

VOLUME I

Research Component: Literature Review and Empirical Paper

By

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OVERVIEW

This thesis is submitted as part of the requirements for the qualification in Clin.Psy.D at the School of Psychology, University of Birmingham. It comprises of two volumes.

Volume I includes the research work carried out by the author during training, and Volume II refers to the clinical work submitted throughout that training.

A literature review is first presented in Volume I, exploring the peer-reviewed papers published in the English language over the past two decades on the application of Self-Determination Theory (SDT) to the psychological treatment of individuals with mental health difficulties. It was written up for submission to Counselling Psychologist. After this, an empirical paper is presented. This is a qualitative study of the experience of psychological therapy by young people with severe mental health problems. The study employs Interpretative Phenomenological Analysis to explore the lived experiences of seven young people, and to identify common themes in relation to how therapy influenced their understanding of themselves and of their future lives. Some implications for future service development are offered in the discussion with a view to highlight what the participants report as both helpful and essential aspects of their psychological treatment. This paper was prepared for submission to Clinical Psychology and Psychotherapy. A Public Domain briefing paper of both papers is presented prior to the appendices.

Volume II of the thesis includes five Clinical Practice Reports produced by the author during training. The first of these pertains to a Cognitive-Behavioural Therapy formulation and a Psychodynamic formulation of a man suffering from depression. Then a single case experimental design of the psychological treatment of a man with an obsessive compulsive disorder, along with an evaluation of the psychology on-call service of a paediatric hospital and the Cognitive-Behavioural Therapy treatment of a young woman

with a first episode psychosis is presented. Finally, the abstract of the oral presentation of a case study of the psychodynamic formulation and treatment of a man with Asperger's Disorder and a complicated bereavement is included at the end of Volume II. All the names and client information have been altered throughout this thesis, with a view to ensure client confidentiality.

LITERATURE REVIEW

How can the Self Determination Theory (SDT) inform the clinical application of psychological models? A systematic review.

Word count: 6781

ABSTRACT

The present conceptual review examines the way in which different psychotherapeutic models draw on the Self Determination Theory (SDT) to improve client engagement and the effectiveness of interventions. It also aims to examine the existing evidence for the effectiveness of the application of SDT principles to the psychological treatment of mental health problems.

Twenty articles were identified and deemed pertinent during the literature search. Three articles explore the SDT premises, the evidence supporting them, and their implications for psychotherapy and counselling. Six papers refer to empirical studies examining whether SDT premises are associated with better clinical outcomes in different contexts. Three papers describe case-studies where SDT premises were applied to a variety of psychological treatments in different contexts. Five papers have a more theoretical focus, describing how different psychotherapeutic models and specific approaches might relate to and benefit from integration with SDT premises. Two reaction papers to a given paper relating SDT to therapy were identified, along with a single paper published in response to the former papers, all of which provide a critical analysis of the integration of motivation within the sphere of psychotherapy and counselling.

The majority of the reviewed articles suggest that client autonomy within therapy should be fostered and that the role of the therapist should be that of a catalyst for change. Despite several articles highlighting the importance of increasing the awareness of personal goals in therapy, only one of the studies reviewed found that it was associated with improvement in anxiety and well-being.

Keywords: Self Determination Theory; Psychological Treatment; Mental health.

1. Aim

The present review aims to summarise the existing empirical evidence for the effectiveness of psychological interventions informed by SDT, and the existing theoretical advances that have been put forward in this field.

The three specific objectives being addressed in this review are:

- 1 – to evaluate how robust the empirical evidence is for the clinical application of SDT to the psychological treatment of people with mental health problems.
- 2 – to highlight existing critiques of SDT, and to show the limitations of its application to the psychological treatment of individuals with mental health problems.
- 3 – to highlight the suggestions and recommendations made by SDT advocates for its use in the psychological treatment of individuals with mental health problems.

2. Inclusion Criteria

- Peer-reviewed journal references;
- References in the English language;
- References published in OVID/Psycinfo since 1989¹;
- References pertaining to psychological interventions from any model, which have been devised on the basis of SDT and specifically allude to this theory in the text;
- References pertaining to any type of psychological treatment of individuals with mental health problems, which has been informed by SDT, with the exception made for the treatment of addictions and physical health conditions;
- References providing an expert opinion on the application of SDT to the psychological treatment of individuals with mental health problems.

¹ The decision to include the references published since the search engine's set date of 1989 was based on the date of the first appearance of SDT in peer reviewed papers (Ryan, 1995).

3. Search strategy

In order to achieve the aims described above, two literature search strategies were employed: a database search and a search on an existing SDT website.

A search of the database Psycinfo was run, from the years of 1989 to 2012. References were first retrieved if the following search terms were identified as being included in the content of the references: “self-determination theory”. This search yielded 4,430 references. After this, the terms “psychotherapy” OR “counselling” OR “counseling” OR “psychological treatment” OR “psychological therapy” were inputted in the search, yielding 280,571 references. The combined search of both the above mentioned references was then run, yielding 1,354 references. Next, the resulting search was limited to “English language” and to “Peer-reviewed journal” references, which retrieved 951 papers. Further exclusion criteria were applied to these papers, this time excluding all papers whose content referred to “physical activity”, “physical health”, “education”, “parenting”, “organisations” and “organizations”. A final number of 237 papers was yielded. From the inspection of these references, their titles and their abstracts, 214 references were excluded due to not being pertinent to the aim of the review. Following the inclusion of two additional references identified via a search in the reference list, and another eight from consultation with one of the SDT authors and the SDT website, the review now totalled 33 references. Full paper copies of these 33 references were retrieved and their content was assessed against the review question and the inclusion criteria. This last analysis resulted in 13 references being excluded from the review (see Figure 1).

Twenty articles were identified and deemed pertinent during the literature search. Three articles explore SDT premises, the evidence supporting them and their implications for psychotherapy and counselling. Six papers refer to empirical studies examining

whether SDT premises are associated with better clinical outcomes in different contexts. Eight papers have a more theoretical focus, describing how different psychotherapeutic models and approaches might relate to and benefit from integration with SDT premises. Finally, two papers published in response to a previous paper relating SDT to therapy were identified, as well as a third paper focusing in turn on these two papers, which provide a critical analysis of the integration of motivation theory within the sphere of psychotherapy and counselling.

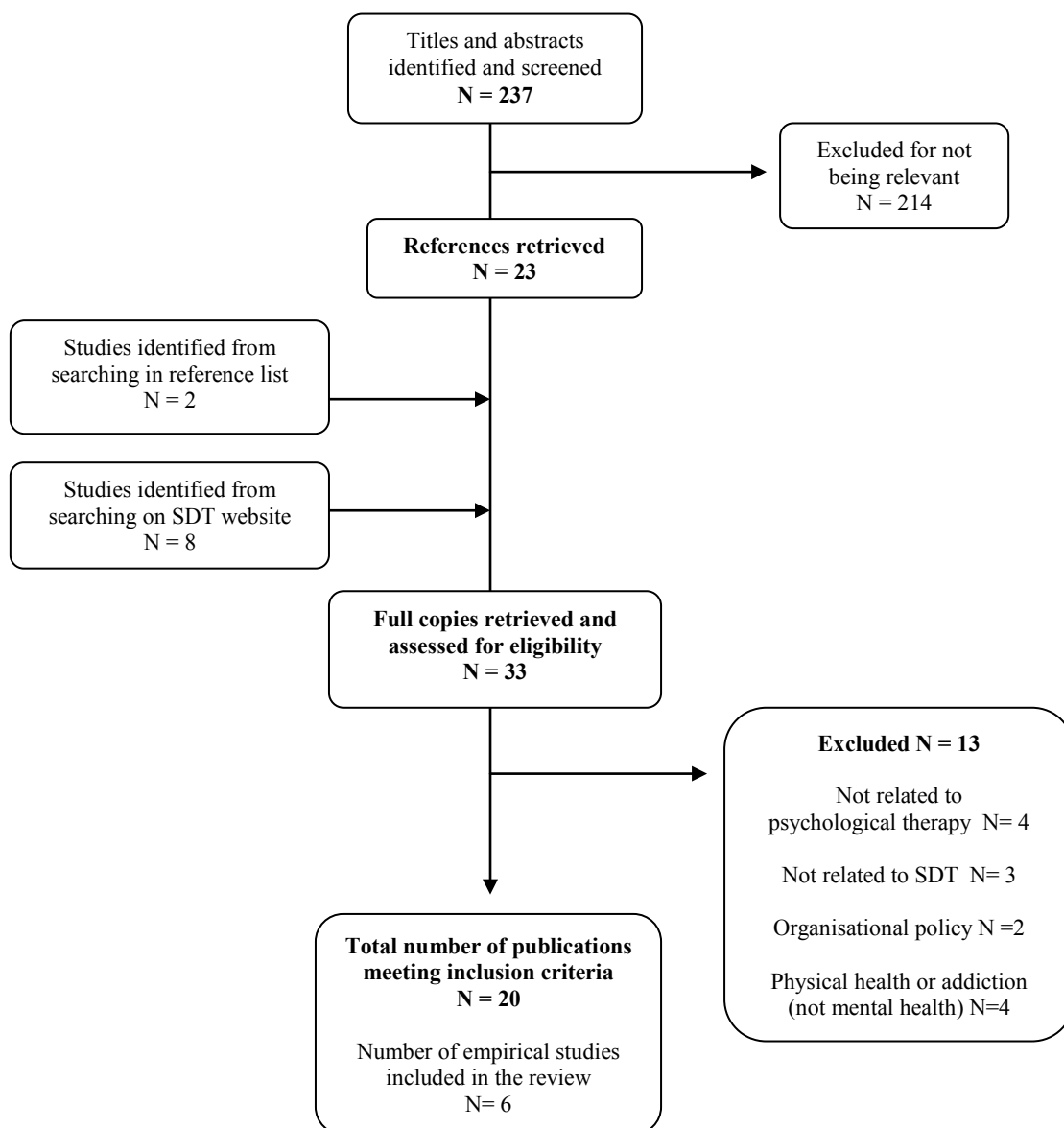


Figure 1. Flow chart of study selection process.

4. Introduction

The present review yielded 20 papers with varying aims and concerns, all of which place a greater or lesser emphasis on the application of SDT to psychological treatment of mental health difficulties. Despite this, an attempt was made to group these papers together and present them according to their overarching themes and aims.

Firstly, three theoretical papers on the application of SDT to psychological therapy are presented. This should provide some key concepts on how SDT may inform psychological therapy, and will guide the understanding of the subsequent papers presented in this review. After this, six empirical papers testing some of the premises of SDT applied to therapy will be briefly presented and their conclusions highlighted. Eight opinion papers, with a theoretical focus on how different applied psychological models may benefit from integration with SDT, are then described. Two additional critical papers on the limitations of the application of SDT to therapy are summarised at the end of this review, along with a response paper issued by the SDT authors which was also retrieved in the search. Finally, a discussion of the papers reviewed here is provided.

5. Main research papers

Implications of SDT for psychotherapy

Three papers were retrieved, each putting forward the application of SDT to psychological therapy. The first of these papers (Ryan and Deci, 2008) provides an overview of how SDT can best inform therapy, by specifying some guidelines on key areas of the content and structure of therapy that ensure that clients undergo an effective and long-lasting change in therapy.

According to SDT, there are three universal fundamental psychological needs. These are the need for autonomy, the need for competency and the need for relatedness. The first need pertains to being able to exercise one's volition, in a coherent and integrated way with one's values and beliefs, as opposed to in conformity to external pressures (Ryan and Deci, 2008). Competency refers to being able to act in accordance to one's abilities and interests. Finally, relatedness pertains to being connected with others and therefore feeling cared for and caring for others. Ryan and Deci (2008) propose that the thwarting of any of these three psychological needs leads individuals to mental distress, whereas their satisfaction is key to achieving and sustaining one's well-being.

With regards to how SDT can inform psychological therapy, the authors draw attention to the importance of the process of therapy, rather than its outcome. In doing so, they highlight the enhancement of autonomy (one of the fundamental psychological needs) as a major task for therapy. More specifically, they suggest that the therapist ought to endorse an attitude that supports the individual's self-organisation and self-regulation of his or her experiences, thus facilitating the client's autonomy. Examples of ways in which the autonomy of clients can be supported are also provided, such as encouraging choices; conveying a rationale for any suggestion or request made in therapy; adopting a stance of unconditional regard; making an active effort to understand the individual's point of view from a non-judgemental position; and reducing any pressure on the individual.

Inherent in this approach is an underlying assumption that, given a supportive and non-controlling environment, most people will strive towards self-actualization, organisation and integration, and will make choices that will bring them closer to health. In fact, the concept of integration is paramount to SDT, since it is believed that these integrative tendencies (i.e. when the choices made are consistent with one's values and

interests) leading to healthy development in individuals can be either promoted or thwarted by the environment. It is proposed that therapists should therefore aim to support individuals in identifying fully with new values and self-regulations, so that these can be integrated within their personality, rather than simply focusing on altering symptoms or behaviours. Moreover, it is posited that only by promoting self-motivated changes and supporting the satisfaction of the three fundamental psychological needs, will individuals derive greater and long-lasting benefits from therapy.

In addition, Deci and Ryan stress the importance of enhancing the individual's awareness of their basic needs, and encouraging the exploration of the opportunities for their satisfaction. The authors suggest one way of instilling the realisation of those needs carelessly ignored by the individual is to promote the individual's emotional awareness. By being in touch with one's emotions and taking an interest in them, the authors argue that individuals are able to recognise the extent to which their needs are being satisfied.

In the second paper retrieved in this review, Sheldon, Joiner, Pettit and Williams (2003) discuss how SDT can be applied to the clinical field, whether this be medical or psychotherapeutic. More specifically, they propose that clinicians support the clients' autonomy, by respecting and validating their perspectives and preferences, and by providing them a choice for treatment, or at least a sound rationale for those cases where the client's choice is not feasible. The authors suggest that this approach is particularly important exactly because of the power unbalance inherent in any therapeutic relationship between clinicians and clients. They further advocate that clinicians employ an autonomy-supportive stance to the psychological treatment of all clients, irrespective of their personality style, as this has been found to be more effective (cit. Deci and Ryan, 2000).

In keeping with Sheldon et al.'s (2003) suggestions and SDT itself, the third paper retrieved highlights the role of motivation and autonomy in the field of psychological therapy (Ryan, Lynch, Vansteenkiste and Deci, 2011). The authors identify several psychological approaches (e.g. cognitive behavioural therapy, psychodynamic therapy, humanistic, etc) and the ways in which autonomy and motivation may be considered differently within these different psychological models. They start by pinpointing the relevance of client motivation in order for their effective engagement into therapy work. For example, they highlight the facilitation of client's exertion of their preferences in how to effectively use therapy as the most important task in therapy, along with promoting their active engagement in it.

