings in this category fell into two distinct types of family difficulty that predicted less, or slower, symptom change. The first was hostile or dysfunctional family climates (Beevers, Wells and Miller, 2007; and Hooley and Teasdale, 1999). The other was fear of abandonment (Yen, Johnson, Costello and Simpson, 2009) or separation (Aaronson et.al. 2008) associated with fear of danger to significant others.

**1NegativeB: Family member with mental health issues** (participant-only data)

Three participants described how dealing with a family member with mental illness made it considerably more difficult for them to work on their own problems.
**Category 2Negative: Ignored problem** means that in spite of experiencing crises as a result of the problem, the problem is not attributed by the participant as contributory; or no decision to address the problem is made in spite of crises. It is connoted by only one element.

**2NegativeA: Unrecognised crisis** (Research-only data)

A study by Barnett et.al. (2010) found that patients who did not attribute problem behaviour to a problem-related event for which they were treated in accident and emergency did not reduce problem behaviour at 12-month follow-up.

Only one participant endorsed this element, which fell below the minimum to be counted as a participant-endorsed element. However it seems worth mentioning that Kyra described how her own and others’ habituation to crises precluded change: *I’d had a few being (laughing) carted away in ambulance and things when I’ve lost consciousness. It almost, to some extent, to some people, defined me, ...a group of people that knew the background to the illness that I had...for quite a long time.*

**Stage B Non-change: No commitment to change**

The non-dynamic **Stage B: No other- or self-directed commitment to change** is connoted by three corresponding ‘state-of-being’ categories: socially disconnected; unready to change; and not minded to use help. Each is now explained along with its connotative elements.

**Category 3Negative: Socially disconnected** means the experience of social isolation but may also involve participants taking more or less active steps to cut themselves off from others. It is connoted by three elements: alienation; guardedness; and social difficulties.

**3NegativeA: Alienation** (participant and research data)

This element, mentioned four participants, means feeling one does not belong culturally, relationally or geographically which compounded or led to problems. Lily described it like this: Dana recalled, *I wasn’t going anywhere in [English city 1]. A lot of my friends had moved away. My parents had moved away. So expensive. We were absolutely stifled.* This type
of alienation can for some people provide an impetus for element 6Positive E: **Proximalising/Distalising.** None of the participants spoke about experiencing stigma as a form of alienation, Ritsher and Phelan (2004) who found that participants who felt out of place or like “less than a full member of society” (p.260) particularly in mental illness stigma predicted greater subjective demoralisation and dysphoria at 4-month follow-up.

3NegativeB: **Guardedness** (research and participant data)

All participants, when well, experienced no difficulty talking with hindsight about their problems and feelings. But this category means being reticent about problems when unwell. It is the counterpoint of 1PositiveB: Speaking with others about the problem. Six participants described experiencing it in the past, including Lucy who said, *I found it very secretive, the [D4] side of me wanted to protect what was happening, and I think that’s where you shut everybody out and not realise you’re doing it. And stop your life, basically.*

Leweke, Bausch, Leichsenring, Walter, and Stingl (2009) found that alexithymic difficulty in verbalising feelings mildly predicted poorer outcome.

3NegativeC: **Social difficulty** (research and participant data)

This category encompasses social withdrawal and social maladjustment. Six participants described this as an aspect of being unwell. For example, Zoey said, *I cut myself off. I’d go aggressive, didn’t want anyone near me.*

Four studies, all conducted with follow-up data, found that social difficulty predicted worse outcome or treatment failure (Ritsher and Phelan, 2004; Dow et.al. 2007; Nakano et.al. 2008 and Hartmann et.al. 2010).

Category 4Negative: **Unready to change** is the sequel to deficits in social connection. It is likely for some that mental health problems are artefact of these deficits, but problems remain unperceived, unacknowledged, or are deemed too formidable to change. It is connoted by two elements: fear and denial.
4NegativeA: Fear (participant-only data)

Three participants explained how fear held them back from making desired changes. Zoey explained why she did not want to mention a serious problem: *Because I thought if I say it then it becomes real and it needs to be addressed, and it’s out there, then I’m scared of doing that.* Lucy explained fear of change this way: *I’ve not come much further [in wellness]. So I’m preventing myself from doing that, in some ways. So why can’t I do the next one? It’s breaking through the fear barriers...because it’s the unknown.*

4NegativeB: Denial (participant-only data)

Six participants described being in degrees of denial about their problems along the way. Lily explained how fear and denial can be connected: *I don’t think I acknowledged I had an issue until I actually said it out loud. I think I was almost scared to admit something was wrong.*

Category 5Negative: Unable to use help means not wholeheartedly pursuing social help; or, where help is accessed, limited commitment or capacity to engage. It is connoted by just one element.

5NegativeA: Find counselling fruitless (participant and research data)

This element encompasses experiences of therapy that doesn’t ‘work.’ It includes (a) participant lack of motivation and (b) therapist inability to strike a useful working alliance. It was mentioned by four participants. It also includes how people may be less inclined or capable of engaging in therapy when demoralised or immobilised by mental illness.

Kyra described the effects of being insufficiently motivated in previous therapy: *I half-heartedly went to counselling and things like that but never really felt like I got...what I needed to out of it....Sometimes because the fit wasn’t right between me and the counsellor. Or possibly because I wasn’t in the right frame of mind to make positive changes in my life.*

Therapist inability to strike a useful working relationship tended to be framed in terms of relational clumsiness. Zoey recalled, *I saw this guy. The first session didn’t go very well.*
was ready to sit down and tell somebody. And he went all around the houses, talking about all the admin and I was starting to get panicky. And it went really badly, because I...when I was telling him things, the expression on his face, I think he was in a lot of shock about what was coming out of my mouth. Similarly Ella recalled, The first counsellor I had said, ‘I don’t know what your problem is. Just pull yourself together. I had [D3] as a child.’ And I’m like, ‘Are you a counsellor?’ It wasn’t really the right thing to say. Thea explained about an earlier course of therapy, I didn’t like my therapist, which was the first bad thing. And so, I didn’t like the work we did together and I viewed it as something stupid that didn’t make sense, and I was very cynical of it.

Therapy may also be fruitless if not sensitively tailored to the client capabilities or level of functioning. A study by Scheel, Seaman, Roach, Mullin and Mahoney (1999) found that client perception of the difficulty of the therapist’s recommendation predicted non-implementation.

Stage C Non-change: No new connections
Stage C Non-change: No new connections is connoted by two categories, first, unable to use help (category 5Negative above). Category 6: Oppressed also occurs at this stage and is explained here along with its connotative elements.

Category 6Negative: Feeling oppressed refers to participant experience of a socially or culturally oppressive environment that impedes psychosocial growth. It is connoted by two elements: adverse work, and adverse partnership.

6NegativeA: Adverse work (participant-only data)

Seven participants spoke about being in situations where they felt strained by too much, or unpleasant occupational or academic work, which caused or worsened their problems. Dana said about her circumstances at university, leading up to becoming unwell: Basically, the course was really stressful, and everything around it. It just wasn’t plausible for a human being to get that amount of work done.
6NegativeB: Adverse partnership (research-only data)

A study of narrative therapy for women in abusive partnerships by Gonçalves, et.al. (2011) found that failed therapy (indicated by participant ongoing ‘problem narratives’) was associated, unsurprisingly, with ongoing abuse in their relationships.

Stage D Non-change: Resource-depletion cycle

Stage D non-change: resource-depletion cycle is connoted by three categories that are counterpoints to their positive counterparts: retained behaviours, retained thinking and unwell identity. These are explained here along with their connotative elements.

Category 7Negative: Retained unhelpful behaviours are identified by participants as things they do that tend to keep themselves stuck; or that represent areas where further work is needed. Research refers to hard-to-change unhelpful behaviours or coping styles. Retained behaviours reinforce retained thinking (the next category). This category is connoted by two elements: unhelpful reactions, and avoidance.

7NegativeA: Unhelpful reactions (research and participant data)

Participants described different types of unhelpful reactivity when stressed. For example Zoey described regressive anxiety: *I tend to react in a childlike way when something bad happens. Or I panic. I’m not calm like a grown woman...I’m quite immature.* Both Thea and Lucy experienced complacency, which Thea described like this: *What felt challenging in the...early stages of recovery is now very easy...I’ve got to a point where I’ve become very, very comfortable. So it’s about challenging, re-challenging yourself.* Lily described indecisiveness: *I don’t trust myself with decisions sometimes, because...I over-analyse everything so I don’t know why I’m making a particular decision.* Esme found her tendency for organising and leading could turn to unhelpful control of herself and others.

Dingemans, Spinhoven and van Furth (2007) noted another kind of unhelpful stress response which they call ‘palliative reacting:’ turning to food, alcohol, drugs, smoking (and, oddly, relaxation) for distraction and comfort. Their study found that palliative reacting was a predictor for treatment failure at 12-month follow-up.
7NegativeB: Avoidance (research and participant data)

Six participants described how being unwell shielded them from facing potentially growth-inducing social experiences. Kyra put it like this: *In a weird sort of way, it’s another crutch in my life, that I can let myself get absorbed by the feelings that you have with [D2]. And sometimes that means you don’t have to make the really tough decisions. If I think about my relationships with good friends… I can use it as a cop-out.*

Three studies supported this element. An experientially avoidant coping style was found to predict worse outcome in studies by Kim, Zane, and Blozis, (2012) and Berking, Neacsiu, Comtois, and Linehan (2009). Also, in counterpoint to positive expectancy, Hartmann et.al. (2010) found that where participants expected painful challenge in therapy, this predicted treatment failure at 3-month follow-up.

Category 8Negative: Retained unhelpful thinking means unchanged and sometimes engrained ways of seeing oneself, and of interpreting internal and external stimuli, that perpetuate psychosocial stagnation. It is a later consequence of social disconnection and can be experienced as ‘living in my own world with my own rules.’ This category also refers to hard-to-change, unhelpful thinking styles and cognitive events. It is connoted by five elements: perfectionism; negative self-talk; obsessions; low metacognition; and dissociation.

8NegativeA: Perfectionism (research and participant data)

Five participants described how variants of perfectionism were implicated in their problems. For example, Lily said, *Before I even had any [D3] issues… I’d obsessively plan all my clothes I was going to wear. And… I’m so competitive. [But] I told my mum, ‘I feel like a failed perfectionist’ because I think I am, but I’m not, because sometimes I have a vision and I don’t do it.*

Three studies supported this element, Hawley, Ho, Zuroff and Blatt (2006) found that perfectionism slowed the rate of participant symptom reduction, while Kyrios, Hordern and Fassnacht (2015) found that it predicted treatment failure at 3-month follow-up. Shahar, Blatt, Zuroff, Krupnick and Sotsky (2004) provide one explanation for
perfectionism’s hindering properties. They found that pre-treatment perfectionism impeded social relations, which in turn predicted persistence of mental ill-health symptoms after therapy.

**8NegativeB: Unhelpful self-talk** (research and participant data)

Six participants gave detailed descriptions of different types of low self-worth, self-put-downs and inner criticism. Thea interpreted symptoms of mental illness like this: *At the time I just thought ‘I’m lazy, and a bad person which is why I don’t do these things.’...I thought I was a terrible person.* Generalised ‘negative cognition’ was found by Beevers, Wells and Miller (2007) to predict slower change in symptoms.

Ella recreated therapeutic dialogue in an unhelpful way: *I won’t take compliments.*

*[Therapist] says, ‘You’re doing so well!’ And I’m like, ‘No I’m not, it’s you! Will you stop!’...In my head I took, ‘That’s because I’m not good enough. I’m not a good person.’* Altimir et.al. (2010) found that participant recreation of therapeutic dialogue with negative emotions predicted non-remission at 3-month follow-up. Although shame is a different construct than self-criticism, it too can induce a sense of worthlessness. Brown, Linehan, Comtois, Murray and Chapman (2009) found shame was found to predict ongoing symptom severity during therapy.

**8NegativeC: Obsessions** (research-only data)

Alonso, Menchon, Pifarre, Mataix-Cols and Torres (2001) found that greater sexual or religious obsessions predicted poorer outcome at long term (1-5 years) follow-up.

**8NegativeD: Low metacognition** (research-only data)

Metacognition refers to awareness and ability to distinguish thoughts and other mental events from the self. A study by Teasdale et.al. (2002) found that lower metacognitive processing of memories of depressing events occurring in the 5 months preceding therapy assessment significantly predicted earlier relapse by 11-month follow-up.
8NegativeE: Dissociation (research-only data)

Kleindienst et.al. (2011) found that dissociation predicted poor improvement in general psychological functioning at one month follow-up. They proposed that dissociative disturbances in psychotherapeutic learning may account for this.

Only one participant endorsed this element, which fell below the minimum to be counted as a participant-endorsed element. However it seems worth mentioning that Zoey described why dissociative experiences delayed her accessing help: *I’d been suffering from flashbacks and I’d not told anybody. I kept it to myself for six-seven years, because I was terrified as to what it was, what it meant.*

Category 9Negative: Unwell identity means, at varying levels of awareness, living with psychosocial debility and decreasing hope of recovery. It is connoted by three elements: endorsed stereotypes; problem-enmeshment and long illness. These are now explained along with their connotative elements.

9NegativeA: Endorsed unhelpful stereotypes (research and participant data)

This element refers to the extent to which participants aligned themselves with unhelpful cultural mores or beliefs. Five endorsed the social expectation that women should be dissatisfied with their bodies, although only Esme noted its cultural origins and pervasive impact.

Ritsher and Phelan (2004) found that when participants endorsed negative 'mental health patient' self-stigmatising stereotypes for themselves, this predicted greater subjective demoralisation and dysphoria at 4-month follow-up.

9NegativeB: Problem-enmeshment (participant-only data)

This element refers to the merging of personal and problem identity. Subtle evidence was present in the use of possessive pronouns by eight participants to describe aspects of the problem, such as ‘my episodes,’ ‘my relapse,’ ‘my tablets’ ‘my [diagnostic label]’ and so on. Problem identity enmeshment was clearly voiced by Lily, who said, *I didn’t realise how much my [D3]...had become a part of me.*
**Negative C: Long illness** (research and participant data)

This element encompasses hopelessness of overcoming mental health problems when people have suffered repeated, severe or unremitting problems for years. It is a key factor in the cycle of resource depletion, and six participants described it, including Ella who said, *I don’t think I’ll ever get rid of it basically. My [D2], I’ve had that since I was a kid.* Luka said, *I’m quite realistic about the fact that I can go back into relapse at some point. So I don’t think it’s been cured. I think I just happened to go into remission. Whether because of counselling or not.* Lucy poignantly described the impact of having had problems since childhood: *It’s always been there, from a very young age and I didn’t recognise it, never got any help or support. And I think that makes it...tricky going into adulthood, and getting treatment when you’re in adult services rather than as a child. Because actually you’ve founded your whole life on something you thought was normal. When now, I can see, it’s not.*

Studies by Ramnerö and Ost, (2004) and Nakano et.al. (2008) both found that participants with longer duration of illness had worse outcomes at 12-month follow-up. Nakano et.al. (2008) suggest that people with long-term mental health problems may have more impaired social role functioning which in turn reduces the benefit of therapy.

**Summary of key findings: Unhelpful client factors**

1. Unhelpful client factors are conceptualised as a cycle of gradual deterioration in psychosocial functioning over time, if unchecked.
2. At the most abstract ‘super-factor’ level of the hierarchy, inadequate social support leads to psychosocial stagnation, where difficulties on an individual and social level obstruct reflective and exploratory learning (Hendry and Kloep, 2002).
3. I applied passive adjectival labels at the categorical level to represent participant narratives about experiencing states of non-change (or insufficient positive change). The personally overwhelming nature of these circumstances leads, for some, to the adoption of an ‘unwell identity’ which is both a signal and promoter of further personal and social resource depletion.
4. Categories of unhelpful client factors form thematic counterpoints to identified helpful factors.