The authors go on to discuss the taxonomy of motivation, which ranges from amotivation (when the individual sees no benefits in changing their behaviour via therapy) to intrinsic motivation (when the individual believes that the therapy tasks are intrinsically self-rewarding and pleasing). They further propose that autonomous motivation might be best promoted by any environment where important others in people's lives would make few demands on the individuals and would support their perspectives and preferences. Similarly, autonomy is thought to be supported in therapy when the therapist adopts the individual's stance and applies little control or pressure.

Regarding behavioural approaches, after examining the evidence the authors conclude that, despite the minimisation of the role of volition and self-determination in this theory, its application to therapy seems to promote the clients' autonomy and willingness as fundamental to an effective psychological intervention. In line with this approach, the authors argue that the cognitive-behavioural approach also seems to emphasise the empowerment of clients, whether by involving them in the setting of therapy goals, or by

openly discussing the changes observed during therapy. Client's motivation for therapy is therefore considered a prerequisite for entering therapy. In the psychodynamic approach, however, amotivation for change is perceived as a symptom which stems from a defensive process of maintaining one's ego intact. In this view, the authors argue, the client's initial resistance to therapy is seen as necessary for effective change to take place.

At the end of their paper, Ryan et al. (2011) put forward the SDT approach to therapy. Here they highlight that clients' effective change in therapy requires that they integrate the values and the skills for change in their personality. This is best achieved, they suggest, by promoting the clients' autonomy, competence and relatedness, thus helping sustain the changes internalised. In other words "the more the person 'owns' the reasons for changing, the more autonomous and therefore the more likely to succeed is the behaviour change" (p. 231). Furthermore, the authors advocate the support of autonomy as a universal value in any culture and context. In doing so, they draw a distinction between the concept of autonomy and individuation, the former meaning the respect for someone's choices and the latter being culturally specific.

Empirical papers testing the application of SDT to psychotherapy or counselling

The literature search further yielded six empirical papers depicting studies where a psychological intervention based on SDT theory is compared with other interventions, or where the theory's predictions for the psychological treatment of individuals are tested. Following is a summary of each of these papers.

In Dwyer, Hornley and Smith's (2011) paper, two empirical studies were conducted where the clinical participants' perceived autonomy during a cognitive behavioural therapy group was compared with their clinical outcomes. In the first study,

109 clinical participants with a diagnosis of either depression or anxiety took part. Their pre- and post-treatment outcome measure scores were compared against their perceived 'autonomy need satisfaction' (i.e. the extent to which one's need for autonomy is being met in a given context) at the end of the treatment. In keeping with SDT, the effect of autonomy satisfaction on symptoms was found to be mediated by changes in the participants' negative automatic thoughts. However, as the perceived autonomy was only assessed at the end of therapy, the direction of its association with the outcome measures remained unknown. In the second study, the outcome ratings of 94 participants with a diagnosis of depression were compared with the perceived 'autonomy need satisfaction' at three time points throughout the duration of therapy. As before, it was found that autonomy need satisfaction predicted a decrease in depression, but that this relationship was mediated by a reduction in the negative automatic thoughts of participants. The authors concluded that therapy can be delivered in such a way as to maximise the satisfaction of the autonomy needs of clients, thus promoting their cognitive change, which in turn enables symptom improvement to take place.

Vandereycken and Vansteenkiste (2009) investigated the SDT prediction that the provision of more choice to therapy clients is associated with better engagement and perceived satisfaction with treatment. The authors compared the drop-out rates during the first few weeks of admission to an eating disorder unit between 87 in-patients who were given a choice about their treatment plan (new treatment) and 87 in-patients who were deprived of such choice (old treatment). The results showed that, consistent with the SDT predictions, the group of participants whose treatment plan was discussed with them had a significantly lower drop-out rate than the second group. However, this difference in the drop-out rate was no longer significant after one month of treatment, nor was there any

significant difference in weight change between groups. The authors posit that these findings might reflect the nature of the treatment provided by the service, in which clients usually attend group therapy, which might be perceived as more challenging in the first few weeks of admission.

Two additional empirical papers were retrieved which test whether depressed clients' perceived participation in their treatment (i.e. autonomous motivation in therapy) is associated with the therapy outcome. In the first paper, Zuroff, Koestner, Moskowitz et al. (2007) randomly allocated 95 participants with a diagnosis of depression to cognitive-behavioural therapy, interpersonal therapy or pharmacotherapy, and asked them to complete self-report questionnaires on the perceived autonomy support of the therapist, motivation for therapy, and therapeutic alliance. The authors found that autonomous motivation for therapy was the best predictor of outcome, regardless of the treatment received.

A second study attempted to replicate these findings, this time with participants in receipt of interpersonal therapy. McBride, Zuroff, Ravitz et al. (2010) had 74 participants attending therapy with a diagnosis of depression complete measures on autonomous motivation, therapeutic alliance and depression. Again, autonomous motivation for therapy predicted a decrease in depression during therapy over and above therapeutic alliance, but only for those participants who had only had two or less episodes of depression. Instead, the remission of symptoms for the more chronic participants was found to be best predicted by the therapeutic alliance. Moreover, controlled (external) motivation for therapy was found to be negatively associated with the remission of depression. Hence McBride et al. (2010) concluded that psychological interventions for depression should take into account the SDT premises.

In an earlier paper, Michalak, Klapheck and Kosfelder (2004) attempted to investigate the relationship between the degree of intrinsically motivated personal goals and the level and type of psychopathology (e.g. severity of depression and anxiety), in individuals in receipt of psychological therapy. Results showed that only for individuals with anxiety difficulties was the endorsement of self-determined goals strongly associated with a reduction in symptoms. Michalak et al. (2004) concluded that the satisfaction of fundamental needs might foster an autonomous goal orientation in individuals, therefore enhancing their ability to cope with difficult life events, making them more resilient to psychopathology. They further propose the integration of the SDT claims into the understanding and treatment of psychopathology, highlighting the role of therapy in supporting the individuals' personal goals beyond the mere relief of symptoms.

Keune and Forintos (2010) were interested in investigating whether the SDT prediction that the practice of mindfulness meditation helps individuals become more aware of their present experiences, promoting the recognition of their personal needs and values, and therefore enhancing their well-being. Thirty sub-clinical participants who attended meditation classes were asked to complete a series of self-report measures on anxiety and mood before and after the classes, and these ratings were compared with those of 30 sub-clinical control participants who did not attend meditation classes. As predicted, the group attending the meditation classes was found to be more likely to have a decreased anxiety and an overall improved well-being, compared with the control group. This was especially true for individuals who extended their practice of mindfulness beyond the classes into their everyday life.

Table 1. Summary description of empirical papers retrieved in the literature search.

References	Brief summary of findings	Strengths	Weaknesses
Dwyer, Hornley and Smith's (2011)	The facilitation of the client's autonomy in therapy was found to be associated with symptom improvement in depression, but mediated by cognitive changes.	Longitudinal design at two and three time points (pre, during and post treatment measurement).	No control group; no follow-up data collected.
Vandereycken and Vansteenkiste (2009)	The facilitation of the client's autonomy in therapy was associated with symptom improvement and a reduction in drop-out rate.	Control group employed; the independent variable manipulated was the actual type of treatment delivered; one month follow-up collected.	Quasi-experimental design.
Zuroff, Koestner, Moskowitz et al. (2007)	Autonomous motivation for therapy was the best predictor of treatment outcome, regardless of the treatment received.	Longitudinal design with pre and post treatment measurement; control group employed (comparison between three treatment groups).	No follow-up data collected.
McBride, Zuroff, Ravitz et al. (2010)	Autonomous motivation for therapy was the best predictor of treatment outcome, regardless of the treatment received, but only for those participants who had less than two depressive episodes.	Longitudinal design with pre and post treatment measurement; control group employed (comparison between three treatment groups).	No explanation provided for the partial confirmation of SDT predictions; no follow-up data collected.
Michalak, Klappheck and Kosfelder (2004)	The satisfaction of self-determined goals during therapy was found to be associated with the improvement of anxiety, but not depression.	Longitudinal design with pre and post treatment measurement.	No control group; no explanation provided for the partial confirmation of SDT predictions; no follow-up data collected.
Keune and Forintos (2010)	The practice of mindfulness meditation was found to be associated with a reduction in anxiety.	Longitudinal design with pre and post treatment measurement; control group employed.	No follow-up data collected; no data collected on the awareness of personal needs and values (as predicted by SDT), therefore limiting the conclusions drawn.

Table 1 summarises the strengths and weaknesses of the empirical papers retrieved in the search. In sum, the empirical studies reviewed here seem to suggest that the facilitation of the client's autonomy in therapy (Dwyer et al, 2011; Vandereycken et al., 2009; Zuroff et al., 2007; McBride et al., 2010), the satisfaction of self-determined goals

during therapy (Michalak et al., 2004) and the practice of mindfulness meditation (Keune et al., 2010) are all associated with a significant degree of symptom improvement. Despite adopting a longitudinal methodology, however, most of these studies failed to use a control group (e.g. Zuroff et al., 2007; McBride et al., 2010; Dwyer et al., 2011), which limited the conclusions drawn from the data. In some studies there was also an omission of any explanation for when the SDT premises were disconfirmed by the data (e.g. when the amelioration of depression was found not to be associated with the endorsement of self-determined goals in therapy in Michalak et al.'s (2004) study) or drew over-simplistic conclusions from partial findings (e.g. McBride et al., 2010).

Theoretical papers on the application of SDT to specific psychotherapy models and approaches

Seven papers were identified in this review, providing an integration of SDT principles with different psychological approaches to therapy. These papers will be described next, according to the psychological approaches or psychological concepts they depict.

Most of the following papers provide a summary or at least an acknowledgement of the existing evidence by SDT researchers on the association between the satisfaction of the three fundamental psychological needs and well-being, as well as on the relation between the motivational continuum and well-being. In addition, some of them draw on the many studies which show the efficacy of the application of SDT premises to the treatment of individuals with physical health problems (e.g. diabetes and obesity) and addictive behaviours (e.g. smoking).

Person-centred approach.

In their review paper, Patterson and Joseph (2007) argue that person-centred theory and SDT share some common premises, in that both theories posit that all human beings are inherently inclined towards growth and development. They further draw some links between the person-centred ideas of the pathological internalization of ‘conditions of worth’ (i.e. a tendency towards judging one’s experiences on the basis of external pressures) and the SDT idea of external or introjected self regulations. These authors describe some empirical evidence supporting SDT claims, which they suggest could be extended to support the premises posited by person-centred theory. For example they report that high openness to experience (hypothesised by person-centred theory as the main goal of therapy, because it represents the least possible defensive functioning) has been found to be associated with an increased autonomous functioning, as postulated by SDT (Knee and Zuckerman, 1996 as cit. in Patterson et al., 2007). Hence Patterson et al. (2007) demonstrate in this paper that person-centred theory has a number of points of convergence with SDT and positive psychology, calling attention to how the former theory may inform the application of SDT claims into clinical practice.

Motivational Interviewing.

A paper describing the theoretical and practical similarities between SDT and motivational interviewing was found (Markland, Ryan, Tobin and Rollnick, 2005). According to Markland et al. (2005), SDT provides a sound framework for the understanding of the efficacy of motivational interviewing and the underlying processes that explain the therapeutic changes observed. For example, it is argued that because motivational interviewing promotes autonomous behaviour, it encourages individuals to integrate the

regulation of novel behaviours which are consistent with their values and beliefs. Akin to the person-centred approach, motivational interviewing is said to share with SDT a similar belief that all humans are innately inclined to strive towards integration and personal growth, and given the right environmental conditions, they will make choices consistent with their self-actualisation. Furthermore, the authors claim that motivational interviewing provides the necessary environment for the satisfaction of clients' fundamental needs for competence, autonomy and relatedness. More specifically, the authors maintain that competence is fostered by providing information to clients regarding behaviour and outcome contingencies (e.g. on how to achieve a given goal) and giving them helpful feedback. Autonomy is thought to be fostered by adopting a non-judgemental stance, whereby the client is made aware of the contrast between their current behaviour and their desired behaviour, and by supporting clients to make choices which are consistent with their worldviews. Finally, relatedness is said to be promoted by motivational interviewing practitioners in the unconditional positive regard they convey and the empathic and genuinely curious attitude they adopt in therapy.

Two other papers depicting the innovative application of SDT principles to motivational interviewing in the treatment of suicidal ideation were retrieved. Both these papers make use of case studies to illustrate their suggested treatment, placing particular focus on the enhancement of client's motivation for therapy. In Britton, Williams and Conner's (2008) paper they recommend that clinicians adapt their therapeutic stance so as to become more autonomy supportive. This in turn is hypothesised to increase the clients' intrinsic motivation for therapy, therefore leading to a better treatment outcome, as predicted by SDT. The authors suggest that clinicians make an active effort to listen and empathise with the clients' ambivalence and points of view, helping them enlist the

different choices they have, whilst providing a meaningful rationale for how a particular treatment can help them achieve some of their personal goals. This approach is hypothesised to stimulate the natural self-developing tendencies that are thought to exist in everyone, as defended by SDT. Also in keeping with SDT, motivational interviewing is suggested to be a particularly helpful method in the treatment of suicidal clients, as it helps clients evoke more “living talk”. The authors illustrate this approach with two extracts from therapeutic encounters between two individuals with suicidal ideation and their therapist.

Finally, in a more recent paper, Britton, Patrick, Wenzel and Williams (2011) integrate motivational interviewing with cognitive behavioural therapy, by employing an SDT framework in the treatment and prevention of suicide (MI-SI). The authors describe the treatment procedure in some detail in relation to a fictional case study, made up of several clients with whom the authors have worked. The treatment is broken down into two phases: phase 1 refers to the exploration of the presenting problem and the motivation to die; phase 2 refers to building the motivation to live. In phase 1, the participants are encouraged to reflect on their reasons for dying, which follow the SDT paradigm of fully accepting and taking the client’s perspective in a nonjudgmental way, thus promoting their fundamental needs for autonomy and relatedness. During phase 2, in keeping with SDT, the therapist is to support the participant’s exploration of the ambivalence inherent in his or her reasons for living, should he or she feel ready for such work. This work is expected to promote the participant’s sense of autonomy and relatedness, thus enhancing his or her sense of inner energy. The paper finishes with a section on future directions, highlighting the need for an RCT testing the effectiveness of this intervention procedure directed at individuals engaged in self-injurious behaviour.

Taken together, these papers seem to propose that SDT is a comprehensive framework which helps to guide clinicians in their thinking and practice on how best to manage and enhance the treatment of clients for whom the motivation for therapy is often a challenge, such as in the case of suicidal clients.

Goal setting in psychotherapy.

Michalak and Holtforth's (2006) paper describes the existing evidence pertaining to the importance of goal setting in different life contexts. Towards the end of the paper, a summary of some key ideas relating goals for therapy is provided, based on SDT principles. Michalak et al. (2006) suggest that clients should be supported in eliciting personal and therapy goals at an early stage in therapy. According to these authors, the therapist's role is therefore to provide information to clients about the existing evidence on the unhelpfulness of setting goals that are either solely symptom focused or hedonistic and materialistic in nature. Instead, as suggested by SDT, therapists are expected to actively encourage clients to pursue goals that are more meaningful and coherent with their personal interests and world views. The caveat, they say, is that therapists remain respectful of the client's preferences and decisions, irrespective of their own.

Collaborative empiricism in Cognitive Therapy.

Tee and Kaxantzis' (2011) paper provides an interesting review of the importance of collaborative empiricism in cognitive therapy, whilst drawing some links between this technique and SDT to best understand its effectiveness. Collaborative empiricism is described as a therapeutic technique frequently used in cognitive therapy, whereby the therapist actively encourages the client to creatively devise empirical experiments which

put targeted cognitions under test. According to these authors, therapeutic change has been found to happen as a result of the client's identification of their own reflective process and the collaborative experimentation, as opposed to the direct influence of the therapist. However, Tee et al. (2011) say that little is known about the psychological underpinnings that contribute to the effectiveness of this process (i.e. the successful modification of the client's unhelpful beliefs). These authors posit that SDT helps to understand why this is the case. For example, SDT maintains that internally generated cognitions tend to be experienced as more autonomously regulated, and are therefore more likely to motivate the individual to modify previously held beliefs. Besides this, because of its collaborative nature, the empirical testing in cognitive therapy is said to increase the likelihood of the client's internal motivation for changing their beliefs. In sum, Tee et al. (2011) defend the use of SDT ideas in explaining and making sense of the therapeutic processes observed in cognitive therapy.

Integrative approach in the treatment of personality disorders (SCRIPT).

Cukrowicz and Joiner's (2005) paper outlines a novel and integrative approach for the treatment of clients with personality disorder, namely the self-control regulation/interpersonal psychotherapy (SCRIPT). Along with other psychological theories, the authors draw on some SDT principles in an attempt to improve the engagement of these clients in therapy and instilling hope for treatment. Examples of SDT key ideas highlighted by this article are the importance of developing an autonomy-supportive environment in therapy and the delivery of an open diagnostic feedback. The authors further illustrate this approach by providing extracts of the proposed treatment applied to particular case studies they have worked with.

Recovery interventions.

As in other papers reported in this review, Abbott's (2008) paper describes how SDT can be a useful framework for understanding the psychological factors underlying an effective recovery process from severe mental health problems. More specifically, the author states that the emphasis that SDT places on the importance of relatedness need satisfaction for all individuals is useful when thinking about the recovery plans which stimulate the individual's social functioning and social integration. Abbott (2008) also suggests that on the basis of SDT, a recovery treatment plan should not be reliant on external control or on contingency systems as a means to influence the client's recovery. Instead, the author claims that the client should be supported so that his or her motivation for treatment and recovery is autonomously motivated and internalised. Ultimately, Abbott (2008) suggests that services should aim to work collaboratively with service users, by transferring some of the responsibility and decision making processes onto the clients they are serving.

Critical papers on the application of SDT to therapy

The following section refers to the few papers retrieved in this review which raise some concerns regarding the application of SDT to therapy.

In Carter's (2011) reaction paper, some ideas are echoed on the limitations of the application of SDT to psychological therapy. The first argument she puts forward regards the naive expectation that clients ought to enter therapy motivated to change their unhelpful behaviours due to feeling intrinsically compelled to do so. Instead, Carter (2011) suggests that a more realistic prerequisite for an effective treatment would be that clients are dissatisfied with something and want it to change. She further points out that a good proportion of clients start therapy without being at a point of understanding or even

considering taking on the responsibility for making active changes to their lives. In this author's view, therapy is often a process whereby the client's motivation for change is purposively developed over time. A second criticism made to the application of SDT to therapy in this paper refers to the concept of intrinsic or internal value assigned to internal motivation for change in therapy. In her view, for this idea to be true, clients would be expected to experience change behaviours as more enjoyable and satisfying, something she argues has not been the case in her clinical practice. In fact, Carter talks about the disparity that some clients experience between their motivation for change and the value and enjoyment that they experience from it. Carter ends the paper by arguing that, contrary to the SDT claim, all therapeutic models lie on a continuum in terms of the importance and focus placed on the client's motivation for therapy and their understanding of the causality of behaviour. The author suggests that motivation for therapy is a factor common to all therapy approaches, irrespective of the different techniques and outcomes employed by each approach.

Scheel (2011) also published a reaction paper in response to Ryan, Lynch, Vansteenkiste and Deci's (2011) article, but his was a more enthusiastic defence of that article. In his paper, particular emphasis is placed on the mutual interplay between what Scheel describes as clients' common factors in therapy (motivation and autonomy) and the clients' effective engagement in therapy (therapeutic alliance). He further suggests that therapists should match their therapy approach to the client's strengths and styles, something that is not advocated by the SDT theorists.

In their response to these two articles, Lynch, Vansteenkiste, Deci and Ryan (2011) attempt to resolve some of the criticisms raised. First, they assert that the client's motivation and autonomy in therapy should be viewed as both a process and an outcome of

therapy. The authors then stress the importance of the quality of the client's motivation for therapy, rather than its quantity. More specifically, Lynch et al. (2011) posit that the more integrated or autonomous is the client's motivation for therapy, the higher the chances of him or her to be engaged in it for longer, and to take more gain from it, compared to a client whose motivation for therapy is high but external. The authors state that clinicians should encourage clients to be more able to make life choices which are congruent with their values and beliefs, and to be more in touch with their feelings, and that external motivations obstruct their self-awareness. They also declare that in no situation do they advocate the exclusion of clients who are not sufficiently autonomously motivated for therapy and change.

Second, Lynch et al. (2011) clarify that autonomous motivation for therapy should not be seen as a prerequisite for therapy, nor should therapeutic change be necessarily experienced as enjoyable. Instead, they stress that enjoyment is only one way in which autonomous motivation may be experienced, given that individuals can autonomously and willingly agree to activities which may be challenging or painful.

Finally, the authors discuss what they class as a misunderstanding regarding their supposedly evaluative take on the types of motivation experienced by individuals (ranging from external to internal). It is rather the empirical findings (e.g. Deci and Ryan, 2000), the authors claim, that have led them to advocate the helpfulness of integrated (i.e. activities consistent with one's values) and intrinsically (i.e. activities inherently enjoyable or interesting) motivated activities over introjected (i.e. activities associated with guilt feelings or aimed at gaining social approval) or externally motivated ones (i.e. activities contingent to secondary gains).

Overall, Lynch et al. (2011) seem to take this opportunity to clarify and therefore shed some light onto some of the more theoretical underpinnings of the SDT theory.

6. Discussion

The present review includes a variety of peer reviewed papers, ranging from theoretical accounts on the application of SDT to therapy, to papers describing studies where some of the SDT premises have actually been tested in different psychological therapy contexts and client groups.

Despite the reasonable number of empirical papers described in this review, none of them actually employed a randomised controlled trial methodology. In fact, a number of them either adopted a longitudinal design without the use of a control group or compared the outcome of existing therapeutic approaches, but no attempts were made to deliberately deliver and test an SDT-informed treatment procedure to the participants. The only exception to this was the paper by Vandereycken et al. (2009) on the treatment of individuals with an eating disorder, which compared a novel treatment which actively took on board the clients' preferences with a treatment which did not. However, the latter study was a quasi-experiment, since the two different treatments were not delivered in parallel.

The close examination of the empirical papers leaves the reader struck by how sketchy and inconsistent the findings appear to be. For example, in one paper comparing the outcome measures of individuals with a diagnosis of depression or anxiety undergoing therapy (Michalak et al., 2004), it was found that only the participants with anxiety seemed to have the endorsement of intrinsic goals associated with an improved clinical outcome. However, no suggestion was made by the authors to explain why the depressed

participants did not seem to benefit from having their intrinsic goals endorsed during therapy.

Other studies found an association between the perceived autonomy motivation in therapy and the amelioration of depressive symptoms (Zuroff et al., 2007; Dwyer et al., 2011) and anxiety symptoms (Dwyer et al., 2011). However, a third study revealed that this same association seemed to be only significant for individuals who had two or fewer episodes of depression (McBride et al., 2010). These inconsistent findings therefore pose some reservations regarding the alleged association between perceived autonomy and therapy effectiveness.

Moreover, Dwyer et al.'s (2011) findings that the association between the perceived autonomy in therapy and the amelioration of depression was entirely mediated by the client's cognitive changes raises some additional questions. Firstly, it suggests that more important than the experience of autonomous motivation in the group therapy for depression, it is the actual modification of unhelpful beliefs which leads to symptom improvement. Secondly, it seems to indicate that, contrary to SDT premises, autonomous motivation might not be such an essential feature of an effective psychological treatment. The fact that cognitive change mediated the effect of autonomy on symptom reduction does not mean that the same cognitive change would be exclusively dependent on autonomous motivation, as Dwyer et al. (2011) seemed to suggest. In fact, Vandereycken et al.'s (2009) study found that the difference in drop-out rate and in the outcome measures of the two treatments provided became non-significant within one month of treatment. As predicted by SDT, however, controlled motivation for therapy was indeed found in McBride et al.'s (2010) study to predict a lack of remission in depression.

Overall, the existing evidence on the effectiveness of SDT-based psychological interventions is still in its infancy. Nevertheless a number of papers reviewed here seem to find SDT useful in making sense of the psychological mechanisms of autonomy and motivation observed in clinical practice.

In addition, the papers reviewed seemed to neglect other important predictions made by SDT on the effectiveness of therapy. For example, only a few theoretical papers mention the concept of relatedness and competence in relation to its application to therapy, and none of the empirical studies described above seemed remotely concerned with or interested in investigating these concepts. It would have been interesting perhaps to study the relationship between the experience of perceived satisfaction of competence and relatedness in therapy and the internalization of one's motivation to change and therapeutic outcome, as predicted by SDT. Perhaps the fact that there are no available assessment measures of such constructs applied to therapy might make difficult their investigation. The devising of reliable assessment measures of the satisfaction of both relatedness and competence in therapy is therefore much needed. The investigation of the impact of identifying intrinsically motivated therapeutic goals and having these met during therapy was also surprisingly neglected. Only one study looked into this important SDT prediction (Michalak et al., 2004), failing to satisfactorily explain the partial corroboration of the theory. In light of these inconclusive findings, it would be interesting to replicate this study, perhaps even extending the experimental groups to individuals suffering from other problems, this time paying a special attention to the specific goals generated during therapy.

Another pertinent suggestion for future research in this field refers to the devising of studies which are actually set to test the efficacy of a SDT informed therapy approach,

as opposed to assessing constructs such as autonomy and motivation in a given therapy. Such studies would also benefit from employing a randomised controlled trial (RCT) design. This would help clarify the efficacy of SDT informed treatments by reducing the likelihood of type-1 errors.

All the studies outlined in this review, including the case studies, seemed to privilege a quantitative methodology of investigation, where symptoms were compared before and after a psychological intervention took place. This type of investigation is based on the positivist premise that there is one reality or ‘truth’ which is liable to be ‘discovered’ by the study of observable and factual information. In quantitative studies one can therefore be persuaded that error and biases are minimised by the employment of rigorous and standardized procedures and the use of statistical packages of data analysis. Qualitative methods, however, are fundamentally embedded in a social-constructivist paradigm, which assumes the existence of multiple ‘truths’. Thus the investigation of the application of SDT to therapy would be much enriched by giving voice to the experience and the sense made by the individuals who undergo an SDT informed therapy. The findings yielded from such studies would most certainly help complement the existing knowledge in the field of SDT and its clinical application. For example, one could gain a better understanding of the contexts in which the endorsement of a given intrinsic goal in therapy might be experienced as beneficial.

Finally, a number of clinical implications derived from the present review are worth mentioning. Firstly, there seems to be a possible link between perceived autonomy in therapy and symptom improvement and well-being. In fact, the effect of perceived autonomy was found to be even stronger than that of the therapeutic alliance, at least in less chronic cases of depression. Secondly, the endorsement of intrinsic goals in therapy

may be associated with a reduction in anxiety as predicted by SDT, but surprisingly not in depression. Thirdly, being aware of one's feelings in the present via the regular practice of mindfulness meditation might reduce the experience of anxiety, at least in mild cases.

Fourthly, other evidence-based therapeutic interventions (e.g. CBT, Motivational Interviewing and Person-centred therapy) may be more effective in the clients' engagement and treatment when integrated with some of the SDT premises as described before.

RESEARCH PAPER

How can psychological therapy help young people with complex mental health difficulties improve their well-being and sense of self? A study of the clients' views

Word Count: 11047 (excluding tables and extracts)

ABSTRACT

The psychological treatment of young people deemed to be at risk of developing enduring mental health problems has recently been proposed to prevent the escalation of their symptoms. But little is known about whether well-being is being addressed in these treatments. This paper describes a qualitative study of the experiences of young people with severe mental health difficulties who have undergone psychological therapy. It explores the extent to which psychological treatment might impact on the participants' self-image and well-being. Seven participants were interviewed using a semi-structured questionnaire, focusing on their experiences of therapy. The interviews were digitally recorded and transcribed in their entirety. The analyses of the transcribed interviews employed Interpretative Phenomenological Analysis, and yielded four main themes: (1) 'the challenge of a psychological account' (i.e. participants' struggle to recognise their suffering as psychological); (2) 'the ambivalence inherent in learning to trust the therapist' (i.e. therapy was perceived as a threat across all narratives, whilst also being described as relieving); (3) 'therapy as a process of *opening* oneself to new experiences, self-knowledge and to a more optimistic outlook on the future' (i.e. therapy was described as a catalyst for trying new things, including understanding oneself better) and (4) 'growing up in therapy' (i.e. realising the importance of autonomy and of being "true to oneself" in order to maintain a felt sense of well-being). The study therefore highlighted, from the perspective of these young participants, that being in therapy facilitated the development of much more than the simple relieving of symptoms.

Keywords: Qualitative Study; Psychological Therapy; Well-being; At-risk population

INTRODUCTION

Over recent years there has been a shift in trying to understand and study mental health phenomena by investigating what contributes to people's well-being, as opposed to focusing purely on the study of risk factors and symptoms (Lemay and Ghazal, 2001; Seligman, 2002). According to positive psychologists, the study of people who do well despite negative life conditions and experiences is the key to understanding and helping individuals. The concept of resilience in this context is therefore thought to be a set of behaviours and internalised capacities which help individuals overcome adverse conditions and enhance their functioning (Gilgun, 2005).