5. To briefly summarise the non-matching areas on the unhelpful side of the reconstructed framework, there was no participant evidence to support research evidence for difficult counselling recommendations not being followed by clients; or for the unhelpful impact of partner abuse, religious or sexual obsessions or low metacognition. There was no research evidence to support participant evidence of fear or denial preventing change or the unhelpful impact of adverse work conditions.

An unhelpful elements density table is available in Appendix 26, which shows the number of participants and studies that yielded findings for each element.
CHAPTER 5: DISCUSSION

5.1 Chapter overview
The purpose of this discussion is to answer the four research questions and to review the adequacy of the concept reconstruction. The chapter is organised over twelve sections.

In the first four sections I answer each of the research questions set out in the introduction (p.24), recapped here:

1. What do participants describe as salient factors in their efforts to make desired psychosocial life-changes, and how are these best conceptualised? This data informed the primary concept framework.
2. How are client factors represented in psychotherapy research? This data informed the comparator framework.
3. What are the key helpful and unhelpful components of a reconstructed client factors framework?
4. What is the utility of the reconstructed concept to counselling psychology theory?

The first two questions are answered relatively briefly as a lead-in to lengthier discussion of the third question which represents the first aim of the study, to reconstruct the client factors concept.

The answer to the fourth question regarding the utility of the concept to counselling psychology theory addresses the first of seven criteria for concept adequacy suggested by Gerring (2012). Each of Gerring’s remaining six criteria is discussed over a further six sections. These comprise domain (scope); fecundity (richness and depth); differentiation (sufficiently contrasted from neighbouring concepts); resonance (familiarity with existing terminology and meanings; avoidance of neologism); consistency (same meaning in different contexts) and operationalisation (ease of observation and measurement)

The chapter rounds out with two further sections: recommendations for further study; and study limitations.
5.2 Study question 1: Factors salient to participants
For the participants in this study, client factors that directly facilitated therapeutic change included capacity for, and persistence with, reflective and exploratory learning; insight-led behavioural and cognitive change; and personal and social reintegration and adaptation. These occur within wider social contexts, assisted by attuned professionals when participants are in the right frame of mind to engage and benefit from problem-specific therapeutic psychoeducation. It could be argued that these client factors might be exclusive to the young, educated, female participant sample that volunteered for this study. But there were clear similarities and considerable overlap between these participant results and those yielded by 68 international studies with broad participant demographic strata (discussed on pp.108-109 in section 3.8 above and also in section 5.3 below).

In terms of factors that posed barriers to desired change reported by participants in this study, psychosocial stagnation and inadequate social support are linked in cycles of mutual influence that can for some lead to increasing social isolation or withdrawal which in turn compounds emotional and behavioural suffering, and can for some have profoundly negative consequences on self-identity.

5.3 Study question 2: Client factors in psychotherapy research
The research sample in this study offered a picture of the client factors concept which mapped well onto the participant concept framework but with smaller subject-territory boundaries (with exceptions as explained further below). My study exclusion criteria account for the absence of research on self-help resources, which feature prominently in the participant framework (as noted in study limitations in section 5.13 below, future work on conceptualisation of client factors ought to include research on self-help resources and strategies). A larger research sample might have extended or deepened the conceptual framework. However a possible explanation for the narrower footprint in the research-informed framework is that psychotherapy research tends to focus on how therapy works, and client factors that account for it not working, rather than on how clients work to make desired changes within broader social systems, over periods of time that for some, extend before and after they are ‘in therapy.’
Where the research contributed information that was not present in the participant framework, it was more on the side of unhelpful client factors, particularly in the area of hard-to-change cognitive features associated with psychological distress, including obsessionality, perfectionism and low metacognition. Demographic features proved to be a contested area with contradictory findings within the research sample and no findings in the participant data sample, and were thus removed. It can be argued however that people are unlikely to know, or to assert, how demographic characteristics such as their gender, age, intelligence, education, social class and so forth have a direct bearing on how they achieve desired psychosocial changes.

5.4 Study question 3: Key components of the reconstructed concept
I have organised the discussion of question 3 to first consider what the reconstructed concept framework tells us about the resources, processes and activities that comprise the client factors concept. I then propose a revised title for client factors: social learning factors. I conclude this section with discussion of conceptual boundaries and scope with reference to Bronfenbrenner's (2005) bioecological model.

Resources

Resources for therapeutic change with this participant and research sample fall into two overarching factors which are represented as super-factors on the concept hierarchy. The primary resource is reliable, long-term, generative social support that inspires and reinforces adaptive change over the lifespan, and across close interpersonal and wider cultural fields of social influence. Caring family members, enduring friendships, loving life-partnerships, meaningful work and leisure activities, and a sense of belonging are examples here. Educational, recreational, health care and counselling services also play an important role, as do a range of self-help media. The availability and accessibility of these resources is a wider social issue. While the determination to access and make the most of these resources is a personal issue, it depends in part, according to the information shared by the participants in this study, on the encouragement of caring others.
The other resource found to be relevant in this study is the capacity for persistent and resilient reflective learning. This is facilitated by a range of naturally occurring, and self- and other-fostered activities that stretch self-knowledge and one’s ability to deal with life’s ‘slings and arrows.’

Insufficiencies in either of these two factors were implicated in this model in the psychosocial stagnation that characterises the inability to make desired psychosocial life-change.

**Processes**

Processes of therapeutic change for all in the participant sample took place over years, and for most involved passage through overlapping stages and turning points that are represented at Level 3 of the concept hierarchy. Starting with problem recognition, this process evolves through commitment, to tapping social resources for assistance and reinforcement (of which therapy is only one of a range of elements), to reflective and exploratory learning, which in turn promotes personal and social integration and realised potential. The helpful process can be summarised in lifespan terms, as ‘coming into oneself as a social being.’ Processes of non-change can be described, on the basis of information provided by participants in this study, as a cycle of personal and social resource depletion. Compromised social or familial support can for some, lead to social disenfranchisement and mental ill-health, with concomitant difficulties recognising, obtaining help for, or finding energy to address problems. Ensuing psychosocial stagnation is a result of unchanged or unhelpful thinking and behaviour that can become entrenched over time as ‘coming into an unwell identity.’ Mental health stigma and detrimental cultural expectations can propel personal deterioration within this cycle.

**Activities**

Activities that participants identified as most helpful in making desired change are represented at the categorical and elemental levels of the concept hierarchy. Helpful activities included trusting and using social resources; persistently seeking and trying different forms of help; engaging in a range of insight-led and insight-promoting behaviours; consciously being open to changing thought-climates; and consolidating
personal gains and losses into a new outlook on self and life. Conversely, participants described difficulties engaging in these activities when they were in a resource-depleted state, particularly if they had been there for years or since childhood. They also described how this state deteriorates, for example through mistrust of self and others, fear, and avoidance of challenge.

**Retitling ‘client factors’**

In the reconstructed concept framework I found social learning processes were centrally associated with psychosocial change. Fields of learning included family of origin, partners, friends; self-help materials; and educational, recreational, health and counselling service resources. This leads me to wonder if the concept title might be fruitfully changed so that its definition is no longer predicated on the semantic component ‘client,’ which indicates dependence on the ‘practitioner.’ ‘Social learning factors’ might more accurately point to the potentially major constellation of wider client and extratherapeutic social contributions to psychological therapy outcome. Concept reconstruction has thus brought me to the brink of concept replacement (see pp. 76-77 above for related discussion).

**Conceptual boundaries**

I discarded the term ‘extratherapeutic factors’ in this concept reconstruction because client work and outcomes within therapy are ultimately inseparable from engagement with wider social resources. Bronfenbrenner’s bioecological systems theory (2005) is useful here in considering conceptual boundaries. He describes human biopsychosocial development as occurring via ‘proximal processes’ of regular interaction between individuals and their immediate social environments over extended periods of time. This is illustrated in the concept reconstruction diagram (figure 27, p.119) particularly in Category **1Positive: Trusting family and friends; 5Positive: Persisting with help; 6Positive: Improving social activity** and **9Positive: Reintegrating.** These socially-oriented categories are tessellated with self-oriented categories **2Positive: Hitting rock bottom; 3Positive: Precluding relational loss; 7Positive: Self-helping behaviours** and **8Positive: Helpful thinking.** I would go further by suggesting that the definition of ‘client factors’ includes interactions taking place across Bronfenbrenner’s (1993) entire
'bioecological' system of person, process, context and time. This system is laid out over four levels. I will illustrate how each fit with the concept reconstruction using just one spine, 2Positive: Hitting rock bottom as an example, although any spine might similarly fit the 'bioecological' system:

The 'microsystem' context involves direct activities and interactions, which can be seen for example in element 2PosB: GP services which involves conversations between doctors and patients.

The 'mesosystem' involves networked interactions between parts of the microsystem including direct effects of indirect events such as accidents and health incidents and consequential interactions with care services that sparked participant awareness that one had 'hit rock bottom.'

The 'exosystem' involves strengths and weaknesses in social policies and services surrounding the microsystem, for example the relative availability, quality, relevance and accessibility of care services.

The 'macrosystem' involves enveloping social structures such as shared values, beliefs, hazards, lifestyles and opportunities within temporal cultural-political shifts. These can be seen in the life courses available to persons repeatedly experiencing helpful versus unhelpful factors. The macrosystem is also responsible for creating and expanding the diagnostic labelling system applied to people experiencing disturbance, loss, disconnection or inequality (Bronfenbrenner, 1967; Walker and Rosen 2004; Wilkinson and Pickett, 2010).

5.5 Study question 4: Concept utility for counselling psychology theory
As one of Gerring's (2012) seven criteria for concept adequacy, causal utility refers to how well the concept serves as a component of a larger causal argument regarding the relationship between independent and dependent variables (for want of better terms to describe 'the changing' and 'the changed'). It is important to note that the research studies upon which the concept reconstruction is based were predominantly predictive designs. This means that (within the considerable limitations in scope and size of this study as discussed in section 5.13 below) any causality implied here is not materially
but socially mechanistic in that there may be a potential or emergent causal interdependence between the variables in the arguments I now discuss.

The causal utility discussion evolves over two parts in order to establish a learning theory into which the concept reconstruction fits. In the first part I contrast evidence for the contributions of therapeutic alliance to therapy outcomes, against the tentative causal argument made in this study’s concept reconstruction, for reflective and experiential learning mediated by broader sources of social support. In the second part I examine aspects of two social learning theories that the concept reconstruction maps onto well: Margaret Archer’s (2007) ‘internal conversations’ model; and Albert Bandura’s (1986) ‘social cognitive’ theory. My fourth and final research question, about the causal utility of the concept to counselling psychology is answered here as I explain how they speak differentially to the causal influences I have interpreted from the findings in this study.

**Causal influence A: Therapeutic alliance**

Some psychotherapy research positions the therapeutic relationship, alliance or bond as a primary healing factor in therapeutic outcomes (e.g. Orlinsky, Graves and Parks, 1994). Further to this positioning, the therapist is credited by some authors for the relational skill required to maintain a therapeutic relationship, while the client’s role is side-lined or rendered void. An example is found in this statement by Norcross (2002), “The [therapeutic] relationship does not exist apart from what the therapist does in terms of technique, and we cannot imagine any techniques that would not have a relational impact” (p.8). Recalling from Chapter 2 that in causal syntax, X is the independent variable input that facilitates change in dependent variable outcome Y, the causal influence diagram in the case of Norcross’ statement is set out in figure 31:
However, the concept reconstruction suggests a differently structured causal syntax. Therapeutic alliance is not present in the concept framework as its role is disputed by contradictory and null research findings (for further discussion of the contested relationship between therapist interpersonal skills and therapy outcome see Truax, 1963; Lambert, DeJulio and Stein, 1978; and Wampold and Imel, 2015). Conducting this study has led me to propose that the potency of the therapeutic alliance is a reflection of client capacity for forming and using relationships more generally to assist in ‘learning by doing.’ To illustrate this reasoning with an example, Lorenzo-Luaces, De Rubeis and Webb (2014) found the predictive relationship between alliance and outcome was related to a critical client factor, namely, the number of depressive episodes the client had previously had. For those with more depressive episodes, the alliance had less predictive value. Perhaps this finding was due to the likelihood that recurrent depressive episodes might cause a person to be more socially resource-depleted and therefore over time less able to form and use relationships, including therapeutic relationships.
This argument does not say that the collaborative bond between client and therapist (Krupnick et al. 2014) is unimportant. On the contrary: without it, clients might understandably quit therapy, or not engage well in joint efforts of goal formulation, action planning and strategy exploration that forms some therapy models (see for example Cooper and McLeod’s 2011 pluralistic approach, which, on a side note, does not use the term ‘alliance’). But the amount of research, practise and theoretical interest paid to therapist contributions to alliance may be disproportionate to their causal association with outcome.

**Causal influence B: Client relational and learning resources**

The causal influence of helpful client factors arising from the reconstructed concept is set out in figure 32:

*Figure 32: Reconstructed helpful client factors causal influence*

As discussed on p.117 in section 3.11 above), in this framework background demographic factors B (e.g. age, gender, level of education, socioeconomic heritage) appear to have an indirect, contradictory, contested or hard-to-measure effect on causal
factors involved in the achievement of desired psychosocial change (dependent variable) Y. Causal super-factor M (mediating/moderating variable) is social support from proximal sources. Adequate social support facilitates and mediates second super-factor X (independent variable) which is the persistent and committed efforts participants made, using a range of relational, social and self-help resources, to learn via exploration and reflection how to make generative relational, behavioural, cognitive changes, and to self-redefine; which in turn led to outcome Y. This model therefore suggests why therapy works well for people who are socially well-prepared to help themselves. Murphy, Cramer and Lillie (1984) found that, in the context of an understanding therapeutic relationship, helpful advice given by the therapist was clients’ most valued curative factor derived from attending therapy. Centralising client learning in this way, according to cognitive psychologist Albert Bandura, can “place the therapist in a less glamorous role, and this may create some reluctance on the part of therapists to part with the procedures currently in use” (1961, p.156).

Turning now to review the results for unhelpful client factors, the causal influence of client factors in the resource-depletion cycle is set out in figure 33:

*Figure 33: Reconstructed unhelpful client factors causal influence*
Persistently inadequate social support, particularly from proximal sources over time (independent variable X) leads to alienation, psychosocial stagnation, non-change, and social resource depletion (dependent variable Y) which can for some, if not ameliorated, turn to a chronic cycle of un-wellness. The model suggests why therapy tends not to work as well for people who are socially distressed, disadvantaged or resource-depleted (Brunner, 2017), because they cannot as effectively ‘convert’ social support to create the critical ‘independent variable’ of experiential and reflective learning. Counselling is chiefly concerned with supporting client strategies for psychosocial change. However, altering or improving clients’ wider social learning environment, would, in this model, be a helpful prerequisite to priming the capacity for change.

**Learning theory and counselling psychology**

To recap, in theoretical terms, the concept reconstruction positions client reflective and exploratory learning enabled by, and interdependent with, social support, as the area where psychological therapy makes its contribution, via active therapist behaviours such as providing appropriately tailored psychoeducation and encouraging client growth-inducing relational connections outside therapy. I now turn therefore to discuss the relevance of learning theory in counselling psychology.

In addressing the position of learning theory in psychotherapy, cognitive psychologist Edward Shoben said in 1948, “Psychotherapy is essentially a learning process and should be subject to study as such” (p.112). He decried the lack of attempts at that time to formulate therapy in terms of learning theory. Subsequently, Albert Bandura said in 1961, “While it is customary to conceptualise psychotherapy as a learning process, few therapists accept the full implications of this position.”