With the emergence of Positive Psychology interventions, the idea of boosting one's strengths and improving one's well-being became a matter of greater concern when planning and setting up mental health services (Seligman, Steen, Park, Peterson, 2005; Taylor, Taske, Swann, Waller, 2007). Examples of these strategies are early intervention services in the prevention of mental health problems, mental health promotion programmes, and the proliferation of non-pharmacological interventions, such as psychological therapy (Taylor et al., 2007).

Despite a growing awareness of the importance of taking into account the individual's strengths, resilience and well-being, this is still far from being a common practice of mental health services across the U.K. For example, due to the funding of services in the NHS being increasingly associated with the outcomes that these services achieve (Department of Health, 2012), this has led to the increasing routine use of measures of outcome which focus purely on symptoms (e.g. Health of the Nation Outcomes Scales - HONOS; Bebbington, Brugha, Hill, Marsden and Window, 1999).

Nevertheless, mental health services across the western world are increasingly providing psychological treatment to individuals deemed at risk of developing severe mental health problems. Despite having complex mental health difficulties and in most cases requiring admission to a hospital, such individuals do not meet the threshold of a full diagnosis of a severe mental health problem. In these cases, psychological treatment has been first introduced in an attempt to prevent the escalation of the individuals' symptoms (McGorry, Yung, Phillips et al., 2002; Morrison, Bentall, French et al., 2002; Morrison, French, Walford et al., 2004). Little focus, however, has been put into studying whether clients' well-being is actually being addressed in these treatments. With the exception of a qualitative study on clients' experience of an early detection and intervention service (Hardy, Dickson and Morrison, 2009), the few randomised controlled trials investigating these obviously pioneering psychological treatments seem to focus exclusively on the relapse rate of participants and on their symptoms, as opposed to providing a more holistic understanding of the impact of treatment on individuals (Morrison et al., 2004; Morrison, Stewart, French et al., 2011). It might therefore be of interest to further investigate how these young clients (who in the past would have received little help from services) experience their psychological treatment.

When thinking about the promotion of well-being, it makes sense to use a framework which helps to understand its underpinnings. The Self-Determination Theory (SDT; Ryan, 1995; Ryan and Deci, 2000) is a social psychology theory, which proposes that well-being is best achieved when individuals have their fundamental psychological needs met. Studies testing this theory's predictions have found that the satisfaction of autonomy and self-esteem are the best predictors of well-being, followed by relatedness and competence (Ryan and Deci, 2000; Sheldon, Elliot, Kim, et al., 2001). It follows from

this that the development of mental illnesses is associated with environments which thwart the satisfaction of these fundamental psychological needs (Sheldon et al., 2001). In addition, it has been found that when people identify goals which are in line with their self values and interests, they are more likely to strive towards attaining them, and to experience higher well-being (Sheldon and Elliot, 1999). However, all of the existing studies in this field have employed a quantitative method of analysis, and therefore lack insight into the personal significance of the concepts underpinning the theory. Furthermore, all these studies have been conducted with subclinical undergraduate samples, and hence their findings cannot be generalised to other populations, such as individuals with mental health difficulties.

More recently, Ryan and Deci (2008; 2011) have put forward a psychological therapeutic approach which is based on SDT premises. According to this approach, the clients' perceived autonomy is paramount, and therefore therapists are advised to promote a therapeutic environment that facilitates the perceived autonomy of clients. The authors suggest that this is best achieved by validating and empathising with the client's point of view, promoting the client's reflection, and offering a sound rationale for any suggestion made. Additionally, therapists are encouraged by this approach to promote the client's satisfaction of integrated and intrinsic needs, whereby clients are assisted in developing self-knowledge and in being in touch with their feelings in the present. However, with the exception of a couple of empirical studies pertaining to the treatment of anxiety (Dwyer, Hornsey, Smith et al., 2011) and depression (Zuroff, Koestner, Moskowitz, et al, 2007), little is known about the effectiveness of this approach. More specifically, there have been no studies looking into the clients' experience of such a therapeutic approach, and their views on its helpfulness.

Given that SDT stresses the importance of the environment in the satisfaction of one's fundamental needs (Deci and Ryan, 2000), it would be interesting to study the extent to which mental health services are actually promoting the fulfilment of such fundamental needs, as opposed to simply reducing the symptoms of their clients. This would help understand how, from the clients' perspective, the provision of psychological therapy may add value to more traditional pharmacological treatments. Moreover, it has been found that most mental health difficulties tend to have their onset in adolescence (Kessler, Berglund, Demler et al., 2005). And given also that adolescence is a ripe period for identity formation (Erikson, 1980), adolescence might be an opportune time for psychological interventions to take place (Berzonsky, Kenneth and Neimeyer, 1990). This is precisely the age group targeted by two innovative psychology-led services which have recently been set up in the West Midlands, with a view to prevent the worsening of these individuals' mental health problems. It therefore seems pertinent to investigate whether these young individuals who have been in receipt of psychological treatment are aware of having any self-motivated goals (Sheldon and Elliot, 1999). It also seems important to study how these clients understand the satisfaction of their fundamental needs and how this relates to their well-being (Ryan and Deci, 2000).

Hence the present study attempts to explore how these young individuals experience psychological therapy, and how this experience might influence their well-being, their views of themselves and their future aspirations. In order to best achieve such aims, it seems important to employ a qualitative method of investigation in general, and a phenomenological approach in particular. This methodology will hopefully provide a more robust insight into the understanding of these individuals' subjective experience. The other advantage of this type of research is that, being exploratory and therefore free of a-priori

hypothesis, it allows for the retrieval of unconventional and original findings (Rodgers, 2002). Tentative interpretations of this descriptive data will be attempted, with a view to help shed some light onto the effects that such innovative psychological interventions may have on the lives of these troubled young people. Finally, a phenomenological approach is useful in bringing out meaningful issues and giving voice to individuals who would otherwise not be heard, such as in the case of these young clients. Perhaps the findings obtained from the present study might come to challenge some existing assumptions on the benefits of such treatments.

METHOD

Aim

The primary aim of the present study was to explore young people's experience and understanding of their psychological therapy. Three secondary aims were also identified, namely (1) to investigate the extent to which young clients with complex mental health difficulties consider that psychological therapy has helped them improve their well-being and sense of self (2) to explore how the latter has been attempted in therapy and to learn what clients have found most helpful, and (3) to understand the extent to which these clients are tuned into their fundamental psychological needs and the different ways of fulfilling their life goals following therapy (Ryan and Deci, 2000). Following from these aims, it makes sense to highlight that only participants ranging between the ages of 16 and 19 are to be included in the present study, due to the study focus being on the experiences of adolescents and their identity struggle and search for meaning.

Service Context

Participants were recruited from two services, the Youth Support Clinical Team (YSCT) and the Early Detection and Intervention Team (ED:IT). The first service's remit is to improve the provision of mental health treatment available in the community to 16 and 17 year olds within Birmingham. This team aims to smooth the transition of young people over the age of 16 into mainstream services for adults of working age, whilst preventing unnecessary hospital admissions and supporting their mental health and the development of skills for adult life. The ED:IT service, however, is part of the Birmingham Early Intervention Service in psychosis. This team provides assessment and psychological treatment to young people (aged 16 to 35 years old) deemed to be at ultra high-risk of developing psychosis, and this was the first service of this kind to be set up in the UK. Both teams are inner-city community based, and employ a multi-disciplinary team of psychiatrists (in the case of the YSCT), clinical psychologists, community mental health nursing and vocational staff. The psychological approaches employed by the clinical practitioners in these teams are varied, ranging from Cognitive-Behavioural Therapy to Psychoanalytic Therapy, or an integration of the two (e.g. Cognitive-Analytic Therapy). Referrals to these teams are received from across the city of Birmingham.

Ethics

An application for the West Midlands Research Ethics Committee was submitted, and its approval was received within less than 3 months, with recommendations being made by this board for some alterations to the participants' information sheet and consent form. The Research Governance approval was also granted by the local NHS Trust's Research and Development committee.

Participants

Table 1. Inclusion and exclusion criteria.

Inclusion criteria	Exclusion criteria
<ul style="list-style-type: none">• Aged between 16 and 19 years old.• Good expressive and receptive English language skills, due to the feasibility of the study relying heavily on the participants' ability to articulate their experiences in a free-flowing and a meaningful way.• Participants will have had a minimum of nine sessions of psychological therapy within the EDIT or the YSCT service.	<ul style="list-style-type: none">• Individuals below the age of 16, or above the age of 19 years old.• People with moderate to severe learning disabilities, so as to increase the chances of gathering sound phenomenological accounts from the participants.• People with a diagnosis of Autistic Spectrum Disorder.

Table 1 provides a summary of the inclusion and exclusion criteria. Seven young clients who had been in receipt of psychological therapy were recruited from relevant NHS services in Birmingham, which provide psychosocial support to this client group.

Due to the present qualitative research project following an Interpretative Phenomenological Analysis approach, a degree of commonality or homogeneity within its small sample was required. For this reason special care was taken in the recruitment of a sample of clients from the above mentioned services who had had similar experiences of treatment (in terms of duration and focus), and of unmet psychological needs (in terms of referral to similar services). Consequently the sampling was purposive and was carried out via the referral from the care-coordinators or the therapists who worked closely with them.

All participants were required to have had a minimum of nine psychological therapy sessions, in order to be able to provide a sound account of their experiences as a client. This decision was based on previous studies which found that for clients to be able to form an understanding of the process of therapy, as well as for therapy to have had an

impact on individuals, they need to have undergone a minimum of nine sessions (e.g. Luty, Carter, McKenzie, Rae, et al., 2007). Participants with a diagnosis of Autistic Spectrum Disorder were excluded from the study, in order to retain the focus on therapeutic interventions with a shared focus on wellbeing. This also ensured that all participants had a degree of metacognition that allowed them to reflect on their experiences (e.g. Williams, Lind and Happé, 2009).

Regarding the demographic characteristics of the participants, two participants were male and five were female, five of whom were of British-White ethnicity, one was of Mixed Afro-Caribbean and White ethnicity, and one was of Asian ethnicity.

Recruitment

Clinical staff were briefed by the author on the profile of potential participants, as described above. Potential participants were first identified by the clinical staff, who were also responsible for introducing the study to these potential participants, by handing out the information sheet, and clarifying any initial questions they might have had regarding the study.

When participants expressed an interest in taking part in the study, their permission for being contacted by the researcher was then sought by the clinical staff. Contact details for those participants who expressed an interest were passed on to the author at this point. Only two weeks after this were participants approached by phone by the author, to ensure that they had enough time to reflect upon their decision to take part in the study.

During this telephone call, participants were informed in more detail about the study. For example, it was made clear to them that the study involved a single one-to-one interview about their experiences of psychological therapy, and that verbatim extracts from

the interview were quoted in the final report, but that their real names would not be used. It was also made clear that participation was entirely voluntary and had no impact on service provision. The author clarified any questions regarding the study and explored any concerns the participants had regarding their anonymity.

A total of 14 potential participants were identified by the clinical staff and contacted by the author. Two potential participants agreed to meet with the author twice, but failed to attend the meeting, without giving any reason. Four other potential participants either declined taking part when approached by the author or were deemed by the clinical staff to be in a highly risky or vulnerable period in their lives, due to an unexpected life event or self-disclosure. Eight participants agreed to meet with the author and went ahead with the interview itself. However, due to a technical problem with the digital recorder, one of these interviews was not recorded and therefore was not possible to be included in the present report. A final total of seven interviews were analysed and their findings are the focus of this report.

Data collection

Participants who confirmed their interest in going ahead with the study were asked to meet with the author on one occasion. At the start of this meeting they were provided with the typed information sheet, and invited to give written consent. If they were happy to proceed, they took part in an interview about their experience of therapy and its impact on their lives. This meeting took on average one hour and a quarter. The interviews were digitally recorded, with the consent of the participants involved. After this, participants were debriefed and the author made herself available to answer any questions they might have regarding the study. At the end of the interview, the author checked with each

participant to confirm whether or not they wished their transcribed interview to be included in the final report.

Interview schedule and service-user consultation

A semi-structured interview schedule was devised bearing in mind the specific age group and characteristics of the population it was addressed to. Effort was made to commence the interview with broader and less challenging questions regarding the individual's experience of therapy, and to enlist as many prompts and suggestions as possible, in an attempt to facilitate the participant's responses. The final version of the interview schedule (see Appendix 1) was concluded following the consultation of a service-user, who offered some important suggestions on the wording and order of some of the questions.

Data analysis

The data were transcribed and analysed using Interpretative Phenomenological Analysis (IPA). This is a psychological qualitative research method with a special focus on the understanding of how individuals make sense of their experience (Larkin and Thompson, 2012; Smith, Osborn and Jarman, 1999). This method was chosen on the basis of the underlying aims of the study, whereby the experience and perspective of young clients with complex problems in receipt of psychological therapy was investigated.

In IPA the researcher's interest lies in the meaning and the significance of the lived experiences conveyed by the individual, as opposed to in the causative nature of events. More specifically, this approach is fundamentally *idiographic*, as it is focused on the specific meaning that an individual in a given context makes of their perceived reality, rather than in uncovering general principles or testing theories. In doing so, the

understanding of someone's experience is not directly accessed by the researcher; instead it is derived from a lengthy process of interpretative sense-making of the individual's accounts. In fact, because of its basis in existential phenomenological premises, IPA follows the principle that all experiences are relational, and hence its understanding is necessary intersubjective and interpretative (Smith, Flowers and Larkin, 2009).

Consequently, IPA researchers are required to hold in mind their own beliefs, judgements and experiences in order to fully relate and understand another's experiences. The process of bracketing one's beliefs is therefore best achieved by first acknowledging and reflecting on the intersubjective nature of the interpretations generated, and second by making a deliberate effort to root them in the participant's narratives (Larkin and Thompson, 2012).

After transcribing the interviews in their entirety, the author attempted to analyse their content more closely, looking for patterns. This yielded a series of "super-ordinate themes", describing the participants' understanding of their experience, all of which are outlined in more detail in the results section.

Process of analysis

All transcripts were first read and, subsequently, the focus of the analysis was on each individual transcript at a time. Each transcript was re-read, then line by line analysis was carried out, whereby the author noted down the matters of concern of the participant. After this the experiential claims made by each participant and the relevant quotes and reference line and page numbers were inputted to an EXCEL file, along with the correspondent interpretative notes made by the author (see Appendix 2). Special effort was made to keep these notes as grounded as possible in the participant's narratives. All remaining interviews followed the same process of analyses.

An in-between participants' analysis was then conducted via the close examination of a table which included all the phenomenological matters of concern expressed by the participants (see Appendix 3). The author tried to look for common patterns in the experiential claims made by different participants, as well as for contradictory matters of concern between participants. This process of analysis was iterative, whereby the author repeated and reorganised the wording and shaping of the themes across the individual transcripts numerous times. Four overarching themes and 13 sub-themes were finally identified and are described below.

Validity

The close and regular monitoring of the data analysis by the author's supervisor ensured a greater transparency of this process. Cross-validation of the data was also carried out by the author's supervisor, who was able to match the transcripts to the identified themes (Smith and Dunworth, 2003). All the interpretations of the themes attempted by the author were well justified and grounded in the participant's views.

Reflections derived from the interview process

The process of adopting a more neutral stance when carrying out the interviews was experienced as particularly challenging by the author (Smith, Flowers and Larkin, 2009). This was because she had been used to carrying out clinical interviews, where the use of active listening skills, including the empathic paraphrasing and reflecting of interviewees' feelings, is commonplace. As a result, the author often provided long summaries and perhaps unnecessary links between the different questions being asked and the participant's accounts. This was particularly apparent in those interviews where

participants seemed a little uneasy with the interview process and struggled to elaborate their points or to provide examples of their experiences and opinions. Perhaps the author's interview style might have helped participants to feel listened to and understood, therefore helping them slowly to open up about their experiences, akin to their actual therapy process.

The other major challenge experienced by the author referred to the “bracketing” of any a-priori hypotheses and theories, both when interviewing the participants and especially in the early stages of the transcript analysis. Regular supervision discussions were especially helpful in the data analysis stage, as it helped prevent such instances of speculative psychological formulation of the participants' accounts. At times, however, the author became aware of how she felt triggered by the negative views that some participants reported about previous therapists or therapy itself. On these occasions, an active effort was made to empathise and give voice to the participants' views, regardless of the author's personal beliefs about therapy.

Descriptions of participants

A brief description of each interviewee's background and history is provided below, with a view to contextualise some of the accounts they go on to share later in this report regarding their problems and their overall experience of therapy.

Participant 1

James is a 19 year-old White British man, who lives at home with his mother and her partner. His parents separated when he was six years old, and prior to this he is said to have witnessed domestic violence between them regularly. He was referred to the ED:IT

team by the A&E department after he sought non-emergency help from them. He presented with infrequent auditory hallucinations, paranoia (he was preoccupied that his friends wanted to kill him and so tended to avoid interactions with others), deliberate self-harm (by pinching and scratching his arm), suicidal ideation and difficulties controlling his anger. At the time he was interviewed he was about to be discharged from ED:IT, after having been in therapy for approximately one year.

Participant 2

Paula is a 17 year-old White British woman, who lives at home with her father. She was seven years old when her parents separated, and she reported that her relationship with her mother had always been strained due to her being frequently absent from her life while she was growing up. Paula was said to have been moved from three primary schools due to being bullied, and she reported feeling “left out” by her peers. She was referred to the YSCT by her GP with complaints of migraines with no organic cause, along with repeated spells of low mood, deliberate self-harming (by making cuts to her arm with scissors) and difficulty controlling her emotions. At the time of her interview, she had been in therapy for about nine months.

Participant 3

Laura is a 19 year-old White British woman, who was referred to the ED:IT service by her GP due to difficulty in sleeping, low mood, obsessive thoughts, paranoid ideation, auditory hallucinations (which happened twice or three times a week) and deliberate self-harm (by cutting her arm with a blade). She lives at home with her parents, and has a brother four years her senior who no longer lives at home. Laura is also said to have suffered physical

health problems in her childhood. At the time Laura was interviewed, she had been in therapy for around two years and was in the process of being discharged.

Participant 4

Delia is an 18 year-old British Asian woman, who is one of six siblings. She lives at home with her mother, her two younger brothers, her eldest sister, her sister's husband and their baby boy. Her parents separated when Delia was 12 years old, and despite her father remarrying soon after the divorce, he is said to frequently stay in Delia's family home. Her first depressive episode occurred when she was 14 years old, following a physical assault by her father. After this incident she stopped going to school for around two months and became increasingly suicidal. She recovered from this depressive episode, but aged 17 years old, following her best friend's sudden move abroad, Delia started feeling low in mood again, paranoid and began to hear voices which made derogatory comments about her. She sought her GP's help around this time due to having chest pain, and was referred to the ED:IT service. At the time of her interview, Delia had been in therapy for approximately one year.

Participant 5

Tom is a 19 year-old White British man, who lives at home with his parents and older sister. He was referred to the ED:IT service by the Home Treatment Team, after seeking help from the A&E department. He complained of social anxiety, intrusive thoughts and images about being a paedophile and of murdering his parents, and excessive preoccupation with soiling himself in public. Tom reported that, aged 10 years old, he had been teased by his peers for soiling his underwear slightly at school. He is said to have

been bullied at school for several years after this incident, subsequently becoming introverted, low in confidence and excessively preoccupied about losing control and soiling himself. At the time he was interviewed, he had been seen for therapy for around one year and was about to be discharged.

Participant 6

Joanna is an 18 year-old White British woman, who lives at home with her parents. She was referred to the YSCT due to being involved in planning a suicide attempt with another friend from school. When she started therapy, she was said to have had a two year history of depression (with intense self-deprecating beliefs), deliberate self-harming (by cutting, scratching and picking at her hands and arms), and suicidal ideation with associated suicidal attempts (having taken an overdose of paracetamol which required hospital admission). She also complained of body-image concerns, and she often vomited and restricted her eating. She later disclosed during treatment that her paternal uncle had sexually abused her in the past; an incident which seemed to have precipitated her mental health difficulties. Prior to being interviewed, Joanna had had six months of therapy. This was interrupted when she was re-admitted to a psychiatric hospital for around five months, following an increase in her risk to self in the context of her disclosing her sexual abuse.

Participant 7

Francesca is a 19 year-old woman of mixed White and Black Caribbean descent, who lives independently in a council flat. She was referred to the YSCT by the Young Carer's project, due to her low mood, alcohol misuse and self-harming behaviour. She reported that, aged nine years old, she started caring for her mother with learning disabilities and for

her little baby brother. This was also the time when her mother and her partner separated. She is said to have attempted suicide by hanging just before being referred to the YSCT, following the social services' decision to place her younger brother in a foster home. Francesca also reported a longstanding history of alcohol misuse, a habit she was introduced to by her mother and her ex-partner (drinking one to two bottles of whisky per week) as a way of managing low mood. At the time Francesca took part in the interview, she had been in therapy for around two years and a discharge plan was being discussed with her.

ANALYSIS & RESULTS

Description and interpretation of the themes extracted

A summary of four themes and sub-themes derived in the analysis is presented in Table 2.

A detailed description of these overarching themes and sub-themes is provided next, along with two or three extracts per sub-theme, as an illustration of the points being made.

Besides this, some interpretations on the data are offered by the author. Effort was made in having these interpretations embedded as closely as possible in the narratives of the participants, by drawing some tentative links between the specific extracts and the whole dataset and existing theories and common sense knowledge.

Table 2. Summary table of emerged themes and sub-themes.

Themes	Sub-themes
1. The challenge of a psychological account	<ul style="list-style-type: none"> - Struggling to recognise their suffering as psychological - Describing their suffering in concrete terms
2. The ambivalence inherent in learning to trust the therapist	<ul style="list-style-type: none"> - Negative expectations about therapy - Mistrusting therapy and testing the therapist - Talking in therapy as both relieving and challenging - Talking in therapy eased by experiencing the therapist as non-judgemental - Talking in therapy eased by worries about disappointing or hurting those you know
3. Therapy as a process of <i>opening</i> oneself to new experiences, self-knowledge and to a more optimistic outlook on the future	<ul style="list-style-type: none"> - Trying new things and learning to trust others outside therapy - Normalising problems and improving self-knowledge - Building resilience, optimism and hope in the future
4. Growing up in therapy	<ul style="list-style-type: none"> - Becoming more understanding of others - Realising the importance of autonomy and of being “true to oneself” - Aspiring to be an agent of positive change

Theme 1: The challenge of a psychological account

1.1. *Struggling to recognise their suffering as psychological*

Several interviewees seemed to talk about coming into therapy on the suggestion of others (e.g. GP, parents, school teachers), as opposed to seeking psychological treatment out of their own volition. This seemed to be especially the case for those participants who experienced their difficulties as physical health problems, who were also oblivious of any psychological contributors to their suffering.

For example, Delia talks about her surprise at her GP’s referral to a therapist:

“ Cuz I thought it would be something like... you know you’ve got a chest infection or what not... and he was just like... cuz I’d been like quite through a

lot in the past three years, it's all clogged up in your mind and he just sent me to a therapist."

Despite being somewhat aware of her ongoing experience of psychological difficulties, Laura recalls being referred by her GP for therapy with the view to having her self-diagnosed sleep paralysis further investigated, something she considered to be physically caused:

"well, at the time I was, I was having negative lots of thoughts and feelings. Err I was going through quite a bit in my personal life... and health problems, particularly sleep paralysis. Errr... I suppose they referred for therapy because they wanted to get to the bottom of the sleep paralysis, but, you know, it kinda lasted longer..."

Curiously, once in therapy, most participants found the psychological formulation of their difficulties particularly helpful, as it provided a sense of control and of self-management of their troubles. In the following transcript, Paula illustrates this idea, when she talks about her psychological understanding of her headaches:

"When you think: oh it's a medical reason, you just think, oh I've got a headache now, I got to take a tablet, and if it doesn't work, so you're getting stressed out. But, If I think that it's probably stress related, say if I'm in a bad situation, I take a step back and just breathe and don't let yourself get worked up cuz then you're gonna get a migraine."

1.2. Describing their suffering in concrete terms

Curiously, participants seemed to talk about their experiences in concrete terms, as opposed to elaborating on their meaning or on abstract impressions. This seemed to be particularly true for those participants for whom engagement into therapy was especially difficult. They often gave one word answers to open ended questions, and struggled to provide more than simple accounts of events and of what they learnt from them. For example, the following extract depicts Tom's description of his suffering prior to coming

into therapy, where he lists the specific difficulties that brought him to therapy and the direct impact that these had on his life:

“I was just going through like... sort of... sort of worry, anxious sort of phase and I sort of... it got to a point, and once I had a breakdown, but, it got to a point where I couldn’t really cope with it anymore and I started having... errr.... hyperventilating. (...) and it’s just got to the point that it was sort of affecting my... sort of my day to day life”.

This extract illustrates the factual way in which Tom recalled the difficulties which brought him into therapy. Again there seemed to be a special attention to the body sensations (“hyperventilation”), but also a suggestion of some psychological affliction (“worry” and “anxious”) which he was struggling with. But it seemed like his decision to seek help came from the impact that these experiences was having on his life, with the choice of the word “breakdown” being suggestive of his perceived collapse of his mind and of his life.

This tendency towards a more concrete pattern of thinking posed some serious challenges in the retrieval of a more expressive account of these individuals’ experiences. For some individuals, most of the questions they were asked by the author seemed to be somewhat novel. This required them to spend some time reflecting on their experiences and thinking them out loud, before being able to give their answers. It was also the case that, since it was often a new construct or idea being formed by the individual during the interview, there were some instances when the participants contradicted previous ideas they had put forward. As a result, the interview process was characterised by huge hesitation on the part of the participants, and at times lacked in coherence. This perhaps mirrored the actual process of therapy, which was described by the participants as non-linear.

Theme 2: The ambivalence inherent in learning to trust the therapist

2.1. *Negative expectations about therapy*

The first major challenge that all the participants seemed to struggle with during therapy referred to that of learning to trust the therapist and managing the uncertainty around the helpfulness of talking therapy.

For some, the novelty of the process of talking about oneself seemed to be out of character, and antagonistic to how they saw themselves and to their usual way of interacting with others. Hence, some participants expressed a considerable degree of scepticism in the helpfulness of such an unusual process. For example, Paula describes expecting herself not to be able to go ahead with therapy, due to feeling shy and unable to talk to others:

“I didn’t think it would help half as much as it did. I didn’t think I’d like it. I didn’t think I’d be able to do it before... I find I’m a lot more confident now than I was a few months ago.... The thought of being in a room with someone, and talk to them, I would have been like: “I don’t want to do that!”. Heeueue [makes noise] like that [laughs]. That was how I felt, because I thought it wasn’t going to help, but I just thought “how is it that is going to help?”, and I really won’t want to talk to her, and I’ll be too shy anyway...”

Laura’s scepticism of therapy is openly manifested by her lack of belief in her previous therapist’s genuine interest and care in helping her. The fact that that therapist was a “stranger”, and therefore not part of her life, seems to permeate a degree of artificiality, which she perceived to be an obstacle for his or her effective involvement and help:

“ a total stranger [therapist] isn’t even part of your life, he can’t do anything to help you. All they can do is just sit and go “ok, yeah, ok, I understand, I understand.... yes, we all have problems, etc”. That’s all they can say, not even come up with comforting words, just generic bollocks that they say to just everyone (...) Just generic things that they’ll say to everyone, like “oh,

yes, yes, everyone has those days”(…), as soon as like… you leave the room, they’ll just have forgotten everything, they don’t care about how you get on. All that you gain is that someone else, some complete stranger knows what’s going on in your life. That’s all you gained.”

From this extract one can sense the degree of contempt with which Laura talks about her previous therapist. It is curious that she would endorse such negative views of therapy, when she has actually given therapy a try three or four times, the most recent experience of which had been ongoing for over two years at the time of the study. This apparent inconsistency between her help seeking behaviour and her dismissal of the therapist she has seen seems to suggest that Laura is someone who has experienced interpersonal ambivalence first hand. She also talked about growing up in a family who she feels usually responded to her in a dismissive and disinterested manner. Perhaps Laura’s strong views of therapy illustrate the importance that young people might put in the establishment of a close relational bond with another, in order for trust to be secured.

Despite the overt scepticism and ambivalence about the benefits of therapy with which all participants seemed to have entered therapy, the majority of them actually pursued therapy voluntarily. However, a few participants experienced the start of therapy as extremely challenging, exactly because they did not want to pursue it, yet they felt they were coerced into it by mental health services. For example, in the following extract, Joanna talks about her failed efforts to communicate to the therapist that she did not want therapy:

“To be expected to talk about everything that happened. I didn’t want their help and I didn’t think they could help me. (...) I said I didn’t wanna see her, that everything was fine, that I didn’t need help.”

When exploring the underlying meaning that some participants assigned to the ambivalence they experienced about engaging in talking therapy, it became apparent that for most of them, coming in contact with mental health services was associated with the

stigma of mental illness (Arboleda-Florez, 2005). Participants therefore seemed to endorse stereotypical views of those seen by mental health services, which seemed to be associated with fears of being judged by others and deemed mad. Examples of these concepts were voiced, for example, by Paula in the following quote:

“Yeah, nobody had ever explained to me what it was.... uhh, people who have therapy are usually really like... I don’t know, when you hear about someone’s having therapy or seeing a psychologist, you just think: “hum? What’s wrong with you, then?””

and by Delia and Francesca, who stressed their fears respectively about the possibility of being thought of as “crazy” by others and eventually admitted to hospital:

“A bit scary at first. I thought I’m crazy, what’s going on? I thought, what will people think of me? That I’m eighteen and seeing a therapist.”