To check if, half a century later, this might still be the case in contemporary British counselling psychology, I searched articles published in *Counselling Psychology Review* over the past twelve years (2006 – 2018) for clues to social learning theories that counselling psychologists might use to inform their work. I found articles in the areas of cognitive behaviour therapy (Boucher, 2006; Davis, McCabe and Winthrop, 2010; Beaumont, Galpin and Jenkins, 2012); pluralistic therapy (Shorrock, 2012); solution-focussed group work (Proudlock and Wellman, 2011); neuroscience (Rizq,
2007; Goss, 2015); working with older adults (McIntosh and Sykes, 2016), and people with HIV diagnosis (Harris and Larson, 2008) that mentioned the transformative role of client psychosocial or relational learning in therapy outcomes. However, none referenced a learning theory that might underpin or support their observations. One article by Gianakis and Carey (2008) reviewed four theories of psychotherapeutic change including Stiles' (2002) ‘assimilation of problematic experiences’ model; Prochaska and Norcross’ (2001) ‘stages of change’ model; Powers’ (2005) ‘perceptual control theory’; and Bohart and Tallman’s (1999) ‘inherent self-healing’ theory. Key aspects of all these theories echo those that appear in the reconstructed concept, including problem awareness/clarification, experiential ‘learning by doing,’ and personal reorganisation through metacognitive awareness. However, Gianakis and Carey point out that none of these models reveal what enables these processes to occur. In the reconstructed concept, the enabling factors are interpreted as the interdependencies of reflective and experiential learning and social support, as previously discussed.

I also conducted an index search of all four Handbooks of Counselling Psychology (Woolfe and Dryden 1996; Woolfe, Dryden and Strawbridge, 2003; Woolfe, Strawbridge, Douglas and Dryden (2010); Douglas, Woolfe, Strawbridge, Kasket and Galbraith, 2016) and found learning theory referenced as follows: John McLeod describes client experiential learning in therapy as a relational process including behavioural change, insight and reframing, and emotional catharsis. The concept reconstruction resonates with these ideas. He and Donati (2016) reference David Kolb's (1984/2014) experiential learning cycle. However, Jarvis (2018) has criticised Kolb’s (2014) model for not emphasising enough the interactive and social aspects of experiential and reflective learning, which were fundamental aspects of the concept reconstruction. It will therefore not be further explored here.

**Ontologies of the ‘learning self’**

Before unpacking relevant learning theories to compare fit with the concept reconstruction, it is helpful to first set out three ontological bases for the notion of the ‘learning self,’ to understand how learning theory might describe learning process.
Perspectives on the nature of ‘the self’ can be described as falling along a spectrum from individualism to social diffusion. On the individualistic side is the humanistic idea of the ‘separate self.’ This philosophy considers the self to be a functional reality. It values freedom, self-reliance and independence from the influence of culture and relationships. Aspects of Rogers’ ideas about learning can be seen to fit on this end of the self-ontological spectrum. Rogers (1983) describes how good teachers create encouraging conditions in which students become responsible for self-directed learning via personal creativity, curiosity and independence. On the opposite side is the social constructionist notion of the ‘dependent self’ who is entirely a product of relationships, society, culture and contingency. For example Gergen (2009) dispatches notions of the individual ‘coherent self.’ Instead he describes ‘multi-selves:’ human constellations of potentials for action existing within the relational dimension.

Lying on the middle ground between these two philosophies is the notion of a ‘transactional self’ who has personal concerns, choice and agency that impact the material and social world in a real way, and whose sense of identity and self-knowledge are mediated through interactions with the material and social world. Here the ‘self’ and the material world are mutually formative.

This ontological middle ground is consistent with a critical realist ontology of the self that acknowledges the neurological basis of the mind and consciousness from which arises epistemologically created selfhood and personal identity, from which in turn emerges social agency (O'Mahoney, 2011; although I would say that personal identity does not precede social agency in order of emergence, but they are interdependent processes). Next I examine two learning theories that lie in this self-ontology middle ground: Archer’s ‘reflexive social action’ theory, and Bandura’s ‘social cognitive’ theory.

**Archer: reflexive social action**

Relational sociologist Margaret Archer (2007) defines reflexivity as internal conversations in which one is both subject and object (speaker and listener). She positions inner dialogue as a vital (and empirically overlooked) means by which people achieve social and occupational mobility. She describes three types of reflexive self-talk: communicative, autonomous and meta-reflexivity.
Communicative reflexivity is intersubjective in that it involves sharing one’s inner dialogue with others for affirmation, information, deliberation, or ascertaining others’ needs. Autonomous reflexivity is task-oriented and kept to oneself, because input from others is not required or desired for self-injunctions or self-directed action. Meta-reflexivity is value-driven and involves reflecting on one’s reflections, for example through self-monitoring, self-analysis, daydreaming, or staging imaginary conversations with others. Meta-reflexivity involves engaging with the possibility that there are at least “two sides to the story” (2007, p.131).

Participants in my study voiced all three types of self-talk and all gave examples of helpful internal dialogue that described and assisted their changing outlook, behaviours and self-understanding (captured in element 8PositiveA: Helpful self-talk). Some also gave examples of unhelpful self-talk that tended to confirm or reinforce a stagnant or resource-depleted state (captured in element 8NegativeB: Negative self-talk).

Archer’s theory fits well with the reconstructed client factors concept, in that she ascribes causal power to self-talk as a method people use for responding to circumstances and enacting desired life-changes:

[Reflexivity enables] subjects to design and determine their responses to the structured circumstances in which they find themselves, in the light of what they personally care about most….Outcomes vary enormously with agents’ creativity in dreaming up brand new responses, even to situations that may have occurred many times before. Ultimately the precise outcome varies with subjects’ personal concerns, degrees of commitment, and with the costs different agents will pay to see their projects through in the face of structural hindrances. Equally they vary with subjects’ readiness to avail themselves of enablements (pp. 11-12).

Archer offers a three-stage model of reflexive learning that sits within a larger ontological philosophy of ‘relational realism’ (2014; Tilly, 2002) which proposes that social interactions constitute society:
1. Advantageous or disadvantageous social features exist across four orders of reality (Archer, 2014). These include (a) the natural environment including human embodiment; (b) evolving technological resources; (c) the social realm including education, politics, economics, culture and personal relationships; and (d) transcendental reality, which Archer describes as belief in God and leads to detachment from over-riding concern with the previous three realms of reality. This bears similarities both with Rogers’ ego-less universe and Bhaskar’s transcendent-emergent realm of the real – although Archer (2014) assigns individual formative moral drive, free will and determinism to this order of reality. One or more of these orders of reality becomes a generative interactive power in relation to people’s projects when...

2. …they ask themselves, ‘what do I want?’ and ‘how do I go about getting it?’ Archer proposes that, following these questions comes three phases of self-determining life-long internal conversations: (a) discernment of predominant satisfactions and dissatisfactions with one’s current way of life, and which of the realms of reality it falls into (which maps onto **Stage A: Problem recognition** in the concept reconstruction); (b) deliberation over which concerns, in which realm of reality one should prioritise and commit to pursuing (which maps onto **Stage B: Other-focussed and self-focussed commitment to change**); and (c) dedication to persevere with a particular area of concern even with the possibility that one’s actions might fail; while giving up concerns in other areas (which maps onto **Category 5Positive: Persisting with help**).

3. Then the chosen course of action is reviewed, adapted, adjusted, abandoned or enlarged with the aim of becoming “what we care about most in society” (p.21) (which maps onto **Super-factor 2: Reflective learning** with the aim of achieving **Category 9Positive: Reintegrating**). Where people are unable to conceive or execute their concerns in any realm, they tend to experience shame, withdrawal and “loss of relational goods” (2014, no page number) with which to engage in social interaction. This maps onto **Stage D Non-change: resource depletion cycle**.

Archer’s theory and my concept reconstruction also overlap where the catalyst for action is desire for a particular way of being that is different than one’s current state.
The major mapping gap is where the reconstructed client factors concept ascribes some causal influence to social relations in inspiring and reinforcing psychosocial change, whereas Archer solely ascribes this agency to individual inner dialogue. Archer’s theoretical framework positions constructs similar to psychosocial change (social actualisation and occupational mobility) as the outcome of reflexive learning, but she describes reflexive learning as if it originates and develops in a mental vacuum, “relatively autonomous from...structural or cultural properties” (p.15) and originating from “first-personhood...as distinct from any social ‘concept of the self’” (p.27).

Reflexivity is examined in Archer’s model insofar as it mediates the intra-personal relationship between deliberation and action in people’s social lives. But in my opinion (which is heavily influenced by relational-cultural theory e.g. Jordan, 2010), the contents of reflexive inner dialogue (the what, why and how one talks to oneself) originate in, and are structured and limited by the socio-cultural foundations of language, relationships, resources and potentialities in which one’s life is embedded. Furthermore, the power of relationality can sometimes override autonomous reflexive agency as a primary determinant of behaviour. These two points are voiced by Archer’s research participants. Some described self-talk that addressed inherently relational, interactive problems in their work (and working identities). Others described occupational decision making based on the influence of trustworthy ‘similar and familiar’ friends; or based on the emotional pull to maintain contextual and relational continuity, over and above following one’s own reflexive inclinations. In this way, ‘learning by doing’ was shown to be a relationally-informed rather than solely reflexivity-informed activity. Nonetheless, Archer does not view self-talk as dependent on social moderators and mediators.

**Bandura: Social cognitive theory**

The ‘self’ in Albert Bandura’s social cognitive theory is a stable single entity that can perform multiple cognitive and behavioural functions, although not simultaneously. He ascribes five reflective capabilities to human nature, which he sees as being formed neither solely by inner mental forces nor by external stimuli, but by a mutually determinative reciprocity between personal behavioural and cognitive factors, and environmental factors. Interestingly, although Bandura does not describe it this way,
four of the five capabilities depend on forms of inner dialogue (as Archer argues): symbolizing (translating experience into internal models that serve as guides for future action); forethought (symbolic representation of future possibilities exerting causal impact on present action); self-regulation (attempting to bring oneself in line with internal standards as well as the expectations of others); and self-reflection (knowledge development and self-alteration through self-analysis). The fifth capability is vicarious learning through modelling and imitative observation.

All five of these capabilities are clearly found in elements and categories of the concept reconstruction. For example, symbolising was found in element 7PositiveB: Insight-led change. Reflexive forethought was seen in 8PositiveD: Hopes for the future as well as Category 3: Precluding relational loss and Category 4: Reclaiming self. Self-regulation was seen in Category 8: Self-helping behaviours and Category 9: Self-helping cognitions. Self-reflection was evident throughout all categories and stages of the helpful factors side of the concept analysis, particularly in Stage D: Exploratory learning. Vicarious learning was present particularly in element 6PositiveF: Role models and more implicitly in some forms of help participants accessed such as 5PositiveD: Support groups and 5PositiveF: Counselling.

Bandura also describes how the individual and their social environment reciprocally influence each other. Idiosyncratic individual behaviour brings about certain interactive responses in others. People select and create environments in a way that can reproduce generative change or stagnation. This is evident on the concept reconstruction in Unhelpful superfactors 1 and 2: Inadequate social support and psychosocial stagnation. Group behaviour can empower individuals. But in different circumstances groups can form detrimental (e.g. coercive) reciprocal systems, or impacts that are felt to be coercive by member participants.

Bandura also describes the determining influence of “chance encounters” in people’s life paths, well as the influence of wider historical and political events. On an individual level he describes how self-evaluative standards (acquired from proximal social influences) give direction to life by guiding choices. This is seen on the reconstruction in categories 9Positive: Reintegrating; and 9Negative: Unwell identity.
Bandura also discusses incentive to action as motivated by two-way interpersonal interaction, and the accommodation of social influence. This is captured in the concept reconstruction in category **1Positive: Trusting family and friends** particularly in the elements of communication to and from supportive people as an aspect of problem recognition.

Two areas included in the concept reconstruction that are not explicitly covered by Bandura’s theory are (a) the recognition of a personal crisis by oneself and/or trusted others as a catalyst for decisive action in seeking life-change; and (b) the requirement of trust for generative social relations.

**Utility of the concept reconstruction to counselling psychology**

The concept reconstruction framework suggests that counselling psychology might beneficially develop learning theories to help clients make therapy work through engagement with social resources beyond the consulting room. Bandura’s social learning theory is explicitly devised to hypothesise mechanisms at work in psychological therapy. It provides a clear, detailed and deep account of how dependent psychosocial learning is on pre-existing and concurrent social resources, the importance of enacted and reflective learning, and, consequently the role of insufficient social support in obstructing the natural human drive to learn and adapt over time.

A potential lack of utility in the concept reconstruction is that it does not explicitly label empathy anywhere within the hierarchy. Empathy has been positioned as a change-producing relational element by a number of researchers (Davis, 1996; Bohart and Greenberg, 1997; Bohart, 2004; Jordan, 2010; Martinez, 2017). However Bandura proposes that empathy is not a unitary phenomenon, but comprises three constructs which are not particularly closely related to one another, as I discuss further here.

**Three constructs of empathy**

The first construct, social perspective taking, can be seen across category **9Positive: Reintegrating**. The second, imaginative self-involvement, can be seen in reflective activities including elements **5PositiveF: Counselling** and **7PositiveA: Journaling**. The third, emotional responsiveness, is present across a number of categories,
particularly **1Positive: Trusting family and friends; 3Positive: Precluding relational loss; 6Positive: Improving social activity** and **9Positive: Re-integrating.** In the concept reconstruction, empathy is subsumed (and therefore assumed to exist) within **Super-factor 1: Social support.**

I now move on to discuss Gerring’s (2012) remaining six criteria for concept adequacy: domain, fecundity, differentiation, resonance, consistency and operationalisation.

### 5.6 Domain

Gerring recommends that the researcher stipulate the conceptual domain, or ‘language communities’ the concept relates to, for example, lay or academic audiences; or ‘schools’ and ‘cultures’ within a discipline. Domain also refers to the distance from lay usage the author has travelled to create scientifically precise terminology.

In this concept reconstruction I have attempted to rely on everyday language rather than psychotherapeutic terminology in line with the ‘muted group’ epistemology that suggests the concept should be meaningful to those who experience it (Wuest, 1994). Tight space on the framework diagrams leaves some labels requiring explanation for example **4PositiveC: Maturity** means participant sense of ‘with age comes responsibility and wisdom’ rather than their numerical age. No participants offered suggestions to change my conceptual labels after second participant review, but this does not necessarily indicate that the linguistic domain was entirely relevant for them.

I have also tried to retain non-pathologising and context-informed terminology in line with the feminist paradigm in counselling psychology (Taylor, 1996). The reconstructed concept also reflects relational-cultural theory (Jordan 2010) that positions amelioration of social disconnection as the purpose of therapy rather than the removal of ‘symptoms.’

### 5.7 Fecundity

Descriptive concepts help explain causal influences in human science by interpreting and illustrating intersections of circumstances, events, intentions and reactions over a set of cases. Good concepts “reveal the structure within the realities they attempt to describe” (Gerring, 2012, p. 125). The large size of the conceptual fishbone frameworks permits the fecund inclusion of detail to the least abstract level. This in turn helps to
clarify the types of elements and categories that belong to the concept; to show coherent relationships between levels of abstraction and over temporal stages; and to delimit conceptual borders. Such delimitation help with the next criterion, differentiation.

5.8 Differentiation
This criterion refers to how well the concept is differentiated from contiguous or similar concepts. The concept reconstruction collapsed extratherapeutic factors into client factors because they were insufficiently distinguished. Then, because the concept includes a wide range of activities and causal influences beyond therapy, I have proposed that the title is inaccurate and could be replaced with ‘social learning factors’ (see discussion on p.164 in section 5.4 above). In this way the concept may be clearly differentiated from contiguous concepts such as therapist or therapy factors.

5.9 Resonance
In assessing the linguistic resonance and conceptual familiarity of the reconstructed client factors concept against existing usage, it is useful to compare and contrast how client factors are presented in this study against how they are represented in well-researched ‘treatment matching’ theory.

Treatment matching approaches shape therapy around client factors known to mediate or moderate therapy processes (which I here differentiate from ‘outcome informed’ approaches that match therapeutic approaches to elicited client preferences for working style or approach e.g. Duncan, Miller and Sparks, 2004). A number of such approaches have evolved over the past quarter century, for example culturally adapted treatments (Benish, Quintana and Wampold, 2011; Smith, Rodríguez and Bernal, 2011); phase-based therapies based on clients’ ‘stage of change’ (Kanfer and Schefft, 1988; Prochaska, DiClemente and Norcross, 1992; Prochaska, Norcross and DiClemente, 1994) or stage of ‘assimilation of problematic experiences’ (Stiles, et.al., 1990; Stiles, 2002, 2005). Norcross and colleagues have developed a treatment matching approach called ‘customized/tailored therapy relationship’ (TTR) (Norcross, 2002; Norcross and Lambert, 2010, 2011; Norcross and Wampold, 2010; Norcross and Wampold, 2011; also called ‘treatment adaptation’ and ‘prescriptive matching’ in Norcross and Karpiak, 2012).
Systematic treatment selection (STS)

The treatment matching approach I focus on here is Larry Beutler and colleagues’ ‘systematic treatment selection’ (STS) (Beutler and Consoli, 1992; Castonguay and Beutler, 2006; Beutler et.al., 2016; also called ‘prescriptive therapy’ in Beutler 2016). STS has been chosen because it conceptualises client factors as impacting outcome in their own right, where other approaches (e.g. TTR) conceptualise client dimensions only in so far as they inform therapist contributions which are in turn viewed as the primary outcome mediators.

Based on decades of direct and meta-analytic research work, STS is a set of technically eclectic treatment principles (Beutler, 1983, 2016) that are tailored to clients’ non-diagnostic ‘predisposing trait-like tendencies’ and problem dimensions. The range of salient client dimensions identified by Beutler and colleagues has been adjusted over time (for development of STS see Beutler 1983; Beutler, Patterson, Jacob, Shoham, Yost and Rohrbaugh, 1994; Beutler and Clarkin, 1999; Beutler, Clarkin and Bongar, 2000; Beutler and Harwood, 2000; Groth-Marnat, Roberts and Beutler, 2001; Castonguay and Beutler, 2006; Beutler, Harwood, Kimpara, Verdirame and Blau, 2011; Beutler et.al. 2011b; Beutler and Forrester, 2014).

Client factors in STS

Beutler et.al. (2016) mention eight client factors that comprise STS (the first four from Beutler, Clarkin and Bongar 2000 and the second four from Beutler et.al. 2006). They explain that these dimensions are not equally well-established in the research literature, and that they are descriptive and atheoretical. At the end of the list of eight I have added a further two relevant client factors that appear in Beutler and Clarkin (1999) but for unknown reasons were subsequently dropped from the model. I describe only the client factors and not the associated treatment recommendations. I concurrently map these factors against the labels and the conceptual footprint of the reconstructed framework to check its resonance with established use in STS.

1. Functional impairment: This dimension includes symptom intensity, chronicity and comorbidity as well as the presence of family problems and/or
isolation from social, school or occupational activity and/or lack of friendships. In previous iterations (e.g. Beutler 1983) this dimension was called ‘symptom complexity’ and highlighted negative social reinforcement for the continuation of client symptom patterns. In the reconstructed concept this relatively vague dimension is redrawn as unhelpful super-factors 1 and 2: **Inadequate social support** and **psychosocial stagnation**. It is also associated with non-change stages A and D: **Problem-maintaining environment** and **resource-depletion**. The main difference is that Beutler et.al. use terminology that locates the problem within the individual whereas the framework here tends to identify problem sources as transactions between the individual and their social environment.

2. **Coping Style** is characterised by internalising or externalising traits (people can display aspects of both). Internalising traits include self-responsibility; self-blame and constricted affect. Externalising traits include self-dramatisation, and experiencing anxiety “only when deprived of a direct, active method of coping with stress or when blame cannot be transferred” (Beutler and Clarkin, 1999. p.78). Neither internalising nor externalising traits are located on the reconstructed concept because they did not appear in this study as contributing to outcome.

3. **A. Resistance** is defined in STS as a psychopathological trait based in unconscious avoidance of threatening personal material. It may involve passive obstructionism or outright refusal to engage in aspects of therapy (Beutler, Harwood, Michelson et.al. 2011). It can be seen in the reconstructed framework in Stage B Non-change: **No commitment to change**. Beutler et.al. use terminology that ascribes to clients more detrimental causal force than the passive description I used.

**B. Reactance** within normal personality expression is the forcefulness of one’s efforts to resist threats to one’s freedom from the surrounding environment. Reactance is not found on the reconstructed concept.
4. **Degree of subjective distress** may be a feature of reactance or functional impairment. More distress was experienced by participants when they were anywhere within the cycle of non-change featured on the **unhelpful factors side** of the concept reconstruction.

5. **Stage of readiness**: Prochaska and Norcross’ (1999) transdiagnostic theory of change proposes that people use different attitudes, intentions and behaviours to effect change over time in five stages: pre-contemplation, contemplation, preparation, action and maintenance. STS refers to stage of readiness theory to inform therapy (Beutler et.al., 2016). Contemplation, preparation and action stages are found in the reconstructed concept in Stages A-D: **problem recognition, commitment to change, new social connections** and exploratory learning.

6. **Preference for type of therapist**: Although this dimension is included in Beutler et.al’s (2016) list of salient client factors, I have not been able to find any research by Beutler that discusses the role of client preference for type of therapist. It appears to have been adopted into STS from Norcross’ (2002; Norcross and Wampold, 2011) TTR. The suitability of the match between type of therapist/therapy and client is found on the reconstructed concept framework in the element 5PositiveF: **Counselling** and 5NegativeA: **Find counselling fruitless**.

7 & 8. **The interactive effect of demographic and symptom variables**: Castonguay and Beutler (2006) examine the impact of age, gender, ethnicity, socioeconomic status and religion in studies on diagnostic categories including dysphoria, anxiety, substance misuse and personality disorders. The chart for interactive effects of demographic client factors on symptom variables that I extracted from Castonguay and Beutler (2006) is in Appendix 21. Socioeconomic status had the strongest evidence-base as a cross-diagnostic, outcome-mediating client factor. It is not found on the reconstructed concept, because
neither the participant or research data pools highlighted social class, employment status or income as having a bearing on outcome.

9. **Client expectation** as Beutler uses the term refers to considerably more than expectations about the type of therapy and the therapist (e.g. Arnkoff, Glass and Shapiro, 2002), the outcome (e.g. Constantino, Arnkoff, Glass, Ametrano and Smith, 2011) or even of themselves as clients (e.g. Beitel et.al., 2009). In summary, they are the “accumulation of wisdom gained through observed or experienced cause and effect relationships. [They] may be situation specific (states) or general (traits) that bear a relationship to one’s age, gender, social position and personal background” (p.58). In the concept reconstruction this dimension is Super-factor 2: **Reflective learning**. The multiple meanings of the term ‘expectations’ in psychotherapy lexicon reduces the resonance of Beutler’s use of the term here.

10. **Environmental resources** refers to social support systems including work, school, friends, partners and family. People with well-established social and familial support systems were found by Beutler and Clarkin (1999) to respond less pathologically to stressful events, and to have higher self-concepts than their counterparts who are more socially isolated. In the reconstructed framework this dimension is **Super-Factor 1 A and B: Social support moderators and mediators**.

**Summary of resonance**

In terms of conceptual resonance, abstraction levels four (super-factors) and three (stages of change) on the helpful and unhelpful sides of the reconstructed framework were well-covered by STS dimensions 1 (functional impairment), 3B (resistance), 5 (stage of readiness), 9 (expectations) and 10 (environmental resources). Dimension 6 (preference for type of therapist) matched helpful and unhelpful counselling elements. Four STS dimensions were not present in the concept reconstruction (2: internalising/externalising coping style; 3B: reactance; 4: subjective distress; and 7/8
socioeconomic status). The main feature of the concept reconstruction that is missing in STS is **Stage C non-change: No new social connections** as a crucial maintaining aspect of the psychosocial stagnation cycle.

There was little terminological resonance between STS and the reconstructed concept. Some terms in STS hold specialist definitions whereas the reconstructed framework generally uses lay terms (with the exception of the term 'proximalising'), in line with Gerring's advice to avoid technical jargon and neologisms. STS terminology tends to adopt a 'deficit perspective' in which client factors are framed as problems upon which the therapist operates; whereas the reconstructed concept takes a much broader and more strengths-based view, in line with counselling psychology philosophy (Gelso and Fretz, 1992). However the primary terminological dissonance is minimal mention of social support in STS, in comparison to the central stage it takes across the reconstructed concept. This may be because STS focusses on the therapist’s role in adapting therapy to best help remediate client dysfunctional stress responses, rather than helping clients harness healing resources beyond the consulting room, which in turn may be viewed as falling beyond the therapist’s preferred or perceived domain of influence. Consequently, the client factors concepts upon which treatment matching approaches are based are skewed by a focus on aspects of client functioning that are within direct awareness and influence of the psychotherapist. The mediating effects of extratherapeutic client factors such as social support and culture tend not to be represented as directly influencing outcome.

Gerring (2012) provides reassurance to the researcher of specialised concepts that they can break with established usage, and thus, as shown above, incur a cost to resonance. Reckoning with this cost requires embedding the concept in concrete, representational data, in other words, at a low level of abstraction. The hierarchy of abstraction method is therefore particularly useful for working with a concept that is relevant within a limited context. I will discuss context further with the following criterion, consistency.

### 5.10 Consistency
“A concept ought to carry the same meaning…in each empirical context in which it is applied” (Gerring, 2012, p.121). The consistency of the client factors concept is easy to
5.11 Operationalisation
“A concept that cannot be measured cannot be tested – at least not very precisely” (Gerring, 2012, p. 205). The process of linking the more- and less-abstract connotations in the reconstructed concept to empirical indicants poses numerous challenges. I will touch on just two here. Firstly, causal events and processes in psychosocial change, and their manifestations in subjective experience, can be difficult to observe, let alone to capture, because they are best described in “actor-defined meanings and motivations” (Gerring, 2012, p.157) via personal, subjective, narrative material that requires careful interpretation to convert for use in research or practice. Qualitative and mixed methods research do make this obstacle surmountable. However, a second challenge is that ideally, the causal factor should be amenable to manipulation by the researcher to understand its impact on outcome. Social support from family, friends, colleagues and so on, is not particularly amenable to manipulation. This may go some way to explaining why social support is rarely considered in psychotherapy outcome research. Likewise, reflective and exploratory learning as the other major client factor relies on mental states and conditions that “stem partly from…free will” (Gerring, 2012, p.208). Such volitional states are not particularly amenable to direct or ethical manipulation.

5.12 Recommendation for further study
On the basis of the results of the client factors concept reconstruction I here make a tentative recommendation for theory development in counselling psychology, in the area of relational learning networks.

It has been proposed by Goertzen (2010, after Royce, 1987) that psychology produces too much empirical data and not enough integrative theoretical research. Evolving theory is a difficult, time-consuming, trial-and-error process that inevitably courts controversy. The idea that therapy works best for people who are already socially positioned to help themselves is not new (Orlinsky, 2009). Likewise, the related idea that clients make therapy work is not new (Bohart and Tallman, 1996), but it has not had the impact it could have had because, I propose here, descriptions of client
presentations have tended to be limited to features that lend purpose to 20th century therapy models that position the ‘problem’ within the individual and the ‘cure’ in the techniques or personal attributes of the psychotherapist. Furthermore, the theory that therapy is a social learning process is not new (e.g. Bandura, 1961) but counselling psychology does not seem to actively embrace – or develop – theories that explicitly embrace client social learning. I further contend that academic circles tend to produce theory in esoteric, self-referential language that is incomprehensible and irrelevant to the ‘labouring class’ of practitioners who have a vital need for theory to inform and develop their work (Beck, 2013).

I therefore suggest that an interesting route for theory development in counselling psychology is in the area of learning exchange via relational networks. From a sociological perspective Crossley (2015) considers the focal points of various networks in which social ties are made. These might include shared values, preferences and interests; ethnic or cultural backgrounds; or professional, educational and income brackets and so forth. Furthermore, I propose that simple proximity determines relatively superficial yet nonetheless influential social exchanges, although deeper affinities may endure tests of time, social mobility and geographic distance. Social learning results from active and interdependent participation in, and identification with, networks and power-alliances within networks. Trust and empathy are essential inputs and outputs in successful relational interaction histories. Crossley (2011) suggests that personal reflexive dialogue tends to be characterised by greater or lesser degrees of interactional trust and empathy, just as social networks are.

Even more theoretically relevant might be the integration of social network analysis with relational-cultural theory (RCT: Jordan, 2000, 2010). RCT proposes that people grow through and towards trusting, empathic, ‘authentic’ relationships over the lifespan. A goal of relational-cultural therapy is the development of relational competence and capability by promoting flexible relational expectations and reducing the isolation, disempowerment, shame and marginalising impact of relational disconnections and relational abuse. Therapy formed from these theories would of necessity be rooted in a formulation process that, insofar as this is acceptable and makes sense to clients,
attends closely to relationship stories; accounts for actual and potential relational-cultural resources within social networks; identifies areas of intra-psychic and relational resource depletion or power inequalities; and sets out a strategy for exploratory and reflective learning through social resource enrichment. This process would decentralise the therapist and even the therapeutic relationship in favour of focus on the client’s social world. This recommendation that mental health providers develop and embrace methods for increasing extratherapeutic social support for clients identified as socially resource-depleted is in line with studies by Turner, 1981; Kelly, 2006; Radomski, 2014; Budge and Wampold, 2015; Probst, Lambert, Loew, Dahlbender and Tritt, 2015; and Amati, Banks, Greenfield and Green, 2017.

This chapter concludes with discussion of some of the study’s limitations.

5.13 Study limitations
In this section I provide a non-exhaustive overview of the study’s limitations in six areas.

Ontological limitation
Critical realist research in some cases, as here, does not seek to make final judgements or generalisable truth claims on an issue but simply to make revisions to previous understandings (Pawson, Greenhalgh, Harvey and Walshe, 2005). Additionally, Scott (2005) brings our attention to the way all social research inevitably lags behind the evolving and emergent nature of reality. However, when we create new knowledge, we can in turn change some small aspect of reality through adjusted human action, but in such evolution, reality once again makes our revised actions obsolete. Over the two years it has taken me in this study to make the obvious-sounding recommendation that therapists can enhance their work by focussing on helping clients enrich experiential learning through active use of social resources - further work has been done in the area of relational sociology, for example into art space and social spaces (Crossley, 2015).

Epistemological limitation
Given the assumptions set out in the introduction to this study, it could be argued that my results confirm what I already believed: that emotional wellness, and recovery from episodes of mental un-wellness depend on social resources and generative relational
events; and that psychological therapy is only as useful as the client’s social resources (or social potentialities) outside the consulting room. Gerring (2012) reminds us that in social science, “descriptive inferences draw from a standard itinerary of tropes” (p.141), and in the case with this study the trope is the recent ‘relational turn’ in social science (see for example, Eacott, 2018). But to balance my partiality I have been clear about my assumptions and views; and I have provided a methodological audit trail so the reader can see how the contents and boundaries of the concepts have been drawn up. And although the result does perhaps reflect the ‘relational turn’ in the social sciences, this does not necessarily reduce the value of its message, that counselling psychology perhaps needs to engage with learning theory for direction.

**Procedural limitation**

Concept analysis has been described as “best done as a collaborative endeavour” (Knafl and Deatrick, 2000, p. 43). This recommendation resonates with my belief that knowledge construction proceeds through social interaction. While my mental interaction with the literature and participant data surrounding my topic could, at a stretch, be considered a social process, this study’s potential scope, richness and reach is restricted by its being of necessity a single-author project. The generalisability of the findings are limited by the small scale of the study, its qualitative design, and its epistemological assumption that knowledge is "situated and perspectival" (Hekman, 1997). The timing of my decision to replace thematic analysis with concept analysis in the design of this study does not have a material bearing on the generalisability of the findings.