“when I spoke to [therapist name] about it [psychiatric hospital] and when he told me about it, I could just picture it was different from way way back... so... you know, the jackets and the people being locked up in dark rooms and stuff [laughs]... so I was like trying not to think of horrible things...”

Here Francesca talks about how her concerns about being forcefully taken into hospital for being considered mentally ill were at the forefront of her mind as she entered therapy. This is indicative of a tendency towards catastrophisation and a deep-seated mistrust of others, which is again unsurprising considering how unsupported and self-reliant Francesca grew up. This is perhaps indicative of how scary and counter-intuitive some young people such as Francesca might find therapy.

2.2. Mistrusting therapy and testing the therapist

Other participants’ mistrust in therapy at the start of therapy seemed to be especially significant to the point that these participants believed the therapist not to be seriously

concerned with their treatment. They therefore expected the therapist to lose interest and to “give up” on them soon after the start of therapy. For example, in the next extract, Joanna talks about her surprise at realising that the therapist continued coming to see her, despite the “shameful” disclosure she had made:

“I thought she was going to be walking away like everyone else... I don’t know.... I thought she would stop coming. (...) It’s always easier to walk away than to come forward. (...). I think I soon realised that it might have been the right thing, cuz she still didn’t walk away... and I thought she would. I told her like the worst thing about me and... I don’t know, she was still understanding of me.”

Francesca’s extract is another good example of the extent to which some participants’ suspiciousness and scepticism of therapy was played out. She talks about how she found herself adopting what appeared to be a defiant attitude at the start of therapy, but which she came to realise was perhaps her way of testing the therapist. Perhaps this testing of the therapist was an attempt to protect herself from being let down by the therapist and of slowly building trust in therapy:

“When I met him and... I think, I think it was kind of a test for me not saying anything. To see how he would react to, you know, things like that, us not to speak. I think that it was like, you know, without myself knowing, I was testing him... but, yeah, I got used to him. He was all right, he passed [laughs].”

2.3. Talking in therapy as both relieving and challenging

Several participants described the process of therapy in somewhat contradictory terms. For example, for some therapy seemed to be experienced as extremely challenging, particularly at the start of the process of building trust, as described before. However, as time went on most participants seemed to become familiarised with the process of opening up in therapy, and seemed to derive a great deal of satisfaction and a sense of relief from it.

The following two transcripts from Tom and Delia, respectively, illustrate how talking in therapy was experienced by these participants as an important and much needed “outlet”.

“So I was just sort of happy to get it all off my chest and tell someone about it. Cuz even with my mum and dad it was sort of... I was sort of, you can’t really let it all out and just tell everything that’s on your mind. So it was sort of nice to have some kind of outlet, and just getting it all off my chest...(...) I don’t know, it just felt like I could do with getting things off my chest so... I remember walking out of the first session feeling sort of... more relaxed than before I had been”.

“It was like, during the week, I’d think think think think, and you know my shoulders... the weight on my shoulders would be so much. And then I’d find that I came here for an hour... it all just went... And it was just like that, it felt like that for the first couple of weeks, that’s how it felt like. It was kind of a weight from me would just release. And that’s what I thought at the beginning, it’s just me releasing”.

Both narratives illustrate the significance that these participants derived from beginning to trust the therapist and open up. It is curious that language chosen here to describe the experience of opening up actually captures a sense of liberation (e.g. “outlet”, “getting it all off my chest” and “weight from me would just release”). Talking in therapy therefore seemed to provide a much needed breathing space for these participants, whilst hinting at how pressured and constrained by these difficulties some participants felt prior to coming into therapy.

In the next quote, Paula describes the benefits she derived from talking in therapy, but she also stresses the struggle she experienced in getting used to the novelty of opening up and trusting in the therapist:

“It was really hard! I found that really difficult... because.... to me... it was just like... you just don’t do that. You never speak to anyone about it. And so much has happened, and I didn’t trust anyone. Cuz so much of bad had happened that I didn’t trust them, I didn’t want to talk about it, I didn’t want

to relive it. But once I started, it felt good. And I felt better in myself, and I felt lighter... I felt... not happier... I can't really explain it... I just felt better!"

In fact, despite being in therapy for several years, some participants talked about their continued struggle in talking about difficult feelings in therapy. For these few participants, talking in therapy and being in touch with difficult feelings continued to be experienced as particularly challenging and threatening even as therapy went on. For example, in the next quote, Laura describes her apparent unconscious attempt at diverting the focus of the session from the difficult feelings she was experiencing:

"I have a masters in diverting my feelings, [therapist's name] says. Errr... and there was another time... it was a different extreme errr... I was very angry about something. And I just sat... I sat like, pretty much where you are, just laughing for about 45 minutes. Just laughing my head off... And I didn't really get anywhere that session because I was just laughing so much, and I couldn't really control my laughter. So I don't know why I was laughing, cuz I was in such a foul mood! (...) But I found it very difficult to speak and I guess that's why I was laughing so much."

This extract shows a very painful time in Laura's life, which she dealt with in a rather peculiar manner. It illustrates the difficulty she can experience being in touch with raw feelings out in the open. It seems that on this occasion the therapist allowed her to unravel her emotional disturbance in whichever way she felt most comfortable doing, i.e. laughing. Laura also talked about being appreciative of the therapist's response, as it allowed her to simply process the pain she was feeling, until another time when she felt more able to directly address it. Laura's struggle to connect with her pain and to show her vulnerability in therapy, illustrated by this extract, is not uncommon amongst these young participants. Perhaps it is a reflection of some of the ways in which these individuals have learnt to manage their overwhelming feelings, i.e. by using avoidance and being cut-off. In

fact, several participants talked about avoidance of difficult feelings as their default strategy prior to coming into therapy.

2.4. *Talking in therapy eased by experiencing the therapist as non-judgemental*

Despite the apparent difficulty experienced by some participants in sharing their difficulties with the therapist, most participants seemed to compare the process of talking in therapy more favourably to talking with people outside therapy. Once trust was gained, therapy seemed to be experienced as a safer space than their home and social environment.

Some participants talked about feeling less worried about being judged by their therapist, compared to their family and friends. In the following extract, for example, Tom talks about his negative expectations of his friends' response to the hypothetical disclosure of his mental health difficulties. He then goes on to describe his contrasting views about his therapist's response to a similar scenario, highlighting the therapist's knowledge about the subject of mental health as a major asset.

"I think people talk about it as having a sort of stigma. I'm sort of, worried that they wouldn't prejudge me for having mental health issues, or he's strange or he's weird. I don't know, I suppose that's what, it just being those mental health subjects that you're just being talked about and joked about (...) It's just a lot easier, and it's sort of... I'm more confident in what reaction I'm gonna get because he's [the therapist] a professional and therefore, he knows what I'm talking about. Whereas my... so the fact that he's a professional helps a lot, because he's not got to think, like he knows what he's doing sort of thing. Whereas if I was seeing some of my mates and I was saying exactly the same thing, I might have thought it aint gonna work sort of thing, because you don't know exactly what you're talking about."

The following quote from Paula is another good depiction of the sense of safety and acceptance that most participants reported experiencing in therapy, compared with outside therapy:

“It was very... it was different, cuz it wasn’t emotional really. And... I was able to just sit there and... and express everything... so that would make me sound like... one day, I just gone in there and I was... oh, yeah, this happened and that’s happened... I probably sounded like, really spoiled and selfish... but, I wouldn’t have got judged... whereas if that was at home... I would have been “oh, for God sake, Paula!”, and then it would have turn into an argument... but I could go in there, you know, with [therapist’s name], and I could be really really upset and I could just have a little cry... and not get judged and nothing. So, it was just different.”

Furthermore, participants described their therapists’ responses to their problems as more helpful, due to the therapists being perceived as neutral, understanding, and overall less prescriptive compared with their family members and friends. These characteristics seem to facilitate the participants’ engagement and their openness in therapy. The following two quotes by Tom and Delia, respectively, provide a good illustration of how positively and helpful these participants perceived their therapists’ responses to their problems:

“At first, he [the therapist] was just very professional and just not reacting particularly... one way or the other, just taking notes and understanding all the different points I made. And he was analysing them, and sort of looking over them, and giving his opinion and that sort of stuff”

“I know [therapist’s name] won’t judge me. I know he won’t.... pick on things in my life, you know. Basically, he won’t tell me what to do and what not to do. He may reassure me and stir me into the right direction, but he won’t tell me to do specific things and that’s what your friends always do. Just do that or do that! And I like that, I could speak to [therapist’s name] and he... he might understand what I mean, but he’ll just... make sure that he knows what I, deep down, I want to pick but for some reason I wouldn’t pick it... and he’ll help me to bring down the reasons, you know, and pick the right one.”

These two extracts also describe a range of perspectives on how much therapists actually do in therapy. In the first extract, Tom reports that the therapist was interested and showed that he understood what had been said, but that he was also unaffected by the content of the session, all of which was perceived to be helpful. In addition to this, Delia

highlights in the second extract the importance of not being told what to do by the therapist, whilst being helped to find her own answers. She describes a process whereby the therapist skilfully and deliberately acted as a catalyst for her self-reflection. Both extracts portray the therapist as knowledgeable and measured, and therefore as someone they could more easily share their problems with.

2.5. *Talking in therapy eased by worries about disappointing or hurting those you know*

A few participants for whom the experience of opening up in therapy was perceived to be safer and easier than in their home environment talked about a pervasive worry about disappointing or upsetting others. For example, Laura reported that she often worried about letting her mother down, and as a result she would try and avoid talking to her when she felt at her lowest:

“my mum, we try and do things together. Some days she’ll want to talk to me and I’ll be like “piss off, get out of my room!”, “I don’t want to talk to you. I don’t want you getting involved”. But I suppose that’s to protect her from my thoughts and feelings. Cuz no mother wants to hear that their child is feeling awful.... and having thoughts of... stuff... [laughs] no mother wants to hear that...”

The following quote from Joanna is another good example that captures some participants’ views regarding the ease with which they are able to open up in therapy. This participant describes how she believed the therapist to be more robust and able to deal with the emotional and distressful content of her experiences, compared with her home environment:

“It’s a different relationship because you’re more impartial. And it’s easier to trust her [the therapist] and tell her things and you know it’s not gonna affect her as much. Like you’d probably worry your friends more, but she’s got supervision and she’s got things she could do back at work that tell her what to do. (...) I don’t wanna hurt them [friends], I don’t think I’ve got the right to. It’s my own shit.”

Overall, it appeared that the building of trust, which required participants to subject themselves to the possibility of being let down by the therapist, was experienced as a major challenge in therapy. In light of these conclusions, it is likely that these young participants were perhaps particularly vulnerable to interpersonal contexts, having developed protective strategies of social withdrawal, avoidance of difficult feelings and self-reliance, and a cautious attitude towards others. Despite the bleak picture that some of them gave of their social and family life, participants seemed to have generally learnt through therapy to drop some of their “safety” strategies as they began to engage fully in a more trusting and honest relation with the therapist. For some this was the first time that they had revealed themselves so significantly to anyone else, which they perceived to place them at serious risk of being rejected by the therapist. However, in doing so they seemed to have realised that therapy was a safe space, where they felt validated, understood and accepted for who they truly were.

Besides the difficult and satisfying task of building trust in therapy, participants also reported an array of other significant challenges and benefits they experienced in the therapeutic process. Overall, there is a sense of deep ambivalence throughout the narratives of these young clients, where therapy is talked about as a satisfying but also a deeply unsettling and difficult journey. A summary of the most significant experiences and knowledge learnt described by the participants in therapy is outlined below.

Theme 3: Therapy as a process of *opening* oneself to new experiences, self-knowledge and to a more optimistic outlook on the future

As we have seen, the process of therapy and of talking openly about oneself to the therapist was experienced as somewhat novel and challenging by the majority of participants. Related to this, another central experience in therapy described by most participants referred to the opportunity to develop a deeper understanding of oneself in the context of their life events, whilst being encouraged to try new and rewarding experiences in and outside therapy.

3.1. Trying new things and learning to trust others outside therapy

A number of participants gave very enthusiastic accounts of how being in therapy had been a catalyst in helping them generalise some of the positive experiences they'd derived from therapy to the outside world. For example, some participants felt deeply touched by the realisation that connecting to and being supported by one other person (in this case, the therapist) was hugely gratifying and seemed to generate a sense of warmth and self-confidence, which was extended to other contexts outside the therapeutic room.

The following quote depicts Paula conveying her realisation about the importance of talking about difficulties to others:

"I never wanted to, or I'd never thought to talk about it, cuz I... I used to think that bottling it up would make you a strong person, whereas now I can see that talking about it harder than you'd think it is, but that you should talk about it."

In the next two quotes, Delia and Joanna, respectively, also give their accounts of how they have changed the way they perceive talking to others since being in therapy:

“I feel like now... I can speak to friends, you know... I don’t have to be... I don’t have to be just one... (cuz I’ve got a split personality) I don’t have to be just one of my personalities, I can be both and friends should accept me for both personalities...”

“Yeah, I used to completely shut myself off. (...) I started talking more, but I thought to myself that when I made the pack that, I’d tell my friend and then my friend did that. But I think that’s helped me see that I can have the support of people.”

Interestingly, other participants experienced the process of therapy as one that “freed them” or “opened them up” from self-imposed restrictions or fears in life. For example, in the following two quotes, James and Delia, respectively, talk about becoming more confident and experimenting with new activities outside therapy, since “being free” or “being opened up” in therapy:

“Now I know that I could just go to Canada, and go “hi, are you alright?” “hi”... or just go and train with them and... And he’s [his friend] already invited me to go to Canada, for when he goes back and stuff. So just go and chill and stuff. So it’s just being again free, and having respect and things like that... therapy helped a lot with that, being able to talk to... sort of being free... and I used what happened in here out there... it opened my eyes a lot more to go, oh, there’s more than I actually thought out here. So today, I push myself to...doing horse-riding, rock climbing, I just try and keep active, and keep going”

“Well, to be honest, if I didn’t start therapy last July then, I wouldn’t be where I am, in my writing. That’s probably the biggest thing that I’m proud of. And I wouldn’t be there if it wasn’t for [therapist’s name] and, you know, the ED:IT team. Because I feel that... if they didn’t come out, you know, and made me come out of the... I don’t know, of my own bubble, they popped the bubble, I’m more friendly, they kinda of opened me, and I didn’t realise that I needed to be opened. And it was just one thing after another, and the voices started to go, and my paranoia started to go, and my confidence... is ok, but when I’m on stage is over the roof. Everything started to fall in place!”