**Data limitations: Literature sample**

The research literature sample excluded comparison studies that found different client factors to be salient predictors of outcome dependent on the type of therapy received. This was because the analytic strategies in those studies were designed to demonstrate differential treatment effects on clients rather than client effects on treatment and outcome. It could therefore be argued that it is impossible to completely separate, or distinguish, client factors from treatment and therapist factors, especially when outcome data is collected in or at the end of therapy. I had considered conducting the concept
analysis only with studies based on long-term follow-up data, where time elapsed after therapy provides some assurance that the client factor measured is not an immediate ‘halo effect’ of the therapeutic encounter. However, after an extensive and time-consuming literature search, only 28 relevant studies were found with follow-up data, which was insufficient for a concept analysis. This led to my decision to include the remaining 40 studies that were based on end-of-therapy data. Future research in this area might see if any difference is found if solely studies using follow-up data are used.

Studies included in the literature concept analysis were chosen on the basis of the presence of client factors associated with outcome. Other studies may find that the same client factors are not associated with outcome, but such studies were not included or analysed due to their null findings relative to this study.

In this study I did not explore client predictors of premature termination, non-completion or drop-out from therapy; nor whether there is a difference in salient client factors between people who do and do not access psychological therapy for help. While drop-out is certainly an ‘outcome’ of therapy that is mediated by client factors, I made this decision for two reasons. First, the process of drop-out did not directly address the research questions (although it might have contributed valuable data to the unhelpful factors side of the research framework). Second, the participant sample had all completed the course of therapy about which they spoke in their interview, so it made sense to match this with the published material.

My literature search excluded self-help resources, which turned out to feature prominently in the participant framework. Future work on conceptualisation of client factors ought to include research on self-help resources and strategies.

Data limitations: Participant sample

The white, young, mostly European, female participant sample was relatively socially homogenous. This raises questions about whether people in other demographic groups might approach psychosocial change using different activity and social factors; or may experience different obstacles to change. Further studies might use the same general client factors concept derived from international research and reconstruct it with data
from groups with other socio-cultural identities (insofar as this is possible given the middle-class western phenomenon of individual talking therapy as socially approved help). While the heterogeneity of the research literature sample led to some research-informed elements (client age, education, therapeutic alliance and experiencing emotions) being cancelled out of the framework due to contradictory findings, no contradictions arose between participants in participant-led elements, so none were cancelled out. It might be possible that a more heterogeneous participant sample could produce contradictory findings that cancel out some participant-informed elements.

It is possible that the homogeneity of the participant group led to a certain loss of individuality in their voices in the results chapter. There was considerable harmony across their narratives in terms of the elements and categories their interviews endorsed. None were found to report factors that were particularly outstanding from the rest of the cohort.

A further limit in the participant sample is that they all accessed counselling for help with debilitating and in some cases potentially life-threatening mental health problems. It could be argued that the ‘recovery trajectory’ these participants followed required a different kind of work – and thus results in a differently shaped client factors concept, than had they, for example, sought counselling for personal development.

**Limitation in scope:** There are doubtlessly other salient client factors that might belong on the detailed elemental level of the concept hierarchy that this study, given its limited data pools, did not pick up. Also, at the most abstract level, the key mediating super-factor ‘reflective and experiential learning’ may have been differently constructed had the participant sample been comprised of people with learning or communication difficulties. This study also does not consider macro-system political, economic, legal or cultural conditions involved in super-factor social resource enrichment or depletion. These are however extremely important considerations, particularly for counselling psychology theory, training and practice development, for example in the area of culturally informed work (Chung and Bemak, 2012). Lastly, this study does not specifically consider differential client factors that might be at work in group or couple therapy (see Perkins, 2010 for consideration of client factors in couple therapy).
CHAPTER 6: CONCLUSION
The conclusion is set out over two sections. In the first, I propose three contributions to knowledge offered by the concept reconstruction. In the second review the study’s results in relation to its aims.

6.1 Contributions to knowledge
This study contributes a provisional process model of client factors; a tentative adjustment to psychotherapeutic change process causal theory; and it introduces concept analysis as a potentially relevant methodology to advance theoretical research in counselling psychology. Each of these contributions is framed under a rubric of ‘risky territory’ as I will now explain further.

A provisional process model of client factors
This study’s main argument is that ‘client factors’ is an under-conceptualised term in psychotherapeutic literature. It requires a coherent theoretical structure to bring forth its meaning and ensure its grounding in lived experience. Based on my analysis and interpretation of participant reports and carefully selected research articles, this study presents a graphic concept framework and description that depicts a system client factors associated with process and outcome in psychotherapy. The model enhances the contextual clarity and definitional specificity of the client factors concept. A practical risk with this model, however, is its size. Its A3 format is not reproducible in any publication format (as the reader will observe in figures 15, 26 and 27 above). On the other hand, while the model is provisional due to its numerous limitations, it is unique in several ways. I touch on four here:

1. It is derived from open participant interviews, rather than questionnaires that force participants to confirm existing client factor theories (as in Thomas, 2006); or that ask about corrective experiences of therapy (as in Constantino and
Angus, 2017). The interview questions used here permitted participants to introduce and discuss factors that were evident and important to them (rather than factors that are important to therapists). This widened the client factors scope to include a diverse range of potent social resources that exert influence beyond therapy, as well as obstacles to achieving desired change.

2. Participant information is complemented with information from published research to enhance the pragmatic utility of the concept analysis (Penrod, 2007). Both types of data are considered valuable but in this study the participant data, as ‘muted group’ evidence (in line with study epistemology), formed the primary framework template against which the research evidence was compared.

3. Arranged over a conceptual hierarchy, the model offers ‘close up’ ‘midrange’ and ‘overview’ perspectives that could assist with further theorising about key mechanisms and stages in client change and non-change processes over time. In particular, it highlights the vital influence of social support before and during participants’ active change processes. It also highlights the role of social resource depletion that makes psychosocial change difficult.

4. The model positions therapy and the therapeutic relationship and learning resources, while client agency within therapy and wider social contexts as the primary driver of change.

**A tentative adjustment to change process causal theory**

A second contribution to knowledge is this model’s spotlight on the causal potentialities of client reflective and exploratory learning within social contexts. This in turn highlights that the experience of being supported with trust, solidarity and empathy may help people to make desired psychosocial changes, particularly where these relational resources are available outside therapy. Without the presence of these extratherapeutic resources there is a risk that for some clients, the effects of therapy may last only as long as therapy does.

Causal theory is risky territory for counselling psychology research (whether quantitative, qualitative, or mixed methods) because from a critical realist ontological standpoint, human intelligence may be unable to fully grasp causality, and can at best
only interpret its signs through faulty epistemologies and contestable concepts. So, through doing this study I have come to understand better how, in the words of philosopher Alan Watts, “your concepts will be attempts to catch water in a sieve” (1960, no page number). I may be no closer to knowing at the end of this work the reality of what client factors are, than I was at the beginning. I have however learned a tremendous amount about the representation of client factors. My learning is illustrated by the Stereo MCs lyrics that open this chapter: Nothing is set in stone, including the little flower with its roots deep in the soil in the rock crack, which this study commenced. We struggle to explain with words the rain and wind of life and relationships.

**Introducing concept analysis as a relevant method for counselling psychology research**

Abstract, complex or contested concepts represent epistemological quagmires: poor places to build a research project. Concepts that are vague and important require critical examination and meaningful reconstruction as a foundational step for any research. I have found concept analysis to be a helpful methodological tool for this job. I am puzzled why, when it enjoys a reputable position in nursing scholarship and social science (both disciplinarily adjacent to counselling psychology) concept analysis is not featured on counselling psychology’s standard menu of favoured qualitative research methodologies (for example, ethnography; empirical phenomenology; grounded theory; narrative, discourse and conversation analysis; protocol analysis; and thematic analysis, Creswell, 1998; Elliott and Timulak, 2005; Braun and Clarke, 2013; Finlay, 2015). Sartori (2009) asserts that because “thinking is language-wrapped” (p.101) concept analysis “plays a non-replaceable role in the process of thinking….At no stage of the methodological argument does…taxonomical unpacking lose weight and importance” (p.19). I worry that lacking a repertoire of critical concept analysis approaches on the ‘acceptable’ list of counselling psychology research methods we struggle to evolve concept-based theories in psychological therapy. This in turn risks counselling psychologists relying on 20th century individualistic theories and therapies that neither acknowledge nor tackle unequal access to social resources in the aetiology of psychosocial distress (Vermes, 2017).
Learning surprises

While the results are provisional and limited, the concept analysis process has proven to be gratifyingly effective for organising and representing the interrelationship of potentially powerful helpful and unhelpful client factors across planes of abstraction. I could never have imagined creating the resulting graphics when I started the study. However, my most important learning is the eye-opening relevance of Bandura’s social learning theory to my findings. Shockingly, given how long I have been a therapist and how many advanced trainings I have undertaken, I do not recall reading or being taught much, if anything, about Bandura’s theories prior to doing this study. Despite my previous ignorance of his work, the extensive mapping of Bandura’s theories to my concept framework may point to the enormous influence and absorption of Bandura’s theories into the zeitgeist of much counselling theory I have read over the past 25 years. The comprehensiveness and accuracy of the mapping also, for me, indicate that my framework is reassuringly ‘on the right track’ and makes me determined to read and rely on Bandura’s work more extensively in future.

6.2 Closing remarks: Results in relation to aims

In closing, I return to the concerns with which I opened the study. Bohart and Tallman (1996, 1999) asserted that the common factor that makes therapies equally effective, is the client working in a therapeutic relationship. With this study, however, I conclude that client work outwith the therapeutic relationship largely accounts for therapeutic outcome. People need generative, long-term and evolving learning relationships with people, places and cultures, not therapy per se, to be as well as possible. In closing their chapter Tallman and Bohart (1999) argue that “truly taking seriously the active, generative nature of how clients change in therapy would fundamentally re-structure how we view the process of therapy…Finally, researchers would focus their study on clients rather than on therapists” (p.119). Here, I have proposed that if we are to account for the active role of the client, we require theories about the mechanisms and purpose of therapy that centre on client factors. And if this theory is ultimately to improve therapy, we must not only conceptualise how the active client achieves change, but also why clients don’t manage to achieve change. This study has produced one
such conceptualisation of the ‘grand theatre’ of how people do, and don’t make desired psychosocial life-changes, in which psychotherapy and its practitioners are bit players amongst a large cast of more important characters. Wampold and Imel (2015) describe “the therapist as an agent of change and patients as active participants” in therapy (p.34). On the basis of participant narratives in this study I have played with reversing this proposition: Clients and their social resources are agents of change, while therapists may be active participants in limited ways for partial aspects of the process.
REFERENCES

References with an asterisk indicate those included in the concept analysis. Those with a double asterisk included client follow-up data.


APPENDICES

Appendix 1: Database search screenshots

Science Direct

PsycInfo

Step one

Step two
Step Three
Appendix 2: Primary study inclusion criteria

(a) quantitative, qualitative, mixed method outcome studies, meta-analyses or systematic reviews of outcome studies that identify client factors that mediate, moderate, predict or are otherwise associated with psychotherapeutic outcomes (no theory papers)

(b) dated 1960 or later

(c) published in English in a peer-reviewed journal, and freely obtainable through the University of Manchester library or Google Scholar

(d) participants aged 18+

(e) studies of treatment participants or completers (not predictors/mediators of early termination or drop-out)

(f) face-to-face therapy modalities including group, family, couples and individual psychological therapy (excluding on-line modalities)

(g) bona fide therapy and psychoeducation (excluding pure self-help)

(h) delivered by trainee or qualified practitioners

(i) inpatient, day patient, outpatient, community, home, educational and organisational settings

(j) clients in voluntary therapy (excluding people receiving mandatory or probationary treatment or those legally detained for mental health treatment)
(k) psychological or behavioural presenting problems including addictions
   (excluding health promotion therapy such as HIV programmes or pain
   management)
(l) client factor is demographic, behavioural, cognitive, emotional or experiential
   (excluding neurological, learning, communication or health conditions)
(m) client factor is a clearly defined personal variable (e.g. demographic
   characteristics), process variable (i.e. activity or learning initiated within therapy)
   or extra-therapeutic variable (e.g. events and circumstances) whose positive or
   negative effects (i.e. mediation, moderation, prediction, or other association) on
   outcome of the intervention were demonstrated through the use of recognised
   statistical methods in quantitative studies; or client quotes in qualitative studies
(n) the interaction between outcome and the associated client variable in
   quantitative studies was statistically significant to p < 0.05
(o) the predictor/mediator is a client-originating circumstantial, demographic,
   psychological, cognitive, or behavioural variable, not a variable that is dependent
   on therapy configuration, for example, client satisfaction with therapy. To further
   illustrate this distinction, for example where client marital happiness is a positive
   predictor for reduced risk of depression relapse, this is a client-originating factor;
   but where client minority status is a positive predictor of outcome only in therapy
   groups comprised of more than half minorities, this is a treatment process factor
## Appendix 4: Research data extraction spreadsheet

All column headings in data extraction spreadsheet

<table>
<thead>
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<th>Date of extraction</th>
<th>No. of P's</th>
<th>Setting</th>
<th>Significance of interaction b/w OM and predictor variables</th>
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<td>Inpt/day pt/outpt</td>
<td>Negative predictors</td>
</tr>
<tr>
<td>Included/excluded</td>
<td>% female</td>
<td>Staff profile</td>
<td>Positive predictors</td>
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<tr>
<td>Reason for exclusion</td>
<td>Mean age</td>
<td>Time points for OMs</td>
<td>Negative mediators</td>
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<tr>
<td>Authors</td>
<td>% Married/cohab</td>
<td>Type of design</td>
<td>Positive mediators</td>
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<td>Year of pub.</td>
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<td>Analysis</td>
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<tr>
<td>Title</td>
<td>% in employment</td>
<td>Primary OM</td>
<td>Positive moderators</td>
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<tr>
<td>Journal</td>
<td>Presenting issues</td>
<td>Outcome variable</td>
<td>Associated w/neg outcome</td>
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<tr>
<td>Issue, pages, DOI</td>
<td>Therapy model</td>
<td>Threshold of improvement</td>
<td>Associated w/pos outcome</td>
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<tr>
<td>Country</td>
<td>Therapy modality</td>
<td>Predictor OM</td>
<td>TA not assoc w/OM</td>
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<tr>
<td>Quant/qual/mixed</td>
<td># sessions/tx length</td>
<td>Predictor variable</td>
<td>TA assoc w/OM</td>
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</tbody>
</table>

### Screenshot of a portion of the research data extraction spreadsheet

- Green = excluded after full-text review
- White = included after full-text review – studies with no follow-up data
- Yellow = included after full-text review – studies including follow-up data
- Pink = column titles
<table>
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<th>Title</th>
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<th>Issue pages</th>
<th>Country</th>
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<th>Age</th>
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<th>Education</th>
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<th>Procedural guidelines</th>
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</tbody>
</table>
Appendix 5: Quality control exclusion criteria

(1) The predictive client factor was an aspect of the presenting problem, for example specific symptoms (e.g. avolition as a predictor of outcome in treatment for schizophrenia), because these conflate the independent and dependent variables in the causal argument.
(2) No therapy was mentioned; less than 3 sessions of therapy were provided; or length of therapy is not mentioned.
(3) The outcome and/or predictor variable or measures were not specified.
(4) The outcome or client variable was partially or wholly judged by the treating therapist, introducing unacceptably high risk of bias.
(5) The relationship between client factors and treatment, or client factors and outcome, was not discussed.
(6) Where studies by author(s) with same findings were already included.

Additionally in quantitative studies further exclusions were made where:

(7) Outcome or predictor measures were not named.
(8) Outcomes were measured using tests with disputed validity (i.e. Rorschach).
(9) Treatment comparison studies that found the predictor variable had differential effects depending on type therapy (indicating the client factor was confounded with a co-occurring process mediator).
(10) The predictor variable could not be sufficiently distinguished from a process variable, for example where a predictor was not a baseline measurement; or where a mediator represented a therapeutic technique (for example, mindfulness skills as a predictor of outcome in mindfulness-based cognitive therapy).
(11) The design (e.g. cross-sectional) or statistical analysis (e.g. simple correlation) inadequately explained the relationship between client factor and outcome.
(12) Time points for outcome measures were not provided.