Paula also described an increase in her self-confidence and her ability to socialise, since being in therapy:

“I’ve just gained so much more confidence. And I’ve started doing so much more... say, like tomorrow, cuz I’m starting college in September... tomorrow, I’ve got like a taster thing, and I’m quite excited about it. But a few months ago that would have been so daunting... to think about and just going to a room and to socialise with people that I don’t actually know. And I would have been like... oh, I’m gonna sit in the corner, and I would have probably not have went. But, I’m looking forward to it”.

It is interesting to see how the relationship built with the therapist, as well as the open communication, was understood to be so instrumental in the development of the participants’ self-belief and trust in others. Again, participants seemed to be more interested in talking about factual changes to their lives (e.g. starting to socialise more), as opposed to describing the internal processes that might have gone on as they felt more and more able to make those behavioural changes. One can only surmise that these young people had been deprived, or had deprived themselves, of having positive, secure and reliable interactions with others, and that the trust and self-respect instigated by therapy made room for it to be also tried outside therapy.

3.2. Normalising problems and improving self-knowledge

The theme of being “freed” and “freeing” oneself in therapy seems pervasive across the narratives of many other participants, who talked about the significance of adopting a more compassionate, understanding and less judgemental attitude towards their lives. In keeping with Hardy et al.’s (2009) study, it was as if the therapeutic process, and the understanding conveyed by the therapist, had allowed participants to reframe their experiences and difficulties in a less shameful and derogatory manner. In the next extracts, participants

Paula and Tom seem to convey this idea when they talk about their acceptance of their difficulties following therapy:

“It taught me it’s ok to talk about things, it’s ok to cry, to show your emotions, to not bottle it up. And that it’s ok to... to write things down, and stick something on your wall if that’s going to help. And it’s ok to not be ok sometimes, as well. And that’s a big thing that I learnt!”

“I learnt that nothing is that wrong with me... and that everyone’s got worries, and maybe they don’t show them, but that there’s nothing that wrong with me that I can’t get over.”

Besides helping individuals “normalise” and accept their difficulties, some participants went on to talk about how therapy, and a psychological understanding of their experiences, had promoted a kinder appreciation of their lives, ultimately helping them feel better about themselves. For example, Paula and Joanna, respectively, illustrate this point in the following extracts:

“from therapy I sort of realised that, a lot of things that have happened wasn’t my fault... and I... sort of blamed myself for it... but it hasn’t been my fault... and then... I used to think that it was sort of big headed to describe yourself as a nice person, but.... to think of the things that I do, then I think, I am a nice person!”

“I think it helped me now to understand why I am like this... I used to think it was just how I was supposed to be. But I think I understand why now, rather than wanting things to change. (...) I think what happened wasn’t my fault now”.

It is striking how these participants had lived through such terrible experiences in their young life as to endorse such denigrating and damaged views of themselves prior to coming into therapy. Therapy was, equally, the first time that both these young women took the risk of disclosing these “shameful” experiences to another individual. In doing so, they were met with compassion and understanding by the therapist; something neither of them felt they deserved given the extent of their self-deprecating beliefs. It thus makes

sense that the positive experiences lived in therapy had such a reparative effect on these susceptible individuals, since they were the exception to an otherwise especially hard life.

3.3. *Building resilience, optimism and hope in the future*

In the process of freeing oneself from derogatory self-views and self-imposed restrictions, participants seemed to describe becoming increasingly surprised and pleased with their achievements inside and outside therapy. Most participants, actually, described this as an iterative process, whereby they would slowly build their confidence and skills outside therapy.

Interestingly, with the increase in the number and frequency of positive coping experiences outside therapy along with the lessening of their difficulties, participants seemed to begin to feel increasingly hopeful and optimistic about their future. The following three extracts by participants Joanna, Tom and James, respectively, are good examples of how participants felt enthused by the successes they perceived during therapy:

“It’s a reason not to give up, because things can change. (...) If something’s happen I’ve got a chance to do something about it.”

“I suppose it makes me sort of feel like I can cope with things, and to think I had that thought that I couldn’t cope with things before so, it makes me feel more independent, because I suppose my mum has always been that sort of rock, that person I could always count on. And when she wasn’t... she was unconscious for like three weeks and that we couldn’t talk about anything... and I seemed to cope with it. (..) now, I can sort of see these things happening, and I can sort of see a future for myself.”

“Therapy mainly helped me out a lot with just... just seeing all this stuff that I’ve got going in my life. I have negative things too, but, I have a lot of positive things so I can focus on them more”

Theme 4: Growing up in therapy

One of the aims of the present study was to investigate how these young clients in receipt of psychological treatment had made sense of their experience of therapy and the impact of this on their understanding of themselves and their lives. When exploring the meaning of therapy for the individuals interviewed, it became apparent that a number of them talked about the process of therapy as one of maturation and growth. The following section tries to summarise the key learning experiences and realisations described by most participants as particularly valuable.

4.1. *Becoming more understanding of others*

Some participants highlighted how the process of therapy had facilitated a deeper understanding of themselves, but especially of others around them. A tendency towards being self-involved and ego-centric, typical of this age group (Elkind, 1967), might explain why for some participants the recognition of becoming aware of other people's experiences and points of view was so important. There was a sense that therapy facilitated the development of mentalisation skills and a more reflective attitude towards life, which seemed to help participants begin to consider putting themselves in other people's shoes.

The following extract from Delia clearly exemplifies the development of this attitude:

"I think I'm more open... and... to... how would you put it?... I'm m... more... like, now I'm not so judgemental when I meet people, I know that, you know, everybody's got a life behind them. Sometimes I think to myself, you know, there'll be someone sitting on the bus, and I'd be thinking, I wonder what his life is like... And it's funny how, before I didn't care about anyone. Even though I thought I cared about everyone, I didn't care about anyone except for myself, like I was so selfish. But now, when I look at people, you know, when someone's having an argument on the bus, I tend to go deeper. I tend to, you know, try to think of... what would start that argument? It's probably something happened at home... you know... and then it's so deep and realise

that everyone does have their own life, and everybody has their own problems, everyone's having something different."

4.2. *Realising the importance of autonomy and of being "true to oneself"*

Despite recognising the external pressures they may come up against, most participants talked about their lives and their plans for the future as aiming towards becoming more congruent with their values and intrinsic interests, likes and dislikes. The following quotes by participants James, Laura and Delia, respectively, depict the significance played by the idea of "being true to oneself" in their views of a fulfilling life:

"I don't see everyone as the same, everyone's different. And therapy helped me to see that. I can't think, like what people want me to be and that, I'll have to be me, which is... different, everyone's different."

"I'd be happy if I could be in a place where I can express myself in these ways... errr a place where I can just be myself... you know.... I'll probably end up self employed, if I'm honest [laughs]. Because... errr... because... you know, having to tolerate people around me, you know, sometimes it doesn't really work. And I don't like being controlled... and I don't like being told what to do, etc.... so probably self employed somewhere along the lines... and just being me, being myself, and trying to be happy and just appreciate what's around me."

"Cuz you won't put in the determination, you won't give in the passion, you know, if you don't enjoy something... if I become a Maths teacher [laughs] I guarantee you, everyone would fail in the class. You know, but if I became an English teacher I can guarantee every pupil in the class would pass, because you have to have that, that edge to wanna do it."

Related to the need to be "true to oneself", some participants stressed the importance of being autonomous in their thinking and making their own decisions regardless of other people's pressures. From the life accounts shared by some participants, it is likely that their early experiences of being expected to care for themselves too soon might explain their becoming too self-reliant in an attempt to compensate for the lack of

assistance from responsible adults. The following quote by Delia illustrates this point especially well:

“you’ll never learn to be independent, cuz if you rely on someone a lot, how will you get their life? You know, life is really curious... you might wake up one day, and that person might not be there anymore. What are you gonna do? Who you’re gonna be? I always learnt like... to depend... now to depend on people but, I will never fully fully depend on someone, because I know that, it’s my life, and everybody needs to have their own life. (...) Cuz I don’t believe in someone sorting out your life. You’ve got to sort out your life the way you want. Cuz only you know what you want.

Delia describes how she has been brought up to “depend” on others. She goes on to say that this is something that she has rebelled against. She highlights the risk she perceives in the over-reliance on others, expressing both a degree of mistrust in the availability of others and an appreciation for the ownership of her life and self-coherence.

Despite some participants describing the concept of “being true to oneself” as fundamental to their life satisfaction and well-being, others seemed to display a degree of ambivalence between the desire to remain authentically engaged in life (and its enjoyment), and becoming more independent, and therefore more “responsible” and “adult like”. This point is clearly argued by James in the following quote:

“I may be at work and I have to be responsible and stuff...but, yeah I can go and climb, and roll around in the dirt and be a child as well, I don’t have to grow up yet... because they respect me, and pay me, ... and... they’re just nice people generally and I’m already quite close to them... even a member of staff would speak me up now”

It is possible that, given the specific age group of the interviewees, most of them were in a transitional phase between becoming fully independent as they approached adulthood and remaining dependent on others. This life task might pose a serious conflict on how to best manage these two apparently opposing needs: the need for autonomy and

independence; and the need for enjoyment and immediacy, as described by James in the last quote.

In fact, the conflict between moving from being dependent to becoming independent was also conveyed by Francesca, who described the experience as a mixture of intense feelings of achievement and fear at moving to a new flat by herself, after being discharged from hospital, where she had been looked after by the nursing staff:

“I think it was getting myself there and actually staying there. Like I had my keys, but I wouldn’t stay there. You know, I was used to be like in a hospital full of people, or to a house full of stuff and obviously a housemate. And then to go from all of that to a house on your own, with nobody there, with nobody to tell you “oh you didn’t have your medication..” blah blah blah... it’s all down to you... it was quite daunting. (...) I don’t know, I was quite proud of myself for doing it. But I was also feeling... like... I don’t know, I am still trying to get used to it now”

For Paula, the satisfaction and the sense of achievement that she derived from her improvement in therapy also seemed to be experienced with a degree of apprehension about becoming fully independent and “grown up”. In the following extract she expresses these conflicting feelings in relation to ending therapy and trying out her newly acquired skills in the real world:

“It’s like you’ve made it [in therapy], didn’t you? It’s like you’ve done everything that you had to do... and it’s like, now it’s time to sort of like... go out... and do things for yourself. (...) [it felt] Exciting and scary... and worrying... but exciting. It’s quite frustrating really, cuz it’s really hard to find a job. But you feel really grown up as well.”

It seems that since therapy, these individuals have become increasingly motivated to resolve the conflicting developmental tasks typical of adolescence, i.e. achieving independence and autonomy. For example, Francesca talked about feeling both “proud” and “daunted” by the prospect of being alone in his new flat and look after herself without anyone’s help. Paula also seemed to become aware of an impending task that followed her

improvement in therapy (“now it’s time to sort of like go out and do things for yourself”), hinting at the next stage of her life as one of emancipation and self-sufficiency (expressed in “do things for yourself”) . She seems to treasure the prospect of being independent, and getting a job, whilst feeling “scared” at the obstacles she may come up against. So it is possible that therapy may have facilitated this drive towards independence, which might have been somewhat impaired by the overwhelming paranoia and self-loathing feelings that they experienced prior to therapy.

4.3. *Aspiring to be an agent of positive change*

Interestingly, when asked to give a balance of their experience of therapy and of how it might influence their lives hereafter, a number of participants talked about wishing to give something back to society in return for the help and support they received in therapy.

For example, in the following quote, Delia talks about wanting to inspire and influence others through her spoken poetry:

“ I wanna be an inspiration, and I wanna be a writer, I wanna... affect people by my words not by my actions. I wanna to be able to stand there and speak to them and then they turn to me and say “you’ve just changed my life, you changed my perspective on whatever you’re talking about.”

James’s aspiration in divulging the Parkour philosophy (which he describes as in keeping with the adaptability and positive self-belief attitude he developed in therapy) to as many people as possible is another good example of wanting to be an agent of positive change to other people’s lives:

“I want to get the message out to loads of people (...) and the rest of stuff is like as if it’s coming into it every day. And like, I’d love to go and then you’d be able to see, like, everyone, everyone would learn in. It should be a sport that, I don’t want it to become mainstream, but I wanted it to be happening outside and stuff, but, unless it’s like happening as part of school a week, it would be amazing for everyone”

It is fair to say that from these young participants' accounts, their experience of therapy resembles a metamorphosis, where they seem to have grown in emancipation, stamina and self-coherence. The apparent improvement in their well-being that they talk about was not without its challenges and uncertainties, which seemed to have made the whole process all the more gratifying.

DISCUSSION

Overall, the most pervasive and compounding theme derived in the present study was perhaps the participants' experienced mistrust. It was striking how all the participants interviewed reported, at least as they came into contact with services, a considerable degree of suspicion and scepticism regarding therapy, the therapist and others in general. This theme of suspicion seems especially relevant when considering the specific problems that these young clients brought into therapy, namely social anxiety, paranoia and suicidal ideation. It is possible that this very sense of mistrust and of fearing full engagement with their surroundings is precisely at the root of these individuals' life difficulties. The pervasive mistrust could also be a defining characteristic of these young people, who when approached for a "treatment" which they know very little about, by seemingly older, more powerful, more knowledgeable and potentially patronising mental health staff, respond with reluctance and suspicion. This is precisely what Laura refers to when she describes in a rather poignant manner her previous unhelpful encounters with mental health services.

Perhaps related to this sense of ambivalence and scepticism described by the participants, is their view of psychological therapy and psychological difficulties as shameful and stigmatising. In fact, numerous studies have found stigma to be associated

with a decrease in mental health service use in general (Motjabai, Olfson, Mechanic, 2002; Sirey, Bruce, Alexopoulos et al., 2001), and especially amongst adolescents (Rickwood, Deane and Wilson, 2007). This negative portrayal of individuals who suffer from a mental illness is very much in keeping with, and perhaps simply a reflection of, stereotypical views, which have been found to be persistently present in western society (Arboleda-Florez, 2005). Interestingly, despite this negative first impression of talking therapy and mental illnesses, all participants remained engaged in therapy and, in fact, seemed to make good use of it.

Another pattern that stood out from close examination of the participants' narratives was a tendency towards disregarding their emotional experiences, and to focus their attention on body sensations. For example, Delia, Paula and Laura all talked about being surprised at their GP's suggestion to be seen by a therapist. This way of relating to one's internal experiences as originating from physical or biological causes is particularly curious, given that most participants actually admitted to experiencing a clear degree of psychological and emotional difficulty as they entered therapy. A more biological account of one's problems is likely to be experienced as external, and therefore less self-damning (Crittenden, 2005). Associated with this tendency towards endorsing a more biological account for their emotional difficulties, there was also a sense that these individuals preferred to talk about and to relate to these experiences in concrete terms. The way in which several participants described their problems as a combination of physiological symptoms and the resulting detrimental impact on their lives is a good example of such concrete thinking patterns. Furthermore, some participants seemed a little thrown by questions regarding meaning and process, often giving single word answers to these questions. For example, Joanna reported that "[the therapist] made me feel about me

differently. I don't dislike myself as much as I did"; but when asked to describe how the therapist did that, she replied "God knows!". As a result, some of the accounts derived from the interviews were poor in symbolism and on in-depth meaning, but rather rich in factual accounts of experiences.