Additionally, in qualitative studies further exclusions were made where:

(13) The analytic focus was on therapist not client action.
(14) The analytic focus was on the 'meaning of change' rather than participants' understanding of how they made change happen.
Appendix 6: Tests, variants and causal syntax chart for moderators

Moderators are qualitative or quantitative variables that influence the direction or strength of relationship between the independent and dependent variables in experimental psychological therapy studies (Baron and Kenny, 1986). Conceptually, moderators help identify for whom and under what circumstances therapies have different effects (Kraemer, Wilson, Fairburn and Agras, 2002). Moderators tend to be contextual factors such as client or therapist demographics, state/trait characteristics, competencies, enduring attitudes, or extratherapeutic events and circumstances.

In causal syntax, moderators exist prior to the commencement of the independent variables they interactively moderate, in the following order:

[Moderator A: Extratherapeutic, client or therapist state/trait characteristic] pre-exists the application of [Independent variable X: client and/or therapist therapeutic activity] and exerts [specific impedance or facilitation quality C in relation to a control or comparison group] on B’s potential to achieve [Dependent variable Y: outcome of interest]

Using variables from an actual study (Beutler et.al. 2011b) moderation causal syntax is illustrated here:
Tests for moderation

Baron and Kenny (1986) describe moderator data types as either continuous, for example age; or categorical, for example gender. It can however be argued that a variety of psychologically relevant observable human traits are categorised according to potentially oppressive, oversimplified, biased, irrelevant or value-laden social constructs. But for statistical purposes, tests for moderation where the independent and moderator variables are categorical or continuous are conducted using hierarchical multiple regression. Where both variables are categorical, ANOVA can be used. The significance of continuous data moderators can be calculated with single degree of freedom F-tests; and of categorical moderators with multiple degrees of freedom omnibus F-tests (Frazier, Tix and Barron, 2004). More detailed statistical procedures for moderator-outcome research can be found in Baron and Kenny (1986); Hoyle and Robinson (2004); and Frazier, Tix and Barron (2004).

Variants
Frazier, Tix and Barron (2004) describe three moderator interaction patterns: (a) ‘enhancing,’ where treatment (or other independent variable) and moderator effect the outcome in the same direction, and together lend a stronger-than-additive effect; (b) ‘buffering,’ where the moderator weakens the effect of the independent variable; and (c) ‘antagonistic,’ where treatment (or other independent variable) has the same effect on outcome but in the opposite direction. Hoyle and Robinson (2004) add a further interaction, (d) ‘crossover,’ where the independent variable has opposite effects on the dependent variable at the two extreme ends of the moderator's expression.

*Categorical moderators* are variables that have certain effects in certain therapies and not others. For example a client who likes observing and documenting their daily activities might gain more insight into how to change certain behaviours by doing self-monitoring in CBT, than might someone who finds self-monitoring difficult or boring. *Continuous moderators* are variables that have the same effects regardless of the type of therapy. For example a client who has a firm belief that God loves him may be emotionally protected by this in difficult times regardless of secular theories of change his therapist might offer him.

The trajectory of moderator effects might be described as ‘linear’ (i.e. increase in effect is proportional to increase in application of the moderator); ‘quadratic’ (i.e. moderator effects are compounded either by time or strength of application); or ‘stepped’ (i.e. time or strength of application yields a smaller then larger effect, or vice versa) (Baron and Kenny 1986).

**Causal syntax charts**

The following chart shows illustrative examples of moderator relationships from four actual studies.

<table>
<thead>
<tr>
<th>Study</th>
<th>A. Moderator (pre-existing circumstance that impacts relationship between B and D)</th>
<th>B. Independent variable (input element)</th>
<th>C. Direction or strength of moderator impact</th>
<th>D. Dependent variable (measured outcome of interest)</th>
</tr>
</thead>
</table>

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Example 1: Beutler et al. 2011b
Therapist directiveness [Therapist factor]
Client reactivity [Client factor]
Facilitates Client tardiness for appointments

Example 2: Lorenzo-Luaces, DeRubeis and Webb, 2014
Number of previous depressive episodes [Client factor]
Therapeutic alliance [Process factor]
Reduces Depressive symptom change

Example 3: Burns and Nolen-Hoeksema, 1991
Client willingness to learn new coping strategies [Client factor]
CBT for affective disorders [Therapy factor]
Enhances Degree of improvement in mood

Example 4: Leibert, Smith and Agaskar (2011)
Level of social support [Extratherapeutic factor]
Lower initial symptom level [Client factor]
Slows Change in symptom level

Appendix 7: Tests, variants and causal syntax chart for mediators
Mediators are transformational mechanisms which are activated or changed by events in the therapeutic process in a way that at least partially accounts for the outcome of the therapy. Some researchers define mediating processes as correlated with treatment type, and that mediators are of necessity treatment effects (e.g. Wilson, Fairburn, Agras, Walsh and Kraemer, 2002). However other researchers allow for mediators to represent client response or activity in relation to treatment effects (e.g. Berking, Neacsiu, Comtois, and Linehan 2009), such as cognitive (e.g. insight), emotional (e.g. dissonance) or behavioural factors (e.g. task diligence) (Baron and Kenny, 1986) that offer explanatory value about why therapy works (Johansson and Høglend, 2007).

Descriptions of mediation should explain the relational role of the mediator between relevant variables, for example, “early homework compliance mediates the relationship between expectancy for anxiety change and initial change in CBT” (Westra, Dozois and Marcus, 2007, p. 363). Descriptions should also indicate that mediation occurred prior to outcome, thereby ensuring that the mediator was a result of therapeutic activity.
Building on the A-X-C-Y causal sentence developed in Appendix 6 above, mediators are introduced as follows:

[Moderator A: Extratherapeutic, client or therapist state/trait characteristic] pre-exists the application of [Independent variable X: client and/or therapist therapeutic activity]. Moderator exerts [specific impedance or facilitation quality C in relation to a control or comparison group] on X’s potential to promote [Mediator D: client transformational thoughts, feelings and behaviours] which partially or completely cause [Dependent variable Y: outcome of interest]

It is important to note that the syntax above is idealised. The impact of moderators and mediators are not commonly examined in the same study, although they undoubtedly simultaneously exert influence on each other and on outcome. The syntax diagram shown here is not based on a specific study:

Lemmens, Muller, Arntz and Huibers (2016) explain various difficulties in demonstrating causal relationships between change in the mediator and change in outcome. Where researchers describe a mediator only in relation to its outcome but not the antecedent
variable it mediates, the relationship is predictive rather than mediating. The majority of quantitative studies included in this concept analysis describe a predictive relationship between independent and dependent variables. Only 9.5% (n=6) identified mediators of change and, interestingly, none identified moderators.

Tests for mediation
Tests of mediation are generally carried out via multiple linear (for quantitative measures) or logistic (for binary measures) regression analyses; multiple regression over four steps, or structural equation modelling. These methods are explained in detail in Frazier, Tix and Baron (2004). In order to establish that change in the mediator precedes change in the outcome it is important that mediator and outcome are assessed at multiple points in therapy, not just pre-and post (Johansson and Høglend, 2007).

Mediation is suggested if (a) outcome is significantly related to treatment; (b) treatment is significantly related to changes in the mediating variable; and (c) the relationship between treatment and outcome decreases or goes to zero when change in the mediating variable is entered into the equation (Baron and Kenny, 1986; Dingemans, Spinhoven and van Furth, 2007).

Variants
While moderators and mediators have distinct and separate roles in influencing outcomes, Frazier, Tix and Barron (2004) describe two ways mediators and moderators can interact in certain circumstances: moderated mediation, and mediated moderation.

In moderated mediation, a mediated relation between input and outcome varies across levels of a moderator. Using smoking cessation in this fictional example, the moderator is client quit-self-efficacy based on the number of previous failed attempts to quit. The client undertakes a group-based smoking cessation programme (the input). One of the treatment mediators is social encouragement to quit provided by group members. The higher the number of previous failed quit attempts, the less beneficial impact social encouragement has on the client, and the lower the likelihood of permanent abstinence.
In mediated moderation, a mediator variable accounts for the relation between the moderator and outcome. Reusing the smoking cessation example where the moderator remains the client’s quit-self-efficacy based on number of previously failed attempts, another mediator in the group programme is targeted self-efficacy enhancement techniques, which interacts with the moderator's influence on smoking abstinence (de Hoog, Bolman, Bernt, Kers, Mudde et.al., 2016).

**Causal syntax charts**

The following chart shows illustrative examples of mediator relationships from actual studies.

<table>
<thead>
<tr>
<th>A. Moderator (pre-existing circumstance that facilitates or impedes B's impact on D and thus E)</th>
<th>B. Independent variable (input element)</th>
<th>C. Direction or strength of moderator impact on Mediator D</th>
<th>D. Mediator (client thoughts, feelings and behaviours arising or changing as a result of therapy that partially or completely cause E)</th>
<th>E. Dependent variable (measured outcome of interest)</th>
</tr>
</thead>
</table>
Example 3: Moscovitch, Hofmann, Suvak and In-Albon (2005)

<table>
<thead>
<tr>
<th>Passage of time</th>
<th>Change in social anxiety</th>
<th>Change in depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Extratherapeutic factor]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Example 4: Teasdale et.al. (2002)

<table>
<thead>
<tr>
<th>Cognitive therapy and mindfulness cognitive therapy [Therapy factor]</th>
<th>Change in accessibility of alternative perspectives</th>
<th>Reduction in risk of relapse</th>
</tr>
</thead>
</table>

In Example 4 (Teasdale, et.al. 2002) low meta-cognitive awareness is a moderator of outcome which is directly addressed by the mediator, but the researchers do not discuss or analyse its moderating impact on outcome, only the possible mediating impact of improving this in therapy.

Appendix 8: Tests and causal syntax chart for predictors

Tests

Predictors are calculated using multiple regression analyses. Predictors should be measured at least at the outset and end of therapy.

Causal syntax charts

The following chart shows illustrative examples of types of predictors from actual studies.

<table>
<thead>
<tr>
<th>Study</th>
<th>Predictor variable</th>
<th>Type of therapy</th>
<th>Time predictor was measured</th>
<th>Function of correlation</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example 1: Kindt, Buck, Arntz and</td>
<td>Conceptual processing [client skill]</td>
<td>CBT Imagery Rescripting for PTSD</td>
<td>Pre- and post-treatment</td>
<td>Positive</td>
<td>Decrease in PTSD symptoms after therapy</td>
</tr>
<tr>
<td>Example 4: Rounsaville, Weissman and Prusoff (1981)</td>
<td>Psychotherapy techniques exploratory, reflective and directive [Therapy factor]</td>
<td>Psychotherapy for depression</td>
<td>Pre-therapy and at 16 weeks after commencement</td>
<td>Zero</td>
<td>Improvement in depressive symptoms</td>
</tr>
</tbody>
</table>
Appendix 9: Participant recruitment poster

Study on how people make counselling work

- Are you aged 18+?
- Will your counselling finish in May, June or July 2016?
- After your counselling is finished, are you interested in confidentially sharing with a researcher your experience of desired changes happening or not happening?

If you answered YES to these questions, you may be eligible to participate in a Counselling Psychology doctoral research study.

The purpose of this research is to learn directly from counselling clients how and why they were able (or not able) to make desired changes in life. And to explore personal and social factors that can be helpful and unhelpful when trying to make desired changes in life.

Research interviews take approximately 30-60 minutes of your time and will be held at Oakwood House, Davenport. You will need to spend a further 15-30 minutes reviewing the researcher’s transcript/analysis of your interview sometime after your interview.

If you are eligible to participate you will be given a participant information form and a list of questions to think about in advance of your interview. Your informed consent will be obtained before commencing. Some demographic details will be collected.

Contact: This study is being conducted by Caroline Vermes, MA, M.Ed, MBACP (Accred.) who is undertaking the Doctorate in Counselling Psychology at University of Manchester. You can contact her at caroline.vermes@postgrad.manchester.ac.uk. Alternatively speak to your therapist who will pass on your details to the researcher.

Ethical approval granted by University of Manchester Institute of Education
Appendix 10: Participant information sheet

Personal and social factors associated by clients with change and non-change since the commencement of therapy

Participant Information Sheet

You are being invited to take part in a research study as part of a student project on the Doctorate in Counselling Psychology. Before you decide to participate it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

Who will conduct the research? Caroline Vermes

Title of the Research: Personal and extratherapeutic factors associated by clients with change and non-change since the commencement of therapy.

What is the aim of the research? This study is designed to explore and analyse how psychological therapy clients describe their own efforts to make desired changes. It aims to understand how and what personal and social resources clients use to help themselves; and what sorts of obstacles clients describe as getting in the way of making desired change. The study seeks a better understanding of how clients work towards therapeutic outcomes. The results may ultimately seek to extend theory about client agency. This will help educate practitioners so they can adapt therapy to identify, work with and support client self-healing capabilities; and understand and address barriers to well-being.

Why have I been chosen? You responded to an invitation to participate. You may have been selected on the basis of demographic characteristics requested in the call for participants.

What would I be asked to do if I took part? You will take part in a confidential interview for 30 - 60 minutes with the researcher about recent desired changes you may and may not have made in your life. About a week in advance of your interview, to help you prepare, you will be sent a short list of questions to think about. Your thoughts about these questions will be discussed in the interview. Afterwards, within 12 months of your interview, you will also be asked to read and comment on a summary of the researcher’s analysis of the anonymised information you and others have shared. This is likely to happen over email so you will be asked to supply an email address that you access regularly. If you do not use email, another communication method will be agreed with you. Reading and commenting on the research summary may take 15 – 60 minutes depending on how much time you want to give it.

Are there any risks if I participate? There is a small chance some participants may become upset when discussing their thoughts about the research questions. This could happen before, during and/or after the interview. It may be related to thinking about or describing any difficulties encountered when trying to make desired changes in life. The researcher will check this with you in the interview. You will be given contact details for support services, along with the researcher and research supervisor’s contact details, should you need to further discuss your reactions to participating in this research.

What happens to the data collected? The interview will be digitally audio-recorded by the interviewer. The audio file will be stored on securely encrypted memory stick that can only be accessed by the researcher. The recording will be transcribed and anonymised. Transcripts will be analysed by the
researcher for salient themes. The audio files will be kept securely in electronic storage for up to 5 years by the researcher then will be permanently deleted by the researcher.

**How is confidentiality maintained?** Participant identifying information will be anonymised upon transcription. This means any personal information you share in your interview that could identify you will be removed before the data is analysed. Basic demographic information including gender, age range, ethnicity and education will be attached to the transcript for differential analysis purposes. The information you share with the researcher is confidential. The researcher cannot disclose to anyone that you participated in the research. However, if you disclosed in your interview any information that suggested that a child or adult was at risk of neglect or abuse, the researcher would have an ethical responsibility to report some details to the appropriate authority. Quotes from your interview may be used in the final write up to illustrate themes or other important findings. These quotes will not include any personal information that could identify you.

**What happens if I do not want to take part or if I change my mind?** It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw up to the date that data from your interview transcript is entered into analysis software 30th September 2016.

**Will I be paid for participating in the research?** No

**What is the duration of the research?** 1 x 30-60 minute interview. Then, within 12 months of your interview you will be sent one or two follow up emails asking for your comments and views on the work. This may take 15-30 minutes depending on how much time you want to spend on it.

**Where will the research be conducted?** By prior arrangement at Oakwood House, 104 Kennerley Road, Stockport, SK2 6EY

**Will the outcomes of the research be published?** This research may be submitted for publication. It may also form background research for further research which may be submitted for publication.

**Criminal Records Check (if applicable)** DBS clearance has been obtained on behalf of the researcher by the University of Manchester.

**Contact for further information** Caroline.vermes@postgrad.manchester.ac.uk

**What if something goes wrong?** If there are any issues regarding this research that you would prefer not to discuss with Caroline Vermes, please contact the research supervisor Terry Hanley on 0161 275 8815 or terry.hanley@manchester.ac.uk. If there are issues with the research you wish to discuss with the researcher, please contact Caroline Vermes on 0786 333 7965 or caroline.vermes@postgrad.manchester.ac.uk.
Appendix 11: Interview schedule

Form A:

1. Please describe one positive or desired change that has happened in your life since you started therapy

2. Why do you think this change happened?

3. Please describe one thing that hasn’t changed in your life as you hoped since you started therapy

4. Why do you think this change did not happen?

Form B:

1. Please describe one thing that hasn’t changed in your life as you hoped since you started therapy

2. Why do you think this change did not happen?

3. Please describe one positive or desired change that has happened in your life since you started therapy

4. Why do you think this change happened?
Appendix 12: Participant consent form

CONSENT FORM

If you are happy to participate, please read, tick the boxes and sign the consent form below:

1. I confirm I have read and understand the attached information sheet about the above study and have had the opportunity to consider the information. I have had the opportunity to ask questions and have had these answered satisfactorily

2. I understand that my participation in the study is voluntary and that I am free to withdraw at any time up to the stipulated deadline without giving a reason

3. I consent to my therapist passing my contact details to the researcher

4. I understand that the interviews will be audio-recorded

5. I agree to the researcher creating an anonymised transcript of the audio-recording

6. I agree to the transcript being subject to research analysis

7. I agree to anonymised quotes from my interview appearing in written versions of the study

8. I agree that any data collected may be published in anonymous form in academic books or journals

I agree to take part in this project

_________________________________  _______________  ____________________________________
Name of participant                     Date                     Signature

_________________________________  _______________  ____________________________________
Name of researcher                      Date                     Signature
Appendix 13: Transcript portion
[blue highlighted text included in concept analysis]

CV: So to kick off the interview [P4] is there anything in particular that hasn’t changed as you hoped it might, since you’ve done your therapy?

P4: So yeah, I’ve had a think about this, they’re quite probing questions actually. The main thing...is it okay to start with a bit of background about me?

CV: It certainly is. And only go as far as you want to with anything that we’re talking about.

P4: Okay. So I was referred through to [service A] by my GP because for quite a long time I’ve had probably underlying [D3] and [D2] issues. So, I’ve had quite a lot of change over the past few months. So I decided at the start of the year that I would need...that I probably needed some additional support to try and break the cycle for good. Because I’ve been through cycles of counselling etcetera before and possibly not taken it a seriously as I should have done, or given as much into it as I should have done in the past. So, (sigh) but off the back of that, having come for therapy or counselling to tackle [symptom of D3] and the associated [D3], the main thing that hasn’t gone as well as I want was the overcoming [D2].

So I still don’t think that I manage that particularly well. And I think I still have times when I feel quite overwhelmed with that feeling of anxiousness. And I’m hoping with time, because I, trying to think when I started with [therapist 4A], it was maybe back in March? And I think...at the time, yeah, it’s probably got a little bit better. But not to the extent that I would have hoped it would have done. And I’m hoping now my one-to-one sessions have stopped with [therapist 4A] I’ll go into group sessions for overcoming [D2] and that will potentially help tackle that a little bit more head on. And also dealing with interacting with other people that have similar issues might actually be quite useful for me because I’m a bit of a “heart on my sleeve” type of person. So, I like to talk things through. So I think that...and bounce off other people, so I do think potentially that will be maybe a more conducive environment to help me get a better balance over those issues. But I think certainly that would be the one key thing for me, that.

CV: So reduce [D2], overall, that would be something you would hope to have gotten out of therapy, and feel like you still got a ways to go with that.

P4: yeah, yeah, maybe I put too much of an expectation on what I’d hoped to achieve. And maybe it...I think part of it is untangling the two issues, although they are very interlinked. I think that, yeah, the
[D2], I’d hoped that that might... because I’d always explain my [D2] on (clicking fingers) causing the [D3]. So, almost like the emotional crutch. So I’d have hoped, and it’s been weird in some sense because, I’ll come onto why, the thing that has got better, that my [D3] is more under control, but my [D2] is still quite high.

CV: Yes, yes. So you untangled them.

P4: So that’s a good thing, which I’ll talk a little bit more about later. So I think I’ve been able to separate the two issues which have been good. But the one that’s benefitted the most over what, the past four-five months, is the [D3] side of things. The bit that’s still quite bad for me is the [D2].

CV: Do you have any thoughts about why the [D2] is still as bad as it is at this point?

P4: yes. So I think it’s because I’ve had quite a lot of transition recently. I’ve been, I’ve changed roles recently. I probably put myself under an awful lot of pressure both from an academic and from a professional point of view. I’ve just moved into quite a senior role. And having left, I was with [previous workplace], I left [previous workplace] after seven and a half years. So it’s where I grew up, [previous workplace], from when I graduated. So it’s been quite a big step for me to leave that support network behind. And moving somewhere that’s completely unknown, and operating at a higher professional level. I think almost because of those pressures that have been put on, that’s probably kept my [D2] up here (demonstrating with hand). And maybe had I not gone through that at the time I’ve been going through therapy, at the moment I may not have had, it may have come down, but I don’t know.

CV: It may have come down but you don’t know. But you’re certainly thinking that the therapy coinciding with this significant change in your workplace social support, and your workplace expectations may have something to do with the [D2] being still quite profound?

P4: Yeah. I think so. I think, well, I haven’t learned yet to be able to drop the expectations that I have on me. And again, that’s compounded by the fact that (clicking fingers) I want to be able to perform well and create a good impression where I’ve gone. So that’s I think, part of the...it’s all tangled up, but yeah. And I haven’t learn to re-programme yet. My, almost setting my expectations of myself lower. Not that necessarily anyone else has that high expectation of me.

CV: Okay, yes. So you see this as coming actually from inside of you, that even though you’ve been through these external changes, leaving [previous workplace], starting your new job, that there’s something going on within you that you want to recalibrate.
P4: Yes. And I think I struggle with that, and I don’t know why. I think that I’m a quite practical person generally. But it’s something that, I don’t know, I’m scared of failing but then I set myself up to fail. Which is probably (laughing) where the [D2] comes from!

CV: (laughing) But you push yourself to, or your expectations are so high that then there is a chance that you might not meet them. And then that causes more [D2].

Appendix 14: Transcription considerations
I gave considerable thought ‘for and against’ replacing references to formal diagnostic terms participants used to describe problems they sought counselling help for (such as ‘depression,’ ‘anxiety,’ ‘bulimia’ and so on). There were several reasons I wanted to replace diagnostic terms with codes. A practical reason was to enhance participant anonymity. An epistemological reason was that this research is expressly not about understanding how therapists work with clients with particular diagnoses - a focus that I believe serves the politics and economics of the psy-professions. I did not want readers, likely to be psy-professionals, to be tempted to make assumptions about the participants’ therapeutic journeys, based on particular knowledge and views about specific diagnoses and their treatment. Ideological reasons to replace diagnostic terms is that they may obscure the contexts in which my female participants described their efforts to overcome health and emotional difficulties (Porter 2002); or may pathologise common female responses to demanding maturational journeys (Chesler, 1972; Brown, 1994). Removing diagnostic terms could assist my intention to contribute to theory about the complexities of people’s efforts at life improvement “beyond the individualizing and pathologizing force of psychological categories” (Farley, 2017).

On the other hand, I also had two reasons not to replace participant references to diagnostic labels. The first was that even with diagnosis terms removed, there was sufficient description in most interviews of participants’ symptoms and therapeutic goals that diagnoses might be guessed by a psychologically trained reader. Additionally, all participants chose to name at least one diagnosis without any prompting from me, and chose to describe their experience of its impact on their life, so I questioned my use of authorial power to obscure terms that were clearly important to participants.
I ultimately opted, on the balance of arguments above, to replace diagnostic terms with coded descriptors. No participant commented on this in their transcript check.

The final transcripts were not wholly verbatim documents. I made three significant modifications from the spoken to written words of the participants:

A. Locally accented pronunciations were transcribed in standard written English, for instance the spoken term, “It sounds good that, dunnit?” was transcribed as “It sounds good that, doesn’t it?” On the other hand, local sentence structure and word choice were unaltered, for instance, “It were wrote all over her face.”

B. Participant speech fillers were removed, including “um” and “you know.” “Sort of” and “kind of” were removed where they were qualifiers that did not change the meaning of the words they preceded; but they were kept where they indicated “a type of something.” “Like” was removed where it acted as a filler, for example ‘Do you mean you, like, didn’t stop at the red light?’ However, it was retained where it was a preposition meaning “for example;” where it was an adjective meaning “similar;” where it was a verb indicating “finds agreeable;” or where it indicated the participant’s introduction to retelling someone else’s speech, for example, ‘My sister was like, ‘Are you coming down the pub with us?’’ Response tokens such as “yes” and “mm-hmm” were also removed from my interjections where they were simply given as encouragement to participants’ narrative, or indicated that I was following what they were saying.

C. Punctuation was added. Where a participant spoke in run-on sentences, these were broken down to briefer segments. For example, the following transcribed text from Participant 4 was actually spoken as one sentence: ‘I probably put myself under an awful lot of pressure both from an academic and from a professional point of view. And I’ve just moved into quite a senior role. And having left…I was with [previous workplace], I left [previous workplace] after seven and a half years. So it’s where I grew up, [previous workplace], from when I graduated. So it’s been quite a big step for me to leave that support network behind. And moving somewhere that’s completely unknown, and operating at a higher professional level.’ While adding punctuation I was careful to retain the
meaning and substance of what was said in the conversations, and to be respectful of participants’ intentions at all times.

Interview texts were tidied or “denaturalised” (Oliver, Serovich and Mason, 2005, p.1277) in this way for two reasons. First, I was interested in what people said about their experiences, thoughts, beliefs, feelings and actions, rather than the mechanics of how they said it. As I planned to include that a substantial number of participant quotes in my findings and analysis chapters, the addition of punctuation and removal of filler words improved the readability of the text (Kvale, 2007). Secondly, this editing was intended to make reading their transcripts more agreeable to participants. My decision to edit the text this way was reinforced when I sent the first transcribed interview to Participant 1 as a completely unredacted verbatim document. In her reply, she expressed disbelief that the transcript accurately replicated her speech patterns: ‘There’s one thing that jumps out at me, which is all the ‘um’s’ and ‘kind of’s.’ At first I thought maybe I just wasn’t aware of how much I said it.’ I did not want to inadvertently adopt a position of ‘academic power’ over my participants by presenting them with transcripts that could distract them from checking that I’d accurately transcribed their narrative; or worse, that could cause them dismay about their conversational speech patterns. “Our scholarly representations of those performances, if not sensitively presented, may constitute an attack on our collaborators’ carefully constructed sense of self” (Borland, 1991, p.71). I explained to P1 I would remove the filler words. After this, I tidied each text as above before sending completed transcripts to the remaining participants.

Addition of descriptive statistics and key attributes to transcripts

- Date of interview
- Length rounded to the closest minute
- Total word count
- Words per minute (combined speakers)
- Number of participant mentions of different types of helping professionals and services (to assist with analysis of how self-directed versus professional-directed participants were)
Appendix 15: Interview summaries

1. Dana 6732 words 48 mins (140.25 wpm) 06.06.2016

The change in practical terms:
Sleeping well
What brought this about?
[Attended counselling, used self-help materials]
Sleep inducing medication
Not watching t.v. before bed
Trying not to worry
Confidence arising from landing the perfect job
Yoga
Homeopathy
Got to a really bad place – calling Samaritans

The non-change in practical terms:
Sexual intimacy with partner
Obstacles to change?
[relative]
History of health issues
Negative change in self-image
[relative]

2. Ella 8886 words 50 mins (177.72 wpm) 16.06.2016

The change in practical terms
No more D3 behaviour
Growing the angel, reducing the devil
Stopped dependence on others pushing me. Doing it for myself and others
What brought this about?
[Attended CBT, service A programme, participating in a combination of modalities]
Got to a really bad place – coma
Not let things bother me
Taking better care of self, thinking more clearly
Changed my goals from unrealistic to healthy
Journaling to understand personal susceptibilities
Change in ‘mindset’ (CBT language)
Pushing myself out of (dis)comfort zone to go out socially
Diversion from upsetting thoughts
Setting self-limits
Becoming part of the group
Being loved and needed
Family party
Awareness of ageing process, time ticking, need to be a grown up
Seeing others not getting better; not wanting to be like others
Creating a different version of me
I have to pick myself up rather than relying on others
Stopping avoiding taking care of myself by over-doing for others. Caring more for others by taking better physical and emotional care of myself

The non-change in practical terms
Still experiencing symptom of D4

Obstacles to change?
This won’t change, I’m stuck with this (it’s not a treatment shortcoming)
Had [D2] since I was a child
Resignation/acceptance that I might be stuck with this

3. Luka 4113 words 30 mins (137.10 wpm) 14.07.2016

The change in practical terms
In remission from disease
Self-acceptance
What brought this about?
[Attended CBT, analytic and online therapy, support group and used self-help materials]
Decision to just deal with it
Got to a really bad place – emergency GP
Asked sister if I was ill and she said yes
Sought help from a range of sources
It just happened naturally, subconsciously; but also through application of “techniques” e.g. goal modification to more realistic self-care

Non-change in practical terms
Underlying issues unchanged

Obstacles to change
Sporadic attendance
I was distracted, not focussed in sessions, did not know what to say
No in-person relationship with therapist


The change in practical terms
Separating D2 from D3 as different problems to work on

What has brought this about?
[Telephone and online counselling an advantage as not “fluffy,” helps contain emotion]
Realising I need to make life changes – frustrated with the unwell cycle
Wanting the option to have children
Not wanting to lose relationships with loved ones especially partner
I don’t want to be defined by a problem that has caused multiple emergency hospitalisations (don’t want to seem vulnerable)
New job, need to be my best
Seeing the problems as a “snappable cycle”
Going to the GP as an entry point
Self-monitoring and reflective learning

Non-change in practical terms
D2 not reduced enough

Obstacles to change

Difficult to change “habits of a lifetime”
Still need to understand and explore causes of D2
Think a group might help better than 1:1
Higher professional expectations in new job
High personal expectations
I’m scared to fail but then set myself up to fail

5. Lucy 7654 words 51 mins (151 wpm) 17.08.2016

The change in practical terms

Getting passion for life back
Getting relationships with friends, family and husband back.

What helped bring this about

Realising I’d become isolated and lonely due to D1
Fear of losing relationships/wanting to preserve relationships
Sharing problems with others; allowing others to help
Seeing I have a choice how to behave, how to look after myself
Physical health deterioration – health crisis
Friends interested in psychology
Self-reflection
Taking ownership of recovery
Reading recovery stories, other people’s experiences in print
Other people’s experiences – known friends
Use of social media support groups
Switching/converting drive for illness to drive for wellness
Using certain character traits as a force for good rather than a force for self-destruct e.g. goal-oriented; perfectionistic; stubborn
Facing the problem; stopping denial; challenging myself to change old habits and beliefs
Turning point: Friend wanting to talk to me about the problem. Going to the GP

Non-change in practical terms
Not overcome D4

Obstacles
Complacency
Denial
False sense of security due to some improvement
The D4 still is strong in my thoughts and feelings
Fear of the unknown

6. Zoey 6609 words 51 mins (129.59 wpm) 22.08.2016

The change in practical terms
More self-awareness. Understanding why I react certain ways and why I have behaved certain ways in the past. Understanding how D2 has been present in my life. Seeing D2 as a problem and isolating it from other issues

What helped bring this about
[Opening up to therapist and trusting them after a difficult start; using CBT techniques]
Confiding in friends.
Reading The Empathy Trap.
Put things in boxes and label them
Online support group
Reflective-autobiographical writing in blog

Non-change in practical terms
How people hurt me and how I react to this in a childlike way – I just put it to one side and keep going.