The other major theme referred to being "opened up" to the world and to trying new, challenging and rewarding things, which seemed to boost their confidence and hope for a brighter future. From the examination of this theme, a further pattern could be observed in that, prior to therapy, some participants seemed to default to using protective strategies, such as social isolation, avoidance of talking to others about problems, over self-reliance and substance misuse. From the participants' reports, these strategies seemed to have been learnt as a way of alleviating some of the intense distress they experienced, at least in the short-term. However, it is likely that these strategies were actually perpetuating these individuals' mental health difficulties (Melo and Bental, 2010; Morrison et al., 2004), which according to the participants' accounts, therapy seemed to have successfully begun to revert. Given the age group of these participants, it is reasonable to imagine that most of them were experiencing a conflict between their negative views of the world as a dangerous and menacing place, with the resulting fears of being let down by others, and their innermost need for what Erikson (1980) referred to as "psychosocial reciprocity". According to Erikson (1980), adolescents form their identity via the recognition and validation of a peer group. However, in the case of a large number of the participants interviewed, there seemed to have been a deliberate attempt to remove oneself from the close scrutiny of others, for fear of being rejected or let down by them. As a result these individuals described how they felt increasingly low in mood and in self-esteem prior to being "opened up" to the social world and to its novelty and many opportunities.

One cannot but wonder about the circumstances which might have led these young individuals to adopt such stringent interpersonal rules, which prevented them from benefiting from the social world they lived in. The accounts that the participants gave of their early life experiences seem to suggest a degree of emotional and physical neglect experienced by some, which they had had to adjust to since childhood. Other participants' history and case notes were laden with reports of physical or sexual abuse. It is no wonder that trusting others was such a major challenge for these young participants.

Conversely, according to the participants' narratives, the development of trust in therapy seemed to have been a crucial experience for most participants. Several of them went on to talk about how it also helped them to learn about the benefits of establishing a close connection with others outside therapy. In other words, therapy might therefore have facilitated the recognition of the importance of satisfying the fundamental psychological need of 'relatedness' (Deci and Ryan, 2000). All in all, the establishment of trust appeared to have been an integral part of therapy, regardless of the therapeutic approach employed by the therapist. In fact, there is very little reflection in the narratives on the details of the therapy itself.

A number of participants highlighted the importance of being true to oneself, following therapy. There was a sense that "opening up" to new experiences, including to being in closer contact with others, might have actually led individuals to experience the fulfilling feeling of being accepted and valued by others for how they truly are. In fact, Erikson (1980) talks about a similar concept developed in adolescence, which he referred to as "fidelity". According to Erikson, adolescents will search for what is truly important in their lives, which will help them identify what to dedicate their lives to in a meaningful way. Related to the idea of the pursuit of goals and actions which are "true to ourselves" is

perhaps the SDT suggestion of the importance of satisfying one's fundamental psychological needs of 'competency' (i.e. engaging in activities which are in line with one's abilities) and "autonomy" (i.e. engaging in activities which are consistent with one's values and beliefs), which are said to be conducive to well-being and better life satisfaction (Deci and Ryan, 2000; Ryan, 1995; Sheldon et al., 2001). The SDT authors suggest further that the endorsement of intrinsic goals, such as contributing to the community or to self-development (which are in keeping with one's values and interests), as opposed to materialistic or externally contingent goals, is also associated with well-being (Deci, Koestner and Ryan, 1999), and with an increased likelihood of persistently pursuing and therefore achieving such goals (Sheldon and Elliott, 1999). Related to this is the final sub-theme extracted in the analysis of aspiring to give to others and/or influencing others positively, which most of the participants seem to share, following therapy. Perhaps becoming less affected by their mental health difficulties (as seemed to have been the case for all the participants interviewed) actually allowed individuals to become more self-aware and to fine-tune their goal setting abilities towards more rewarding life aspirations.

Limitations

The present study made use of a purposive sample, which has its drawbacks. More specifically, all participants seemed to have had a generally positive experience of therapy and of mental health services. This might suggest that the accounts presented here are somewhat skewed, as they refer to individuals for whom the service and therapy were overall perceived as helpful and meaningful. It would have been interesting perhaps to have interviewed other participants whose experience of therapy might have been less rosy. Moreover, all of the participants taking part in the study were still in receipt of

therapy at the time of being interviewed. Despite the assurances provided by the author on the absolute confidentiality of the information disclosed, participants might have felt compelled to give a reasonably positive account of their therapists and of their experience of services for fear of repercussions.

Some participants struggled to give more in-depth accounts of their experiences of therapy, describing therapy in more general terms, which is not uncommon (Rodgers, 2002). One option might have been to use material from a recent session, in order to prompt a more focused reflection on the participants' part.

Clinical implications

As we have seen, in order for these young people to do well in therapy, they needed to learn to trust the therapist and to use therapy as an opportunity to “release” their feelings, whilst making sense of their experiences in more helpful ways. It was striking how a number of participants entered therapy feeling guilty and ashamed, and holding very critical views of themselves. Interestingly, for these same individuals, therapy seemed to have allowed them to build a whole new image of themselves and to relate to their difficulties in a more compassionate and understanding way. This process of re-scripting one's self-image seems to have been slowly acquired via the close contact with an understanding, validating and reliable other (the therapist). These findings are in keeping with some therapeutic theories, which highlight the importance of the development of self-compassion (Gilbert, 2010) and the reparative nature of being met with “unconditional positive regard” by another (Rogers, 1961).

The testimonies of the young clients interviewed in the present study seem to suggest that the therapists from these services are rightly paying closer attention to the

establishment and maintenance of trust throughout therapy. According to the participants' reporting, this seems to have been best achieved when the therapists presented themselves in a humane, neutral, curious and non-judgemental manner, whilst skilfully stirring up the sessions in a given direction which helped participants to reflect and arrive at clearer understandings of their difficulties. Perhaps the deliberate use of psychological formulation driven interventions by the therapists in these services contributes to these experiences. The therapists in these services seem also to be striking the right balance between respecting the clients' autonomy and providing the required consistency and perseverance, which a number of participants reported as being beneficial to their successful engagement in therapy.

Despite arriving into therapy with little idea about the psychological nature of their problems, as they approached the end of therapy, these young clients reported that they benefited greatly from it. More specifically, participants gave consistent accounts of how they developed in self-awareness, confidence and trust in others over time. All of this seemed to have taken place as individuals became more engaged with the outside world; a process that seemed to occur alongside a decrease in the symptoms that had originally brought them to therapy. The present study therefore highlighted that, from the perspective of these young people, being in therapy facilitated the development of much more than the simple relieving of symptoms.

It would be interesting to follow these participants into adulthood, and explore the extent to which this early experience of therapy might continue to influence their life's decisions, subsequent experiences and overall well-being.

This is the first phenomenological study to investigate, from these young clients' perspective, the impact that talking therapy might have on their lives and sense of self. In

the current financial climate, more qualitative research studies such as this are needed in order to evaluate the acceptability and meaningfulness of existing treatments as they are applied to new populations, and to illuminate our understanding of the mechanisms of change (Elliott, 2008; Rodgers, 2002). This would help further the limited knowledge in this clinical field and would hopefully guide best practice decisions being made by both commissioners and clinicians.

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PUBLIC DOMAIN BREIFING

The present paper is a summary of a literature review and a research paper carried out by Sara Melo as part of her Doctorate in Clinical Psychology at the University of Birmingham. It was supervised by Dr Michael Larkin and Dr Amanda Skeate. NHS Ethical approval was received by the West Midlands Ethics Committee and Research Governance approval was granted by the local NHS Trust's Research and Development committee.

LITERATURE REVIEW

Background

There has been a growing tendency for clinical psychologists to be required to justify the treatment choices they make. Narrower diagnostic specific evidence-based treatments have therefore been favoured over other perhaps less well researched treatment approaches. As a result of the on-going political agenda, the available psychological treatments tend to have a greater focus on changing target behaviours or symptoms, as opposed to developing a greater understanding of holistic theories with a particular focus on change processes. By contrast, it has been proposed that the Self Determination Theory (SDT; Deci and Ryan, 2000), because of its empirically derived principles, may be a helpful framework to inform the practice of different psychological treatments. The present conceptual review therefore attempts to investigate the existing empirical evidence on the application of SDT to the psychological treatment of individuals with mental health difficulties. It also aims to explore how SDT is depicted in the peer review literature by the different

psychotherapeutic schools, and whether there are common overarching principles that might inform clinicians, regardless of their framework.

Summary of findings

Twenty articles were retrieved in the literature search. Three articles explore SDT premises, the evidence supporting them, and their implications for psychotherapy and counselling. Six papers refer to empirical studies examining whether SDT premises are associated with better clinical outcomes in different contexts. Three papers describe case-studies where SDT premises were applied to a variety of psychological treatments in different contexts. Five papers have a more theoretical focus, describing how different psychotherapeutic models and specific approaches might relate to and benefit from integration with SDT premises. Two reaction papers to a given paper relating SDT to therapy were identified, along with a single paper published in response to the former papers, all of which provide a critical analysis of the integration of motivation within the sphere of psychotherapy and counselling.

Drawing from the SDT, most of the opinion papers focus on the fostering of client's autonomy in therapy and on the importance of increasing the awareness of personal goals, whether this is indirectly (by engendering hope and a sense of agency in clients) or directly (by actively setting goals for therapy which are not just focused on the reduction of symptoms). However, the empirical studies which tested the SDT premises seemed to pay especial attention to the impact of the clients' perceived satisfaction of autonomy, neglecting the investigation of other important aspects of the theory (e.g. fundamental psychological needs).

Discussion

From the empirical papers reviewed some clinical implications can be drawn. There seems to be a possible link between perceived autonomy in therapy and symptom improvement and well-being. In fact, the effect of perceived autonomy was found to be even stronger than that of the therapeutic alliance, at least in less chronic cases of depression. In addition, the endorsement of intrinsic goals in therapy may be associated with a reduction in anxiety as predicted by SDT, but surprisingly not in depression. Being aware of one's feelings in the present via the regular practice of mindfulness meditation might also reduce the experience of anxiety, at least in mild cases. Finally, other evidence-based therapeutic interventions (e.g. CBT, Motivational Interviewing and Person-centred therapy) may be more effective in the clients' engagement and treatment when integrated with some of the SDT premises as previously described.

RESEARCH PAPER

The present paper describes a qualitative study examining the experiences of seven young clients with severe mental health difficulties who have undergone psychological therapy.

Aims

The study explores to what extent psychological treatment influenced the self-views, the future expectations and the well-being of these young individuals.

Participants

Seven young service-users of two innovative psychologically informed mental health services in the West Midlands took part in the study. Suitable participants were identified

by their care-coordinators, who provided them with an information sheet and received their informal consent for partaking in the study. Participants were then approached by the author and given more information about the study, after which their written consent was sought.

Method

Participants were interviewed using a semi-structured questionnaire, focusing on their experiences of therapy, and on its impact on their self-views and beliefs about the future. The interviews were digitally recorded and transcribed in their entirety by the author.

Data analysis

The analyses of the transcribed interviews employed Interpretative Phenomenological Analysis. This methodology was chosen for the ease with which unconventional data can be retrieved, such as how young people make sense of their experiences of therapy. Through an iterative process of transcript analysis, four main themes and sub-themes were identified.

Results

Four over-arching themes were identified and are briefly described below.

‘The challenge of a psychological account’

Participants struggled to recognise their suffering as psychological, and tended to describe their experiences in more concrete terms (i.e. detailing symptoms and factual experiences), as opposed to elaborating on the underlying meaning of such lived accounts.

‘The ambivalence inherent in learning to trust the therapist’

A mistrust of the therapist and therapy itself was prevalent across all the narratives.

Related to this, participants talked about the stigma associated with mental health services.

Most of them started therapy with a profound disbelief either in its effectiveness, or in the genuine interest of the therapist in helping them. Some even described engaging in testing the therapist, in order to ascertain whether or not he or she was to be trusted. In spite of this initial negative expectation of therapy, over time therapy became a safer place where talking was perceived as easier and at times described as relieving. This seemed to be associated with recognising the therapist as non-judgemental, and with endorsing exaggerated concerns about disappointing or hurting others in their home environment.

‘Therapy as a process of *opening* oneself to new experiences, self-knowledge and to a more optimistic outlook on the future’

Therapy was described as a catalyst for trying new things, including extending the trust developed in therapy to others outside it. This process of opening oneself to the world seemed to be experienced as self-reinforcing and deeply healing, and helped these young participants build some resilience, optimism and hope for the future. In addition, the normalisation of their problems and the opportunity to develop a better understanding of themselves was also talked about by these participants as crucial aspects to their recovery.

‘Growing up in therapy’

A final theme of maturation and growth was described by several participants, who highlighted the importance of becoming more understanding of others whilst gaining a better understanding of themselves. Some of them also talked about coming to realise the

importance of pursuing their autonomy and of being “true to oneself” in order to maintain a felt sense of well-being. Other participants described that whilst being in therapy they had become aware of how they could make positive contributions to improve other people’s lives.

Clinical implications

From the close examination of the themes, it seems that these young participants needed to learn to trust the therapist and to use therapy as an opportunity to “release” their feelings, before being able to make sense of their experiences in more helpful ways. The process of re-scripting one’s self-image seems to have been slowly acquired via the close contact with an understanding, validating and reliable other (the therapist). All of this seemed to have taken place as individuals became more engaged with the outside world; a process that seemed to occur alongside a decrease in the symptoms that had originally brought them to therapy.

This study therefore highlighted, from the perspective of these young people, that being in therapy facilitated the development of a much more than the simple relieving of symptoms. More qualitative research studies such as this are needed in order to evaluate the acceptability and meaningfulness of existing treatments as they are applied to new populations, and to illuminate our understanding of the mechanisms of change.

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APPENDIX 1

Semi-Structured Interview Schedule

APPENDIX 2

Participant Table of Analysis (Delia's)

APPENDIX 3

In-between Participants Table of Analysis

APPENDIX 4

Delia's interview transcript

APPENDIX 5

Participant Information Sheet

APPENDIX 6

Participant Consent Form

APPENDIX 7

Instructions for Authors: Literature Review

APPENDIX 8

Instructions for Authors: Main Paper

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