Obstacles/perpetuators
Friends hurt me. They don’t know how to react to my disclosure about abuse.

Negative reaction to blog
Not being able to trust my friends
Being lonely
7. Thea 5656 words 38 mins (148.84 wpm) 31.08.2016

Change in practical terms

Happier

Going to Uni

Self-worth improved

What helped bring this about

[Got on well with therapy team and TS2 therapist]

Met gf on Tinder

She made me happier

I trusted her so could accept her compliments which improved how I felt about myself

Physical activity club made me feel strong and capable, sense of mastery

Extended social life though physical activity club

I took therapy more seriously – I was ready – I asked to practice known CBT techniques

Non-change in practical terms

Motivation to do routine self-care activities and domestic maintenance (making bed, drawing curtains)

Obstacles/perpetuators

This goal wasn’t the focus of therapy, not what I was referred for, not a pressing health issue

Family did not acknowledge D1 as a problem for me

8. Lily 8037 42 mins (191.35 wpm) 06.09.2016

Change in practical terms

[Improved D3 through CBT techniques and therapist instructions]

Realising relationship with [exercise] isn’t healthy. Realised there are other things in life. Don’t want to worry about it any more

More confident

Moving to [English city 1]: fresh start, getting away from environment that reminds me of being ill. Hope of establishing new routine

What helped bring this about

Planning ahead. Weekly lists. Awareness of perfectionism and how it works. Internalised therapist tells me how to respond
Pie chart of self-evaluation

New job

Non-change in practical terms

Still bothered by D3 and feelings. Hoped they would go away completely.

Obstacles/perpetuators

2 months of therapy isn’t enough to help me change thoughts and feelings. All it can do is help me change how I can react. I have innate traits i.e. perfectionism and inner competitiveness that I have to learn to channel the right way. D3 voice – how to disentangle that from an activity I love and that defines me.

9. Esme 8730  62 mins (140.84 wpm) 07.02.2017

Change in practical terms

Relaxing over-self-control without letting go completely

What helped bring this about

[therapist helped me realise I was too controlling. She didn’t mollycoddle me. She pushed me]

Giving some control over housework to bf and generally being less controlling with him

Pushing myself out of my comfort zone

Getting impatient with myself

Trusting bf’s view of the problem and its effect on our relationship

Reducing self-absorption, improving empathy

Seeing myself through others eyes – adjusting self-perception

Not being able to deny impact of behaviour on health

Aiming to help a friend then realising I should take my own advice

Non-change in practical terms

Nothing. But I regret having gone through this experience. It wasted part of my life and didn’t make anything any better

Obstacles/perpetuators

Culture makes women discontented with themselves
Appendix 16: Entire interview data spreadsheet

Appendix 17: Example ephemeral reflective notes page
Appendix 18: Example of peer debrief meeting minutes

Thesis progress meeting

Online meeting minutes Wed 26/09/17

Chair: [redacted]
Minutes: [redacted]
Attended: Caroline, [redacted], [redacted]
Apologies: [redacted]

Caroline:
- ‘Old’ intro chapter now split into more usual format intro + short lit. review.
- Meeting with Terry on Tuesday 03/10
- Methodology needs some more work, but not re-opened yet.
- Submission planned in May

Aims: next week 04/10/17
- Complete both intro and lit review complete for the meeting with Terry (by Monday)
- Restart the methods chapter

[remainder of minutes redacted]

Next meeting

Proposed time Weds 04/10/17, 10:30am
Appendix 19: MIE Approval emails
Ethics Education

To:
Caroline Vermes
Cc:
Terry Hanley

Inbox

Tuesday, November 24, 2015 10:28 AM

Dear Caroline

Ref: PGR-7232175

Project Title: Personal and extratherapeutic factors associated by clients with change and non-change since the commencement of therapy.

I am pleased to confirm that your ethics application has now been approved by the School Research Integrity Committee (RIC) against a pre-approved UREC template.

If anything untoward happens during your research then please ensure you make your supervisor aware who can then raise it with the RIC on your behalf

This approval is confirmation only for the Ethical Approval application.

Regards

Georgia Irving

minor MIE ethics change

Terry Hanley

Actions

To:
Caroline Vermes

Tuesday, March 08, 2016 11:58 AM

For info – your thesis change is approved

Terry

Dr Terry Hanley CPsychol AFBPsS | Senior Lecturer in Counselling Psychology | Ellen Wilkinson Building, A6.15 | University of Manchester | Oxford Road | M13 9PL | tel: +44 (0)161 275 8815 | email: terry.hanley@manchester.ac.uk (preferred contact) | skype: terry.s.hanley | @DrTerryHanley [personal twitter] @UoMCounsPsych [programme twitter]
Appendix 20: Adverse event flow chart

**Interviewee discloses adverse experience at OPS**, e.g. sense of being insufficiently helped; sub-optimal experience with therapist, type of therapy offered, admin, context of service provision etc.

- **Researcher suspends or abandons research interview. Researcher offers apology. Ascertains if this adverse experience was reported to staff within the service (e.g. to the therapist, on the feedback form)?**
  - **YES**
    - In this case the feedback will have been considered for action/response. Did interviewee receive a response?
      - **YES**
        - Was the response satisfactory?
          - **YES**
            - No further action required. Researcher ascertains whether interviewee wants to finish interview.
          - **NO**
            - Researcher considers, based on info given, if BACP 2016 ethical guidelines might have been compromised
    - **NO**
      - Would interviewee like this issue to be investigated further?
        - **YES**
          - Researcher explains that an anonymised ethics review will be undertaken by the OPS clinical leads. Apologies for the situation and addresses any concerns. Ascertains whether interviewee wants to finish interview.
        - **NO**
          - No further action required. Researcher apologises for the situation. Ascertains whether interviewee wants to finish interview.
### Appendix 21: Client factors in Castonguay and Beutler (2006)

<table>
<thead>
<tr>
<th></th>
<th>Dysphoria disorders</th>
<th>Anxiety disorders</th>
<th>Substance misuse</th>
<th>Personality disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>Age of adult clients is inversely related to the quality of outcome</td>
<td>Evidence that age has no prognostic value</td>
<td>Better outcome associated with abstinence-based social support for adolescents</td>
<td>Not assessed in Castonguay and Beutler (2006)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>Young male clients more likely to drop out</td>
<td>Mixed evidence favouring the conclusion that gender has no prognostic value</td>
<td>Mixed and contradictory evidence</td>
<td>Insufficient evidence</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td>Insufficient evidence</td>
<td>Evidence that ethnicity has no prognostic value (further research recommended)</td>
<td>Insufficient evidence</td>
<td>Not assessed in Castonguay and Beutler (2006)</td>
</tr>
<tr>
<td><strong>Socioeconomic status</strong></td>
<td>Clients from lower SES more likely to drop out</td>
<td>Clients from lower SES more likely to drop out</td>
<td>Employed clients have better outcomes</td>
<td>Clients from lower SES more likely to drop out</td>
</tr>
</tbody>
</table>
Appendix 22: Demographic information sheet

Research participant information sheet

Participant number________________________ Counselling at _____________________

Gender (please circle the best option)

<table>
<thead>
<tr>
<th>Female</th>
<th>Male</th>
<th>Trans</th>
<th>Other</th>
<th>Prefer not to say</th>
</tr>
</thead>
</table>

Age (please circle one)

<table>
<thead>
<tr>
<th>18-25</th>
<th>26-30</th>
<th>31-40</th>
<th>41-50</th>
<th>51-60</th>
<th>61+</th>
<th>Prefer not to say</th>
</tr>
</thead>
</table>

Relationship status (circle all that apply)

<table>
<thead>
<tr>
<th>Single</th>
<th>Boyfriend/girlfriend</th>
<th>Married (heterosexual)</th>
<th>Married/civil partnership (same-sex)</th>
<th>Same-sex long term relationship</th>
<th>Heterosexual long-term relationship</th>
<th>Divorced</th>
<th>Widowed/Widower</th>
<th>Other</th>
<th>Prefer not to say</th>
</tr>
</thead>
</table>

Ethnic group (please circle the best option)

<table>
<thead>
<tr>
<th>British White</th>
<th>Irish White</th>
<th>Other White (state)__________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Black (Caribbean)</td>
<td>British Black (African)</td>
<td>Other Black (state)____________________</td>
</tr>
<tr>
<td>Mixed Black</td>
<td>Mixed heritage Black and White</td>
<td></td>
</tr>
<tr>
<td>Indian (Asian or British Asian)</td>
<td>Pakistani (Asian or British Asian)</td>
<td>Bangladeshi (Asian or British Asian)</td>
</tr>
<tr>
<td>Other Asian</td>
<td>Mixed Asian</td>
<td>Mixed heritage Asian and White</td>
</tr>
<tr>
<td>Other ethnicity (state)__________________________</td>
<td>Prefer not to say</td>
<td></td>
</tr>
</tbody>
</table>

Last level of education completed (circle best option)

<table>
<thead>
<tr>
<th>Primary school</th>
<th>Secondary</th>
<th>GCSE</th>
<th>A Level/ A Level equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apprenticeship</td>
<td>Vocational training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>University Bachelors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>University Masters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>University Doctorate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (state)__________________________</td>
<td>Prefer not to say</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Current employment (circle all that apply)

<table>
<thead>
<tr>
<th>Homemaker</th>
<th>Self-employed</th>
<th>Full-time employed</th>
<th>Part-time employed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-time student</td>
<td>Part-time student</td>
<td>Jobseeker</td>
<td>Apprentice</td>
</tr>
<tr>
<td>Other (state)__________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Email address: _________________________________________________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 23: Definitions of causal relationships in research

<table>
<thead>
<tr>
<th>Definition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative predictor</td>
<td>The presence of this factor during therapy predicts a poorer outcome at end of therapy or at follow-up. Statistical analyses include variants of hierarchical multiple regression</td>
</tr>
<tr>
<td>Positive predictor</td>
<td>The presence of this factor during therapy predicts a better outcome at end of therapy or at follow-up.</td>
</tr>
<tr>
<td>Negative mediator</td>
<td>This factor arises during therapy and mediates between therapy factors (or other client factors) and a poorer outcome at end of therapy.</td>
</tr>
<tr>
<td>Positive mediator</td>
<td>This factor arises during therapy and mediates between therapy factors (or other client factors) and a poorer outcome at end of therapy.</td>
</tr>
<tr>
<td>Negative moderator</td>
<td>Client characteristic present before the commencement of therapy that negatively effects outcome.</td>
</tr>
<tr>
<td>Positive moderator</td>
<td>Client characteristic present before the commencement of therapy that positively effects outcome.</td>
</tr>
<tr>
<td>Other association with negative outcome</td>
<td>Non-statistically derived client factors that negatively effect outcome</td>
</tr>
<tr>
<td>Other association with positive outcome</td>
<td>Non-statistically derived client factors that positively effect outcome</td>
</tr>
</tbody>
</table>

Appendix 24: Included studies with social factors findings

A. Negative prediction (i.e. adverse social circumstance predicts worse outcome)
   Hooley and Teasdale (1999)
   Hooley and Teasdale (1989)

B. Positive prediction (i.e. supportive social circumstance predicts better outcome)
C. Positive association (i.e. supportive social circumstance associated with better outcome)

* Khattra, Angus, Westra, Macaulay, Moertl and Constantino (2017)
* Davidson, Borg, Marin, Topor, and Sells (2005)
* Constantino, Morrison, Coyne, Goodwin, Santorelli and Angus (2017)
## Appendix 25: Helpful elements density table

<table>
<thead>
<tr>
<th>Element</th>
<th>Number of participants (out of 9)</th>
<th>Number of studies (57 out of 68)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1Positive: Trusting family and friends helped with problem recognition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1Positive A: Partnership quality</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>1Positive B: Speaking with family and friends</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>1Positive C: Family/friends raised the problem</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>2Positive: Hitting rock bottom</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2Positive A: Accessing crisis services</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>2Positive B: Accessing GP services</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>3Positive: Precluding relational loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3Positive A: Preserving current relationships</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>3Positive B: Protecting future relationships</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>4Positive: Self-reclamation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4Positive A: Autonomous responsibility</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>4Positive B: Intention</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>4Positive C: Maturity</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>5Positive: Persistently accessing help</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5Positive A: Help from family/friends</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>5Positive B: Help from staff at school/work</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>5Positive C: Self-help and social media</td>
<td>7</td>
<td>0*</td>
</tr>
<tr>
<td>5Positive D: Support groups</td>
<td>5</td>
<td>0*</td>
</tr>
<tr>
<td>5Positive E: Medication</td>
<td>3</td>
<td>0*</td>
</tr>
<tr>
<td>5Positive F: Persistence with counselling</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>6Positive: Improving social activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6Positive A:</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>6Positive B: Re-engagement</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>6Positive C: Secure private home</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>6Positive D: New job/leaving bad job</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>6Positive E: Proximalising/distalising</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Positive: Role models</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>------------------------</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Positive: Self-helping behaviours</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive A: Journalling</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Positive B: Insight-led behavioural change</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Positive C: Exposure and flexibility</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Positive D: Exercise</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td><strong>Positive: Helpful thinking</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive A: Helping self-talk</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Positive B: Thought-stopping and restructuring</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Positive C: Recognising accomplishments and self-efficacy</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Positive D: Hope for future</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Positive E: Spirituality</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Positive F: Gratitude</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Positive: Reintegrating</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive A: Owning evolution</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Positive B: Self-acceptance</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Positive C: Life on life’s terms</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Positive D: Minding regret</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Positive E: Rejecting unhelpful stereotypes</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

*study exclusion criteria precluded possible entries*
## Appendix 26: Unhelpful elements density table

<table>
<thead>
<tr>
<th>Element</th>
<th>Number of participants</th>
<th>Number of studies (29 out of 68)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1Negative: Compromised support</td>
<td></td>
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<tr>
<td>1Negative A: Difficult family relationships</td>
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<tr>
<td>1Negative B: Family mental health issues</td>
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<tr>
<td>2Negative: Ignoring problem</td>
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</tr>
<tr>
<td>2Negative A: Unrecognised crisis</td>
<td>1*</td>
<td>1</td>
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<tr>
<td>3Negative: Socially disconnected</td>
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<tr>
<td>3Negative A: Alienation</td>
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<tr>
<td>3Negative B: Guardedness</td>
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<tr>
<td>3Negative C: Social difficulty</td>
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<tr>
<td>4Negative: Unready to change</td>
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<tr>
<td>4Negative A: Fear</td>
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<tr>
<td>4Negative B: Denial</td>
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<tr>
<td>5Negative: Unable to use help</td>
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<tr>
<td>5Negative A: Find counselling fruitless</td>
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<tr>
<td>6Negative: Feeling oppressed</td>
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<tr>
<td>6Negative A: Adverse work</td>
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<tr>
<td>6Negative B: Adverse partnership</td>
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<tr>
<td>7Negative: Retained unhelpful behaviours</td>
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<td></td>
</tr>
<tr>
<td>7Negative A: Unhelpful reactions</td>
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<tr>
<td>7Negative B: Avoidance</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>8Negative: Retained unhelpful thinking</td>
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<tr>
<td>8Negative A: Perfectionism</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>8Negative B: Unhelpful self-talk</td>
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<tr>
<td>8Negative C: Obsessions</td>
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<tr>
<td>8Negative D: Low meta-cognition</td>
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<tr>
<td>8Negative E: Dissociation</td>
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<tr>
<td>9Negative: Unwell identity</td>
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<tr>
<td>Negative A: Endorsed unhelpful stereotype</td>
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<tr>
<td>Negative B: Problem enmeshment</td>
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<tr>
<td>Negative C: Long illness</td>
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</table>

*1 fell beneath threshold of 2 to be considered a participant-informed element